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A SHORT OVERVIEW OF THE HEALTH CARE APPROACHES BEING DISCUSSED IN THE 2020 ELECTION: WHAT ARE THE DIFFERENCES? WHICH IS BETTER?

The US health care system is complicated and fragmented. It consists of a mix of public and private programs that cover most—but not all—of the population. According to the US Census, approximately two-thirds of the population is covered by private insurance (most commonly through their employer) and about one-third is covered through public programs.[1] In 2018 about 27.9 million people (about 10.4% of the non-elderly population) had no insurance coverage at all, an increase of nearly 500,000 people from 2017. Most uninsured people are in low-income families and have at least one worker in the family.[2] In addition, people of color are at higher risk of being uninsured than non-Hispanic whites. Census data estimate that 8% of people in Montgomery County are uninsured.

The US is unique in having no national health care system and no universal access, although some programs resemble components of a national system. For example, Medicare is a national program that covers people 65 years of age and older, as well as people with chronic kidney disease and other disabilities. Medicaid is a state-based program that is jointly funded with state and federal dollars. Each state determines who will be covered under its Medicaid program to include people with incomes below a certain threshold, some people in nursing homes and others. The Children's Health Insurance Program (CHIP) is also state-based and functions under federal rules. It insures children up to age 19 from families whose incomes are too high for Medicaid. Other programs operate at the federal level to cover special populations such as Native Americans, veterans and the military and are run by the Indian Health Service, Veterans Health Administration and the Department of Defense, respectively.

Although more than 90% of the *total* US population has some type of insurance coverage[3] and, as a country, we spend more than other developed countries on health care—16% of GDP—our health outcomes are mixed. For example, compared to other developed countries, the US has a lower life expectancy at birth, higher infant mortality rates and higher rates of hospitalization for unmanaged diabetes or asthma.[4] On the other hand, mortality rates after hospitalization for heart attacks and blood clots (ischemic strokes) are lower in the US and mortality due to breast, colorectal and cervical cancers is lower in the US than other developed countries.

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[1] https://www.census.gov/library/publications/2019/demo/p60-267.html.
[2] Jennifer Tolbert, Kendal Orgera, Natalie Singer, Anthony Damico, *Key Facts About the Uninsured Population,* Kaiser Family Foundation. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.
[3] US Census reports that 8.5% of the total population had no health insurance in 2018.
[4] *How Does the US Healthcare System Compare to Other Countries*, Peter G. Peterson Foundation, July 22, 2019. https://www.pgpf.org/blog/2019/07/how-does-the-us-healthcare-system-compare-to-other-countries.

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People voice many concerns with the current health care system. People who have insurance through their employers may feel locked into their jobs because changing jobs may mean losing insurance coverage or having to switch to a different insurer and find new doctors. People also express dissatisfaction with the affordability of health services because each year they may be paying thousands of dollars in premiums for themselves and their family. In addition, every contact with the system often requires some out-of-pocket spending for co-pays and deductibles.[5] Patients often do not know the total amount of what they owe until after the visit or procedure has been completed and the insurance has been processed. Surprise! If a patient sees a provider outside their approved network—which the patient can't always control—the surprise can be even bigger (this is known as "surprise medical bills"). People are also unhappy with the accessibility of services. Office hours are often inconvenient and require taking time off work or are not available during evenings and weekends. Finding a primary care provider who is taking new patients can be difficult, as can getting an appointment with a busy specialist. It sometimes seems like addressing even a single health issue can involve a variety of visits to doctors, hospitals, laboratories, radiology centers, rehabilitation facilities, drug stores and other places. Getting the necessary care and then understanding the subsequent bills, which arrive separately from each provider, can be confusing and exhausting.

At the end of the day there are many good things about the health care system in this country—including the dedicated providers who care deeply about their patients and do their best to navigate it—but the US health care system is difficult for both patients and the providers caring for them. It is no wonder people find dealing with the health care system frustrating and expensive!

WHAT ARE THE MOST COMMON HEALTH CARE APPROACHES TO REFORM THE SYSTEM?

