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CONGRESSIONAL HEALTH POLICY EDUCATION PROGRAM

Health Policy Bootcamp

- **12:30pm — 1:30pm**: Private Health and Medicaid
- **1:35pm — 2:20pm**: Public Health and Well-Being
- **2:20pm — 3:10pm**: Medicare 101
- **3:15pm — 4:00pm**: How to be an effective health care staffer

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PRIVATE HEALTH AND MEDICAID 101

Brian Blase — President, Paragon Health Institute
Theo Merkel — Director, Private Health Initiative, Paragon Health Institute

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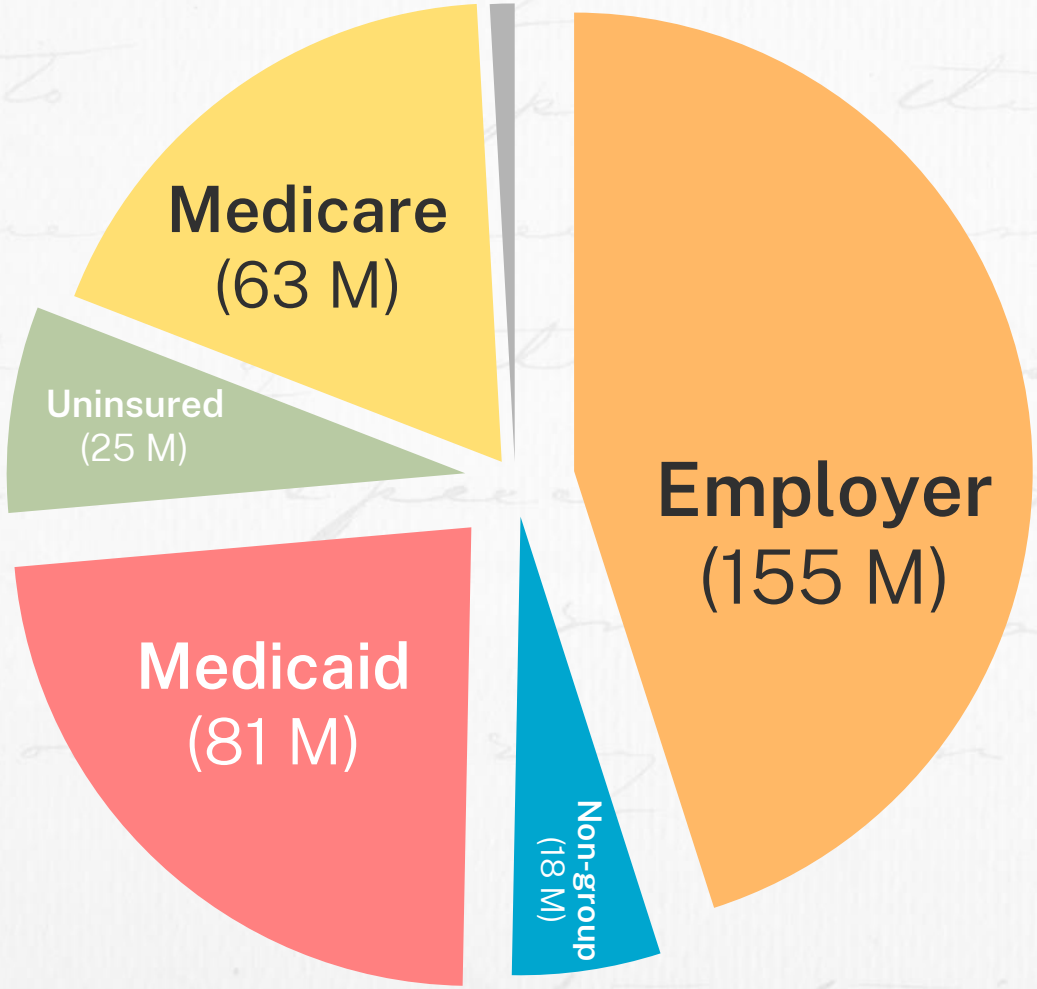
How do Americans get health coverage? (2022)



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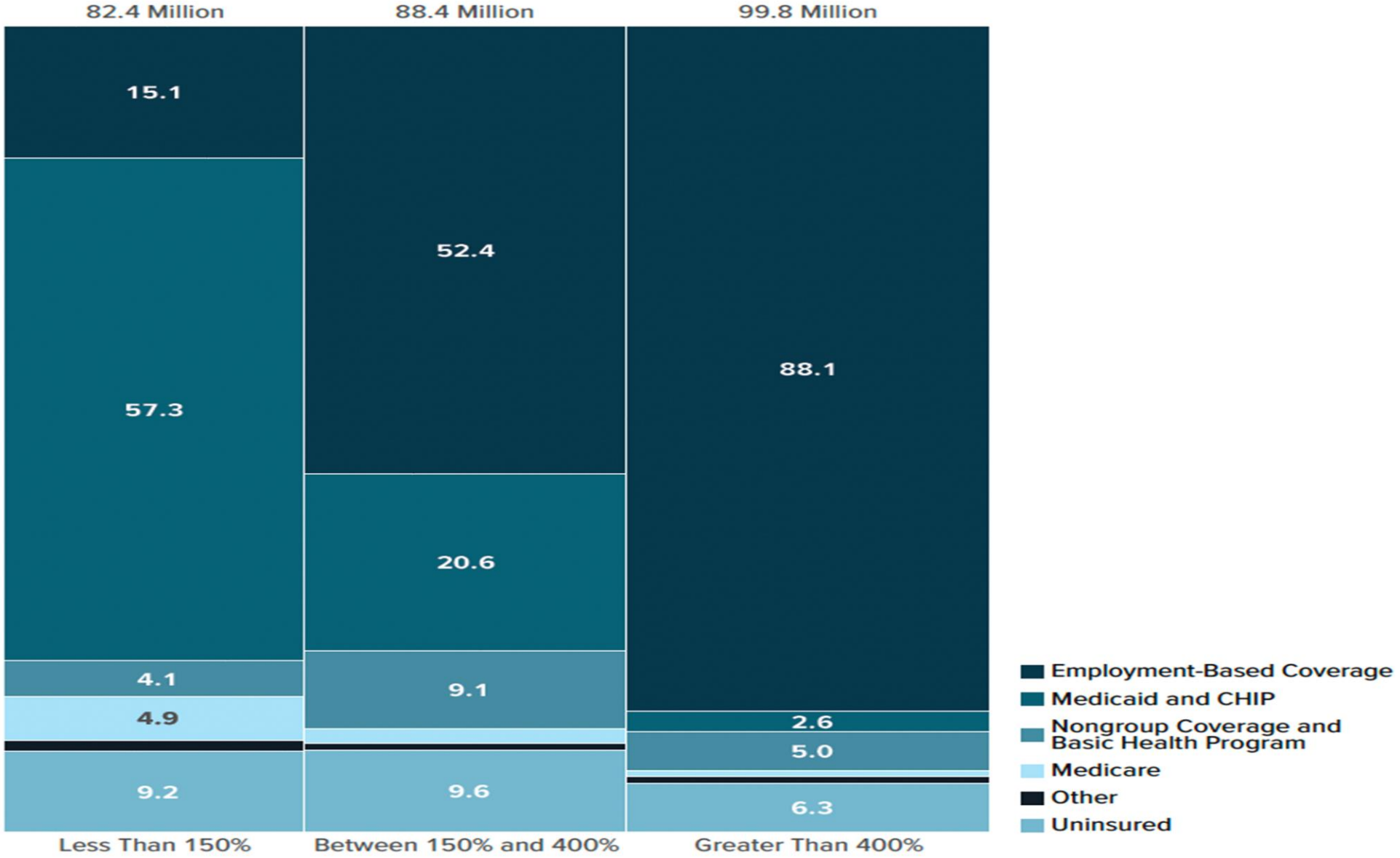
SOURCE: CBO

Health Insurance Coverage for People Under Age 65, by Type and Income, 2022

Millions of People



Source: Congressional Budget Office

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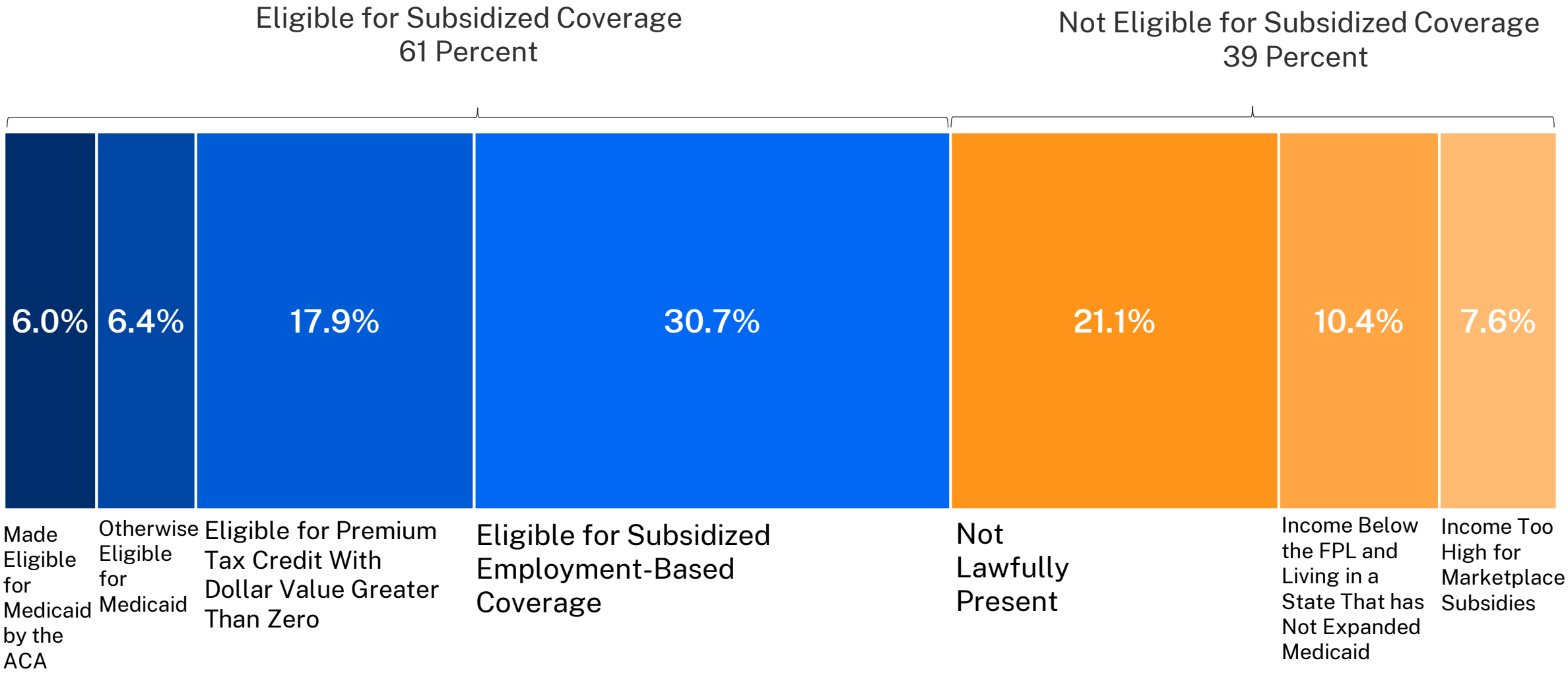
Eligibility and Subsidized Coverage Among the Uninsured in 2022



Source: Congressional Budget Office

Very Few Uninsured are Legal Residents & Lack a Way to Get Coverage

- 270 million people under the age of 65
- 245 million of them are insured
- Of the 25.1 million uninsured, 15.3 million are eligible for subsidized coverage & another 5.3 million are not lawfully present.
- That leaves 4.5 million uninsured who are lawfully present and lack a subsidized way to get coverage. This is 1.7% of the under-65 population.

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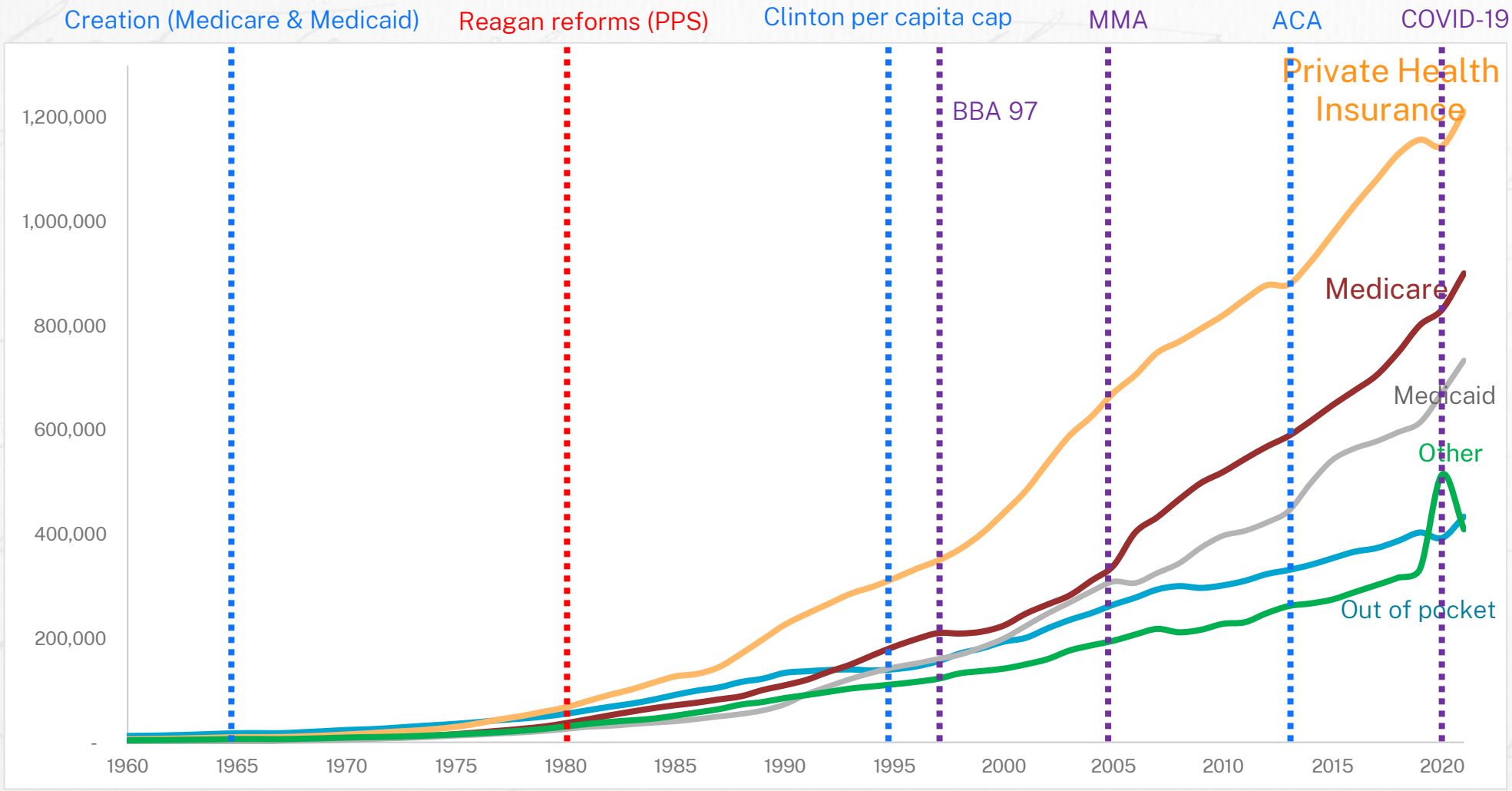
National Health Expenditures In Millions of Dollars