Health care is a big issue in the 2020 election. One reason may be that the Trump administration has taken steps to change aspects of the Affordable Care Act (ACA). For example, people are no longer required to buy health insurance, which makes it difficult to reach a goal of universal coverage and forces people with insurance to subsidize the costs of care for people without insurance. Programs that helped people sign up for coverage at Healthcare.gov have lost funding, and access to "skinny" health plans—which are cheaper but cover fewer services—has been expanded. In addition, Democratic candidates running in 2020 have put forward various plans for addressing health care and have taken approaches that range from "tweaking" the current system to entirely eliminating parts of it. This background information is intended to provide some comparisons to stimulate discussion on the pros and cons of the various approaches and give you an opportunity to consider how we might build a better health care system.

[5] Co-pays are the amount paid by a patient for a visit. It might be a flat fee (such as $20) or a percentage (such as 20%). Deductibles are the amount paid by the patient before the insurance coverage kicks in. It is usually a flat fee and can be a few hundred dollars or a few thousand dollars.

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Below is a summary of the key approaches, although this is not a comprehensive analysis of them:

- Medicare For All: in general, this would replace the current health insurance system with universal Medicare coverage for all US citizens.
- Medicare Buy-In: in general, this would permit certain individuals with an opportunity to purchase Medicare coverage before they are otherwise eligible for Medicare (at age 65). It has sometimes been called "Medicare for All Who Want."
- Public Option: this would create a publicly administered health insurance plan that is offered for purchase on the ACA marketplace (the service available to people to shop for and enroll in an insurance plan).
- Build on the ACA: also known as Obamacare, this would include actions to increase financial assistance to people buying health plans on the ACA marketplace and to restore outreach efforts and other actions to maintain or expand insurance company participation.

HOW DO THE APPROACHES COMPARE?

As you discuss the various features of these approaches, consider the following:[6]

- Universal coverage can be achieved through a variety of public and private systems. It is not synonymous with single payer.
- Medicare is an example of a single payer system. Medicare pays the bills but the delivery system—such as hospitals, doctors and other providers—is private.
- Surveys show that people tend to be more concerned today with affordability than coverage. In 2016 the US spent 25% more per person than the next highest spending country, Switzerland. The New York Times reported that an M.R.I. costs $1,420 in the US but only $450 in Britain.[7] The higher spending is not due to greater use of services but rather because the prices for services are higher in the US.
- Most health care spending goes to hospitals and doctors; less is spent on pharmaceuticals. The Centers for Medicare & Medicaid Services (CMS) estimates that the largest categories of spending in 2018 were[8]:
    - 33% on hospitals ($1.2 trillion)
    - 20% on doctors ($725 billion)
    - 9% on retail prescription drugs ($335 billion)

[6] Adapted from Julie Rovner, "A Guide to Following the Health Debate in the 2020 Elections," *HealthBent*, Kaiser Health News, January 30, 2020. https://khn.org/news/a-guide-to-following-the-health-debate-in-the-2020-elections/.

[7] Margot Sanger-Katz, "In the US, an Angioplasty Cost $32,000. Elsewhere? Maybe $6,400," New York Times, December 27, 2019.

[8] CMS Office of the Actuary Releases 2018 National Health Expenditures, December 5, 2019, cms.gov.

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This table offers a side-by-side comparison of the options on selected features. Key elements of this are taken from a publication of the Center for Health & Research Transformation at the University of Michigan[9] and from a publication of Kaiser Family Foundation[10] and are based on multiple bills that were introduced in 2019. The information in any cell may not reflect a single bill but rather commonalities across several bills. Various features—such as age eligibility—can change as specific bills and approaches are discussed. Our own discussions may also suggest "tweaks" to some of the cells.

Selected Feature	**Medicare For All**	**Medicare Buy-In**	**Public Option**	**Build on the Affordable Care Act (ACA)**
Who might be affected?	All people in the US.	Depends on the proposal. Could include adults over 50 and/or people who have access to few plans in their area and/or small employers.	Individuals who are eligible to buy on the ACA marketplaces.[11]	Individuals who are eligible to buy on the ACA marketplaces.
What would be covered?	Benefits currently covered under Medicare, plus vision, dental, prescription drugs, long-term care and	Could include benefits currently covered under Medicare (Parts A, B & D) and/or essential health benefits.[12, 13]	Essential health benefits as defined under ACA.	Essential health benefits as defined under ACA.