Source: National Health Expenditures Data

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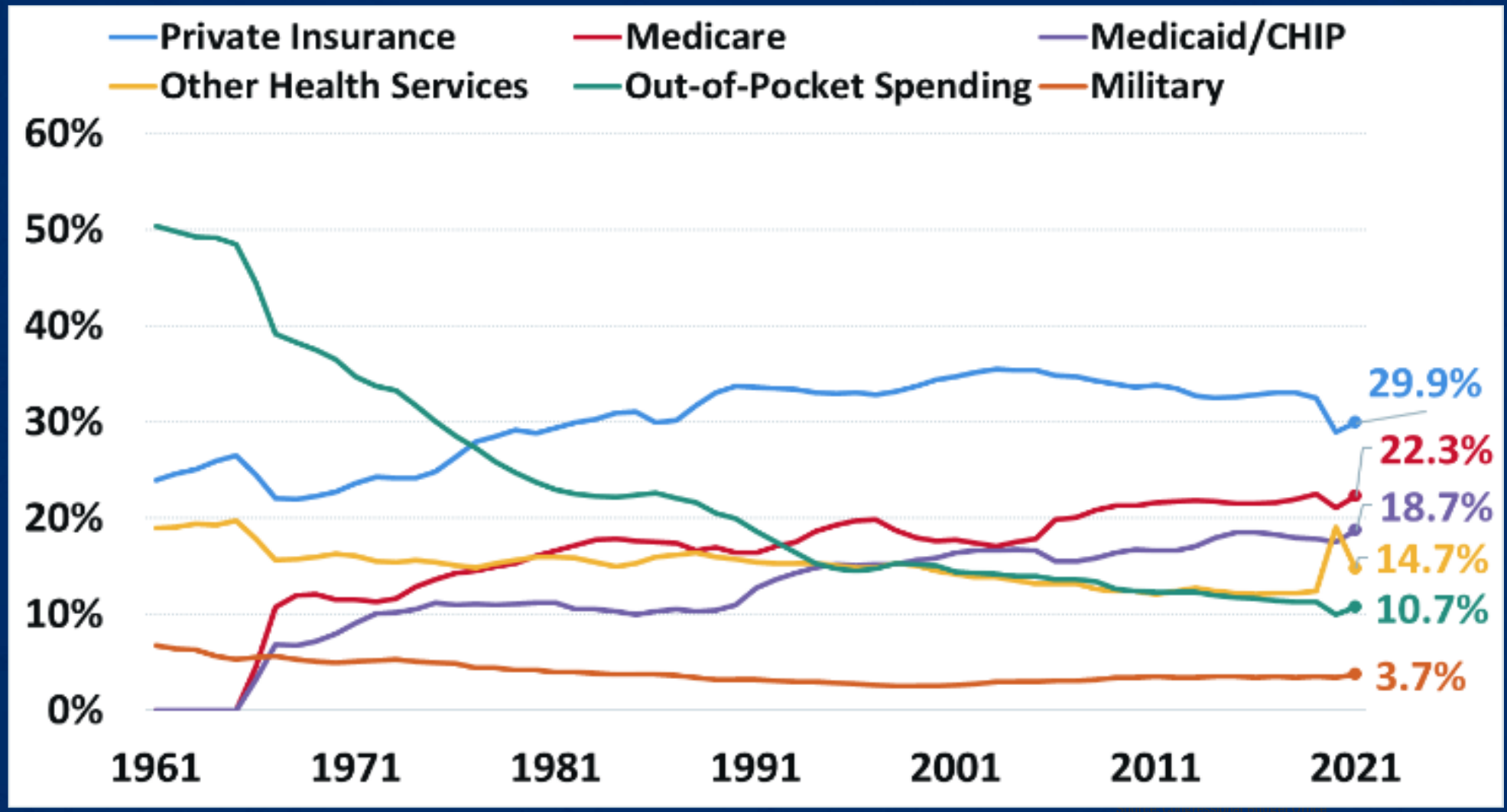
Health Consumption Expenditures (HCE) by Source as a Percentage of Total HCE, 1961-2021



Source: Centers for Medicare & Medicaid Services, National Health Expenditure Accounts — National Health Expenditures by Type of Service and Source of Funds, CY1960-2021, December 2022.

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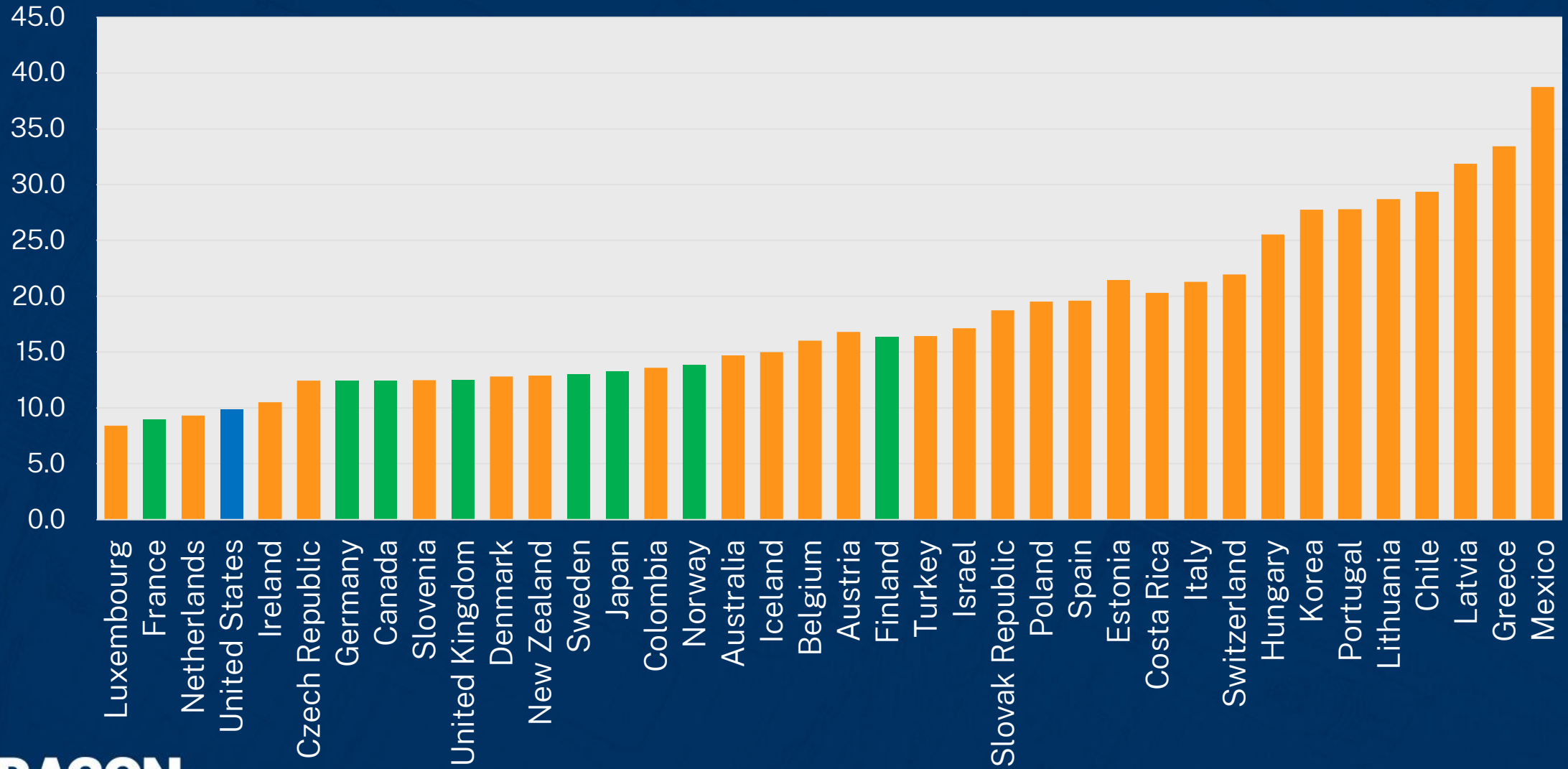
OECD: Out-of-pocket expenditure, % of total health spend



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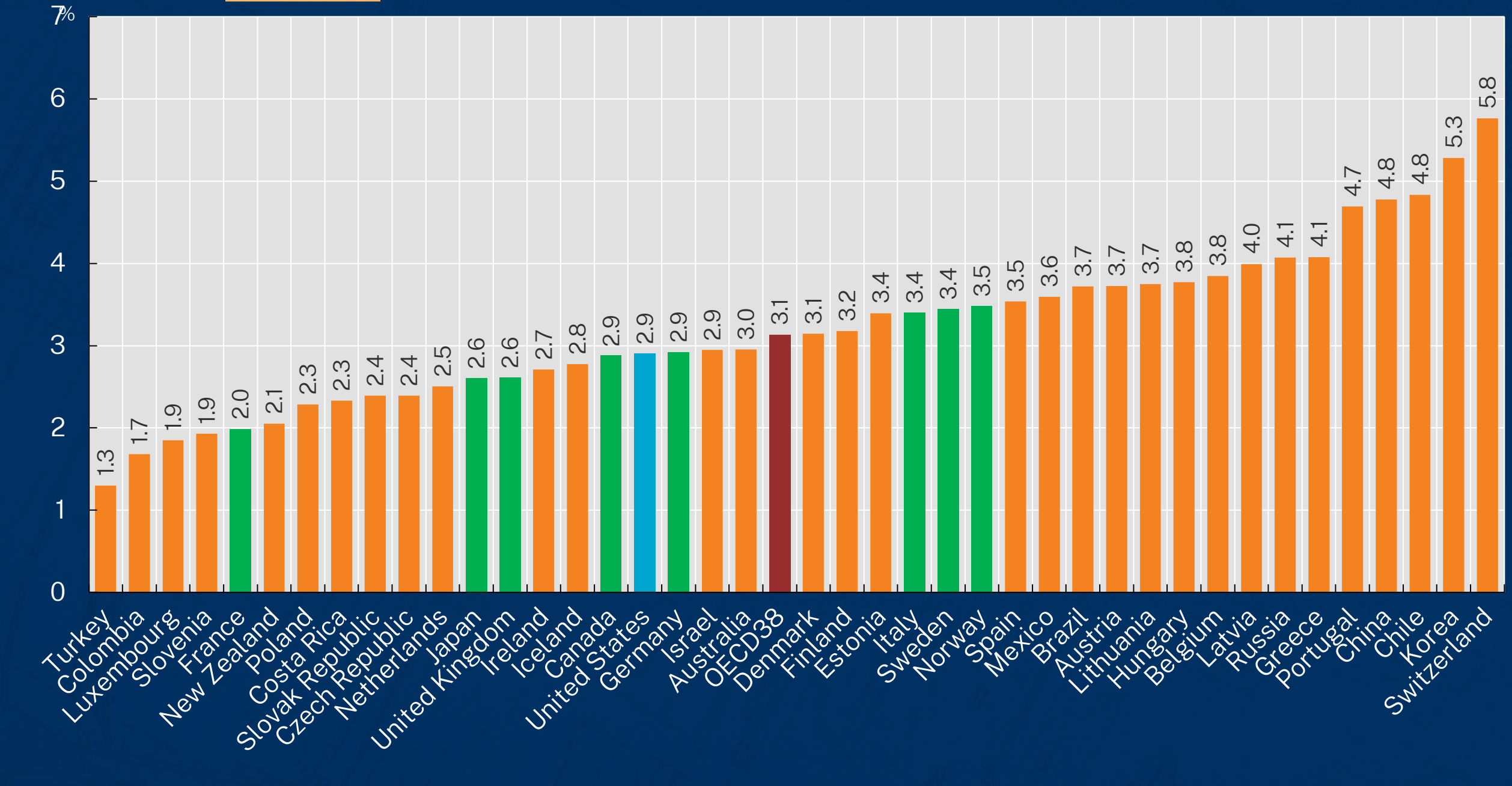
OECD: OOP spending as a share of final household consumptions, 2019



Employer sponsored insurance

- In 1954, the exclusion of ESI from income and payroll taxes was codified in the Internal Revenue Code. It is worth $312 bn in 2022 ($4.6 T over 10 yrs.)
- Economists agree that full cost is borne by workers through lower wages.
- Most large companies are self-insured and regulated by the Dept. of Labor under the Employee Retirement Income Security Act (ERISA) of 1974
- Most workers don't get an option of more than 3 plans.
- Workers tend to be spread out geographically, so employer plans tend to have wide provider networks.
- Prices paid by employer plans are much higher than Medicare rates.
- People value getting health insurance through work.
- Few negatives: job lock; lose your job, lose your health insurance.

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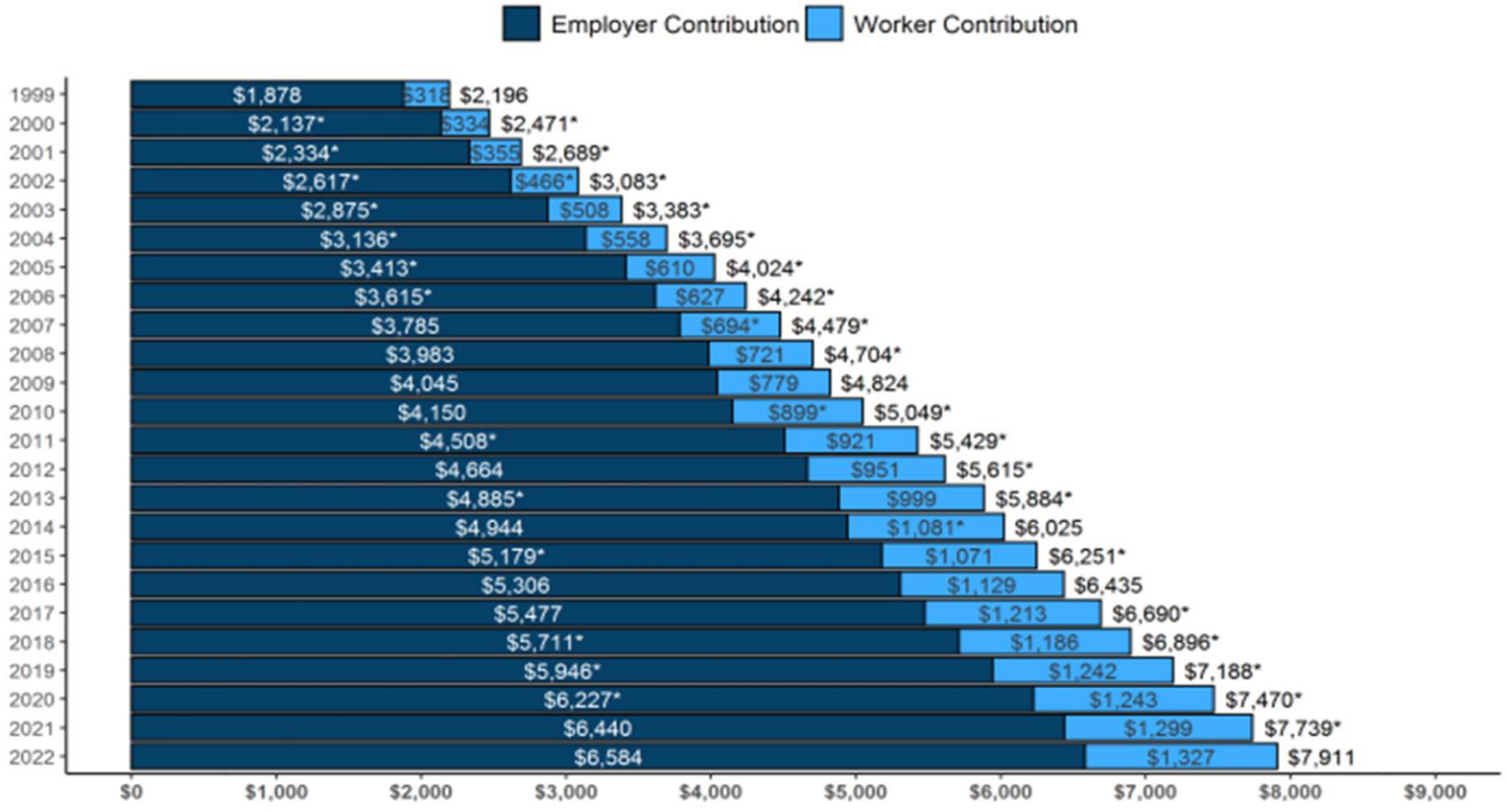
Figure 6.4
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single Coverage, 1999-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Premiums grew 260% versus a 63% general increase in the price level, or 4x as much.