[9] Center for Health & Research Transformation, University of Michigan. www.https://chrt.org/publication/comparing-recent-health-care-proposals-building-on-the-aca-to-medicare-for-all/.

[10] Kaiser Family Foundation, "Compare Medicare-For-All and Public Plan Proposals," May 15, 2019. http://files.kff.org/attachment/Table-Side-by-Side-Comparison-Medicare-for-all-Public-Plan-Proposals-116th-Congress .

[11] Marketplaces, also known as "exchanges," are a service that helps people shop for and enroll in insurance coverage from the plans available in their area under ACA. The service includes help in qualifying for premium subsidies as appropriate.

[12] In general, Part A covers inpatient care, Part B covers outpatient care and Part D covers prescriptions. Part A is supported through payroll deductions from working individuals (not the enrollees). Parts B & D are paid (in part) through premiums that the enrolled individual pays.

[13] Essential health benefits are the services that health insurance plans must cover to comply with ACA requirements if the plans are offered on exchanges. They include: (1) preventive and wellness care (including chronic disease management), (2) maternity and newborn care, (3) mental health and behavioral health

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Selected Feature	Medicare For All	Medicare Buy-In	Public Option	Build on the Affordable Care Act (ACA)
	reproductive health.			
What is the cost sharing?	No premiums or other cost sharing except for prescription drugs.	Enrollees pay premiums and out-of-pocket costs (to be determined). Cost sharing same as currently under Medicare. Could include subsidies as provided under ACA.	Enrollees pay 100% of premiums, plus cost sharing for out-of-pocket costs, which may be similar to cost sharing required under ACA plans. Could also include subsidies as under ACA.	Premium tax credits provided based on income. Cost sharing depends on the insurance plan selected by the enrollee.
How would providers be affected?	Federal government would create a fee-schedule for provider payments.	Providers who participate in Medicare would participate in the new buy-in program. Payment rates could be same as Medicare or vary.	Providers who participate in Medicare could choose to opt in or opt out of the public option.	A more stable ACA marketplace could help provider predictability in maintaining their patients and payers.
How is it financed?	Likely to require some type of tax increase. Current funding for Medicare, Medicaid, Tricare and ACA would transfer to a trust fund and those programs would cease to exist.	Enrollee premiums.	Enrollee premiums.	Unstated.

treatment, (4) services and devices to help people with injuries, disabilities, chronic conditions, (5) lab tests, (6) pediatric care, (7) prescription drugs, (8) outpatient care, (9) emergency room services and (10) hospitalization.

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WHAT MATTERS TO YOU?

1. Which approach(es) would be better for assuring universal coverage and managing costs?
    a. Should people be automatically enrolled or should they be able to opt out? If people can opt-out, universal coverage cannot be achieved. Should it be automatic for everyone or just certain populations (e.g., children)?
    b. Should people have a choice of plans? A single payer could set prices for services to control the costs of care (think of Medicare), but do people prefer to have more choices? Having lots of insurance plans is also a hassle for doctors and hospitals.
    c. Should people have co-pays when they visit a doctor or be responsible for a portion of the premium for health insurance? Some worry that people will delay needed care, especially the poor. Others believe co-pays help reduce unnecessary use of services.
    d. How comprehensive should covered services be? Other countries with public systems, such as Canada and Great Britain, allow people to buy private supplemental coverage like people here do for Medicare. Is that okay or does it make for a two-tiered system?
2. Which approach(es) would be easiest to implement?
3. Think about your own health care costs. Try to estimate how much you spend each year on:
    a. Premiums for health insurance.
    b. Premiums for long-term care.
    c. Out-of-pocket costs, such as co-pays to visit a doctor or get a prescription.
    d. Out-of-pocket costs for services that are not covered at all, such as long-term care, hearing aids, eyeglasses, home care, etc.
    e. Given an estimate of your own costs, which approach do you think would be best for you and your family?
4. If you were developing the “best” approach for the country, would you use one of these approaches or would you choose different elements from different approaches?

Thank you to LWVMC members John Triplett and Richard Guerin for their reviews and thoughtful comments on previous versions of this document.