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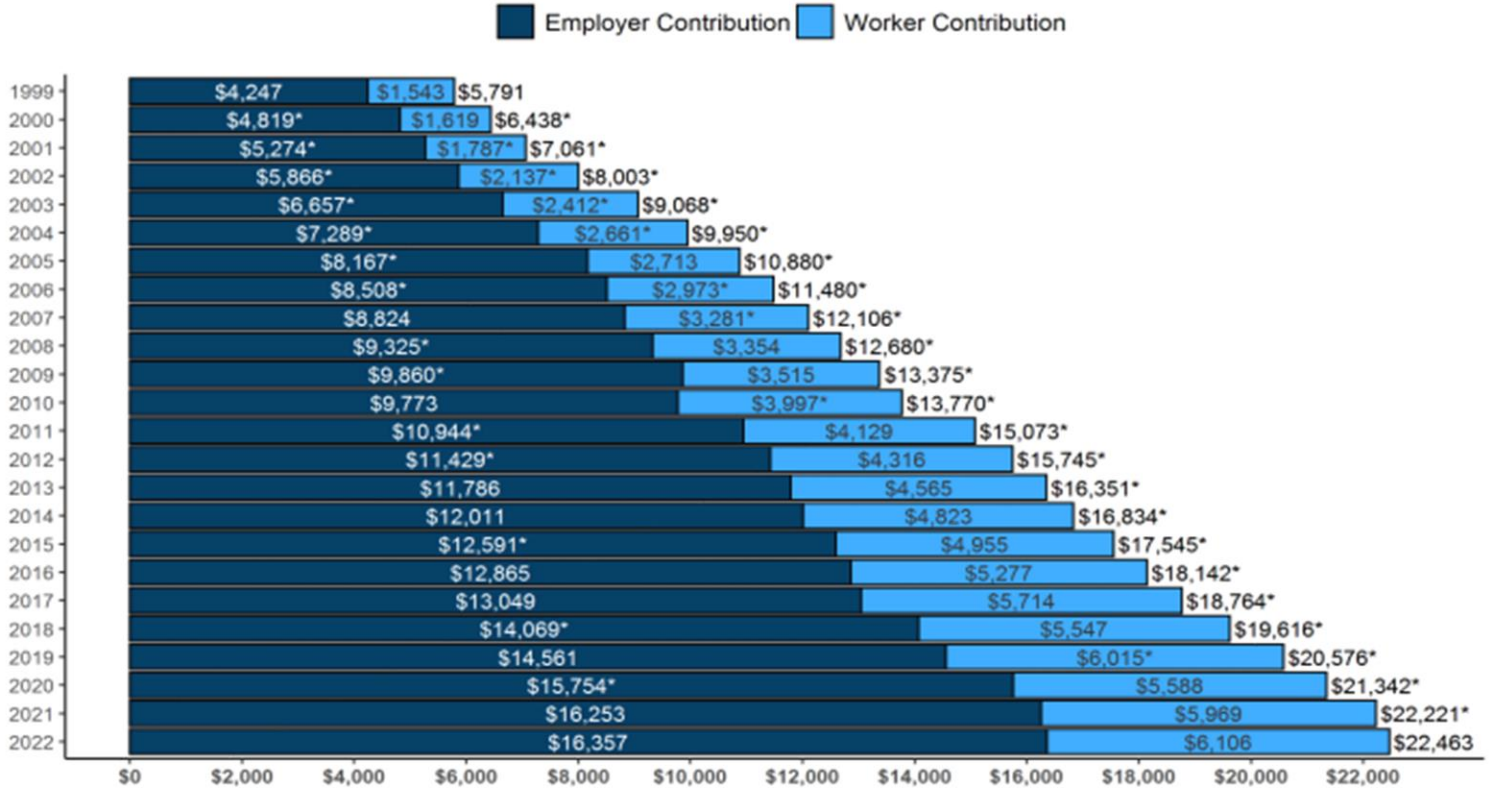
Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Premiums grew 288% versus a 63% general increase in the price level, or 4.5x as much.

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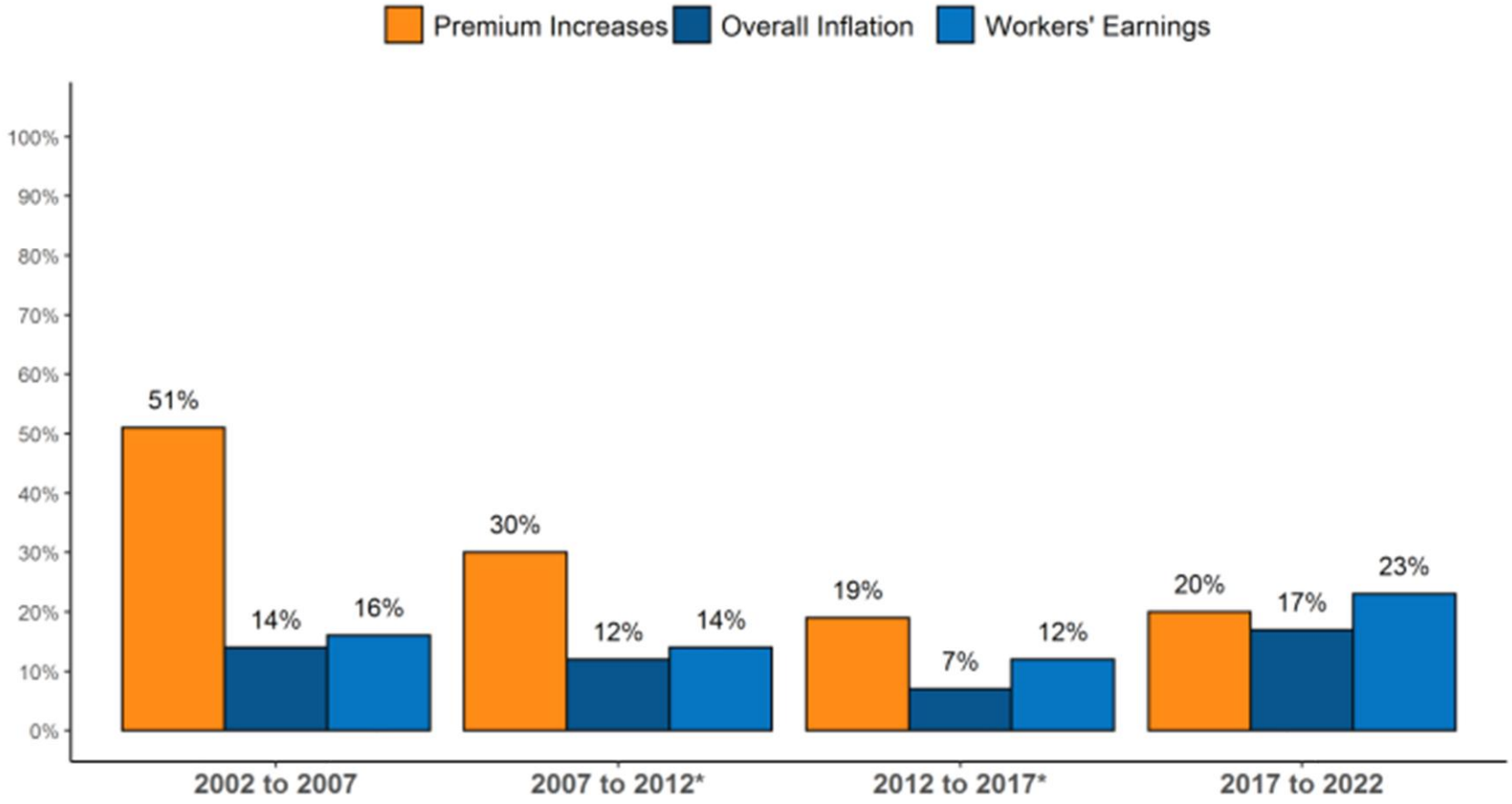
Figure 1.15

Cumulative Premium Increases, Inflation, and Earnings for Covered Workers with Family Coverage, 2002-2022



* Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2002-2022; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2002-2022.

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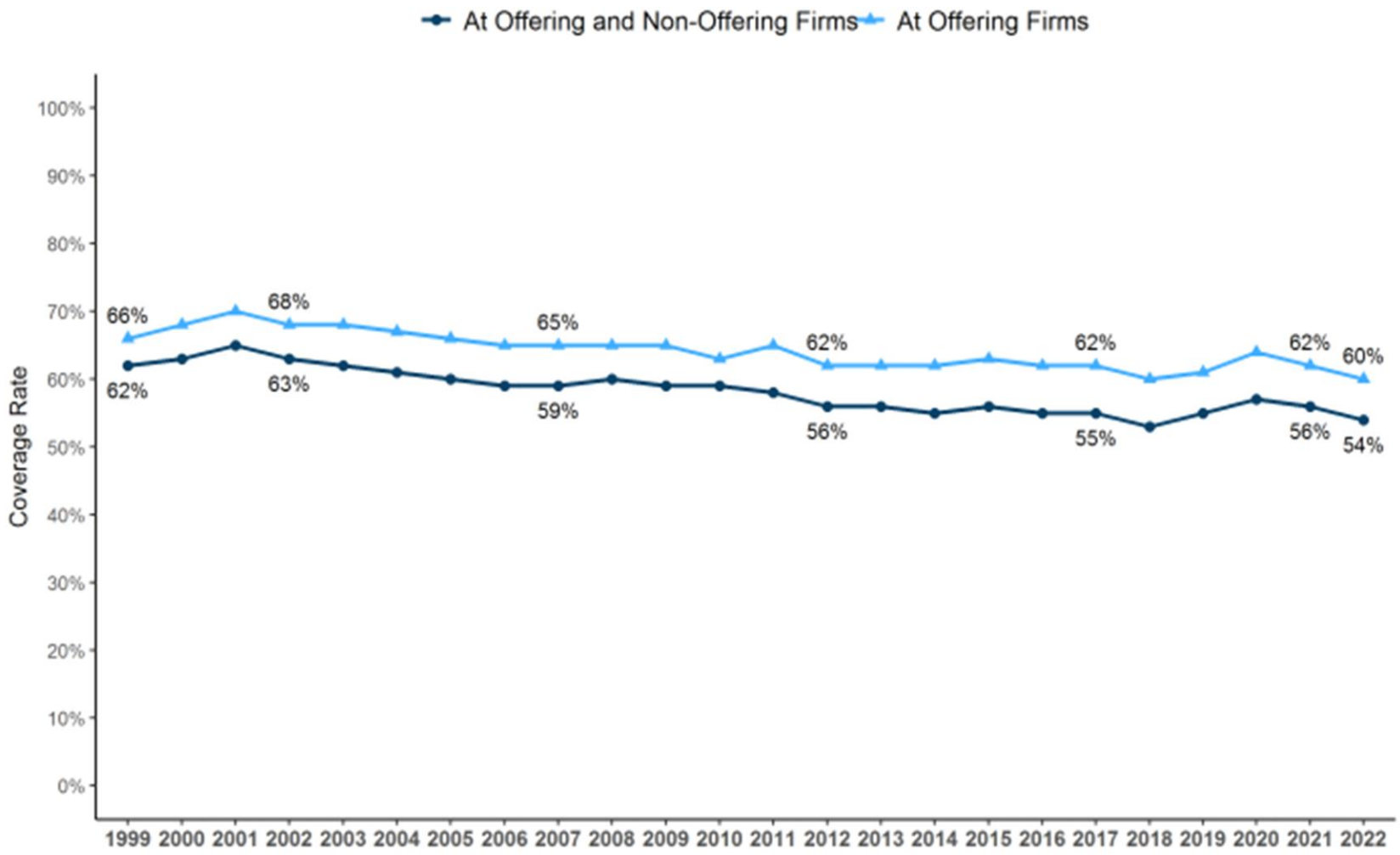
Figure 3.10

Percentage of Workers Covered by Their Firm's Health Benefits, 1999-2022



Tests found no statistical difference from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

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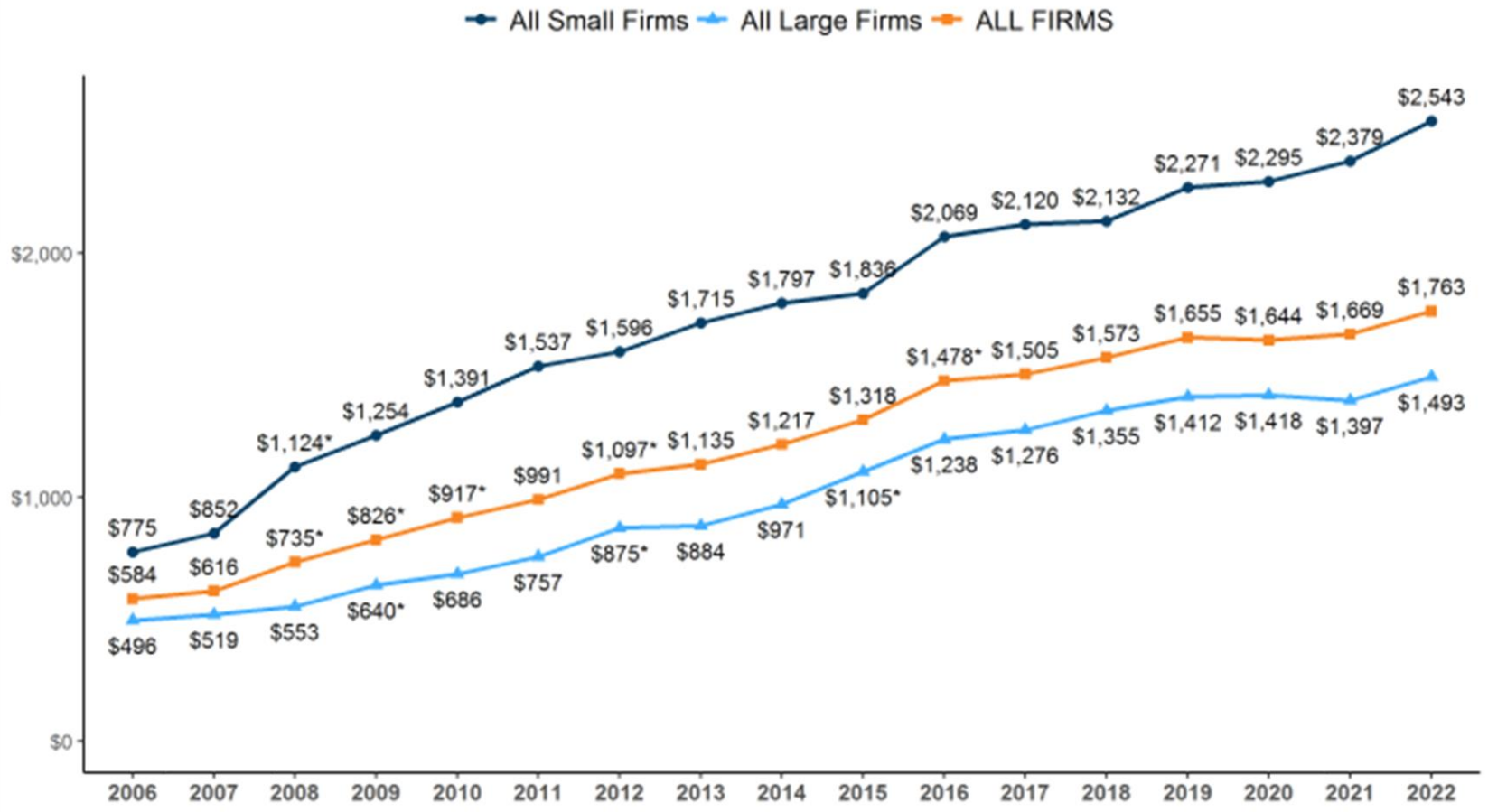
Figure 7.11

Among Covered Workers Who Face a Deductible for Single Coverage, Average General Annual Deductible for Single Coverage, by Firm Size, 2006-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

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Health savings accounts (HSAs)

- Controlled by the individual and stays with them over time and from employer to employer
- Must have a high deductible health plan (HDHP) or HSA-qualified plan to make contributions.
- Annual contribution limits ($3,850/$7,750)
- Must be used on any qualified medical expenses (IRS 213d list)
- Other accounts (HRAs & FSAs) are controlled by employers.

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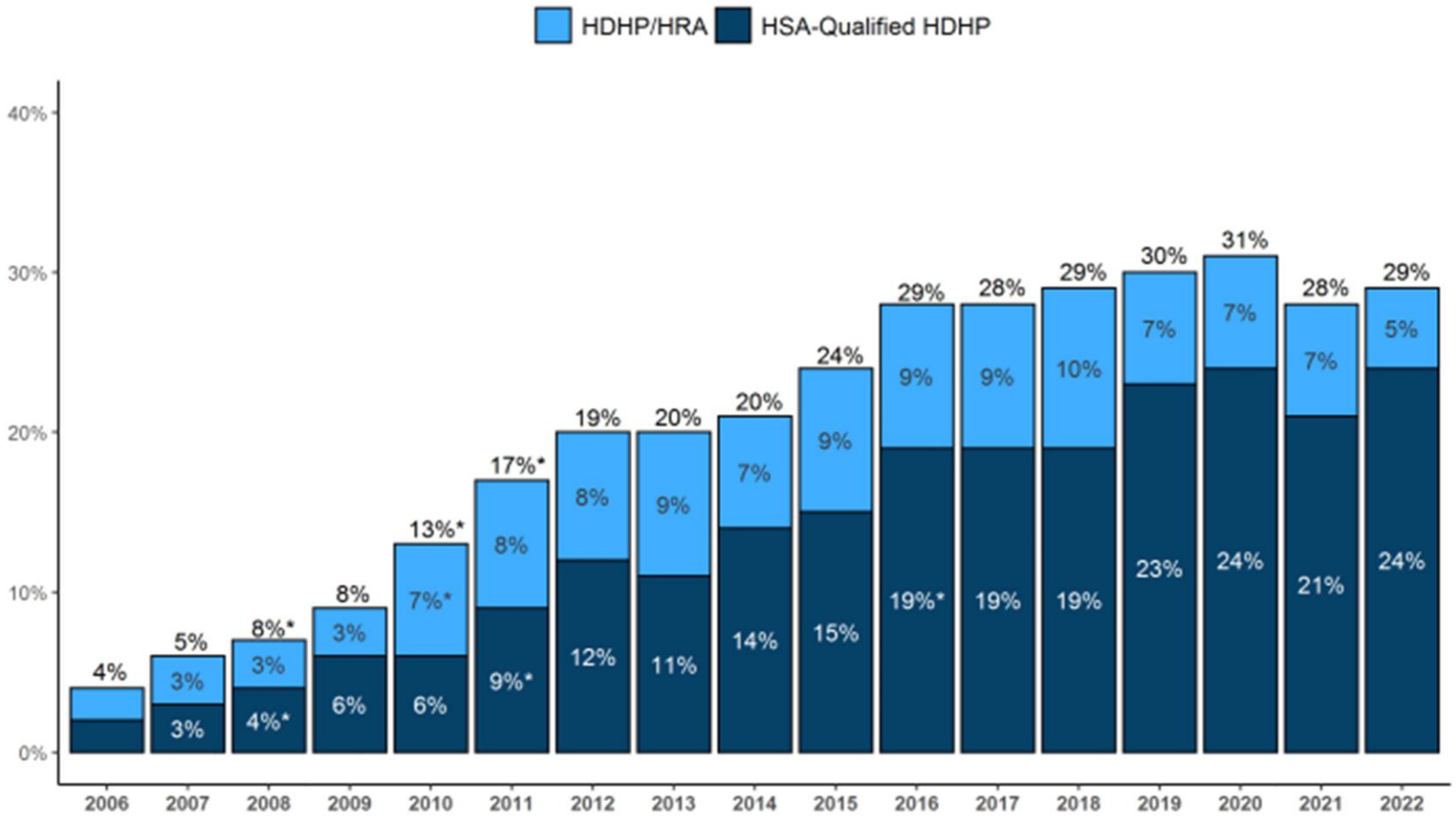
Figure 8.4

Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2022



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Covered workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. Values may not sum to totals due to rounding.

SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

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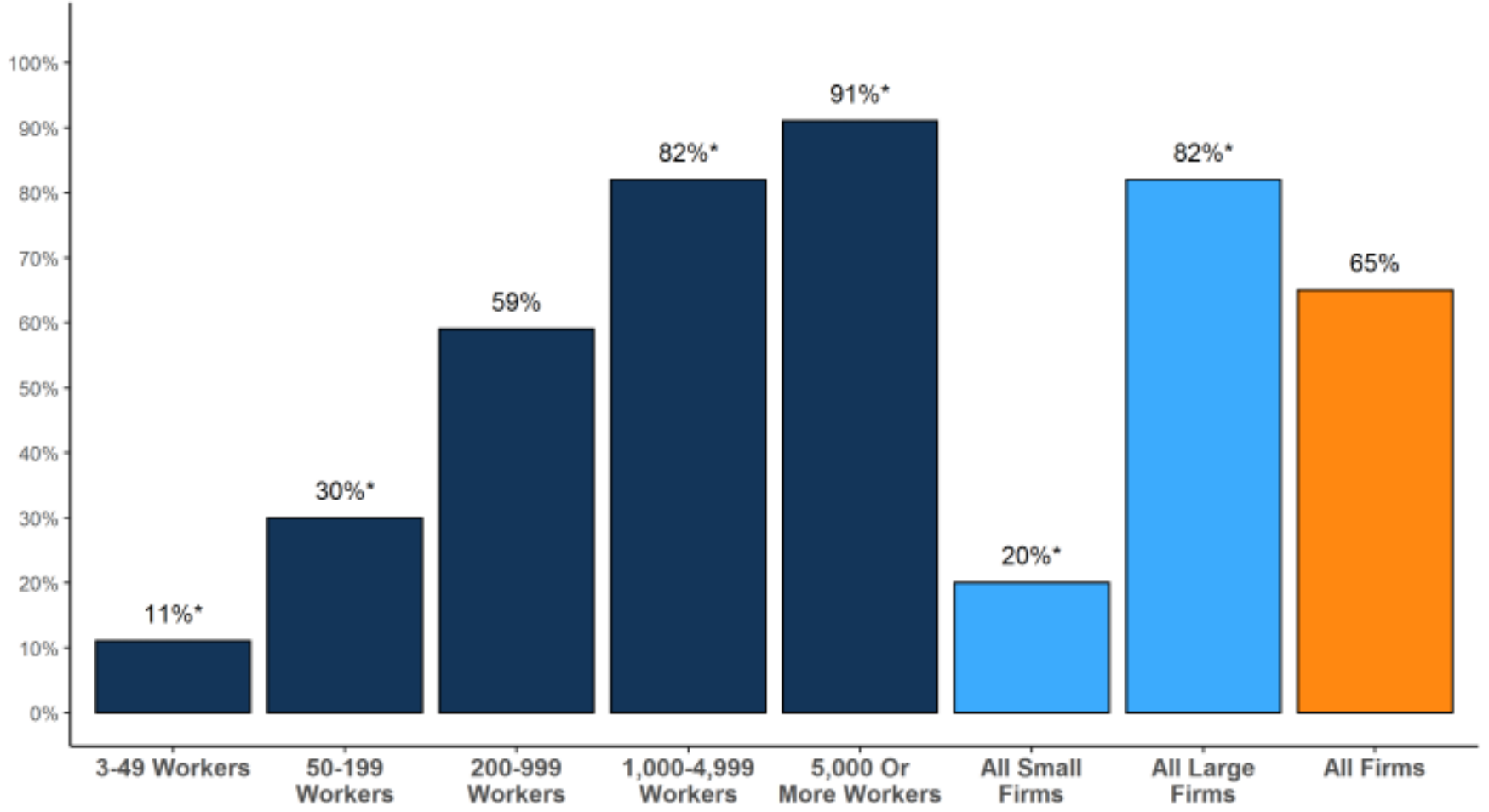
Figure 10.1

Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 2022



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2022

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Two Trump administration ESI reforms

Association Health Plans

- Way for (small) employers to join together to offer coverage

Individual Coverage Health Reimbursement Arrangements (ICHRAs)

- Way for employers to offer a contribution that workers then use toward the purchase of individual market coverage.

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Price transparency

- Hospital prices (insurer specific & cash)
- In-network rates and historical out-of-network rates
- Consumer facing tool
- No Surprises Act “Good Faith Estimate”
- Observations

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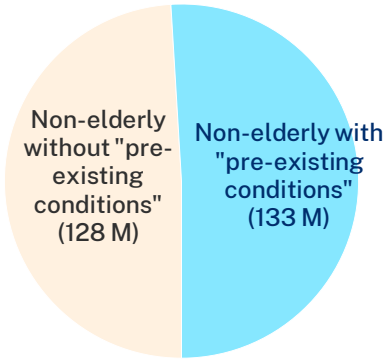
Affordable Care Act Health Insurance Regs & Subsidies

- During an open enrollment period, guarantee issue (everyone who applies for coverage must be offered coverage).
- No premium variation permitted based on health status.
- Premiums can only be 3 times as much for 64-year-olds as young adults.
- Minimum coverage standards (minimum actuarial value + essential health benefits)

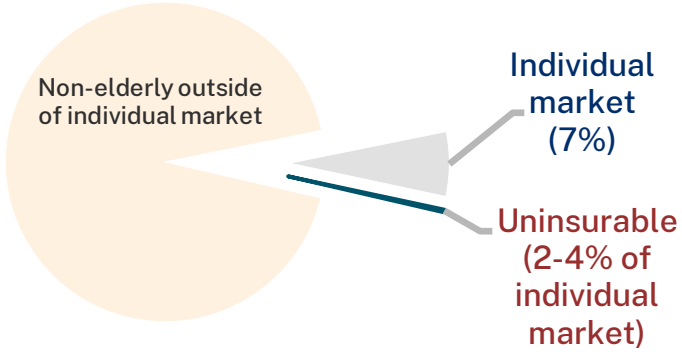
→ For the most part, these rules have produced plans with high premiums and deductibles and narrow networks. The only people who routinely buy are those who qualify for large subsidies. Subsidies limit the amount of income that a household must pay for a benchmark plan.

Context for pre-existing conditions

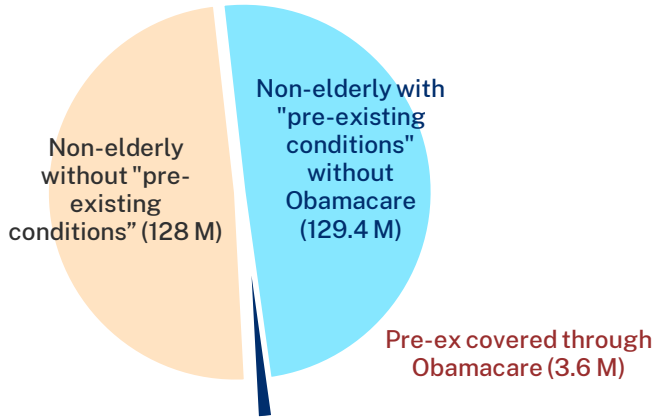
CAP (2014): Non-elderly with pre-existing conditions



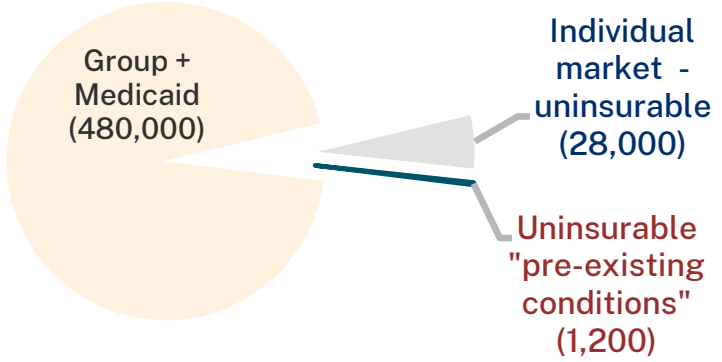
Pauly (2010): Uninsurable population under 65



Obama HHS (2017): 2.7% of non-elderly with pre-existing conditions acquired coverage because of Obamacare



Case study (2017-2020): Alaska Section 1332 Waiver



What's new on the ACA?

- Expanded subsidies through 2025
- Family glitch fix
- Alternatives like short-term plans

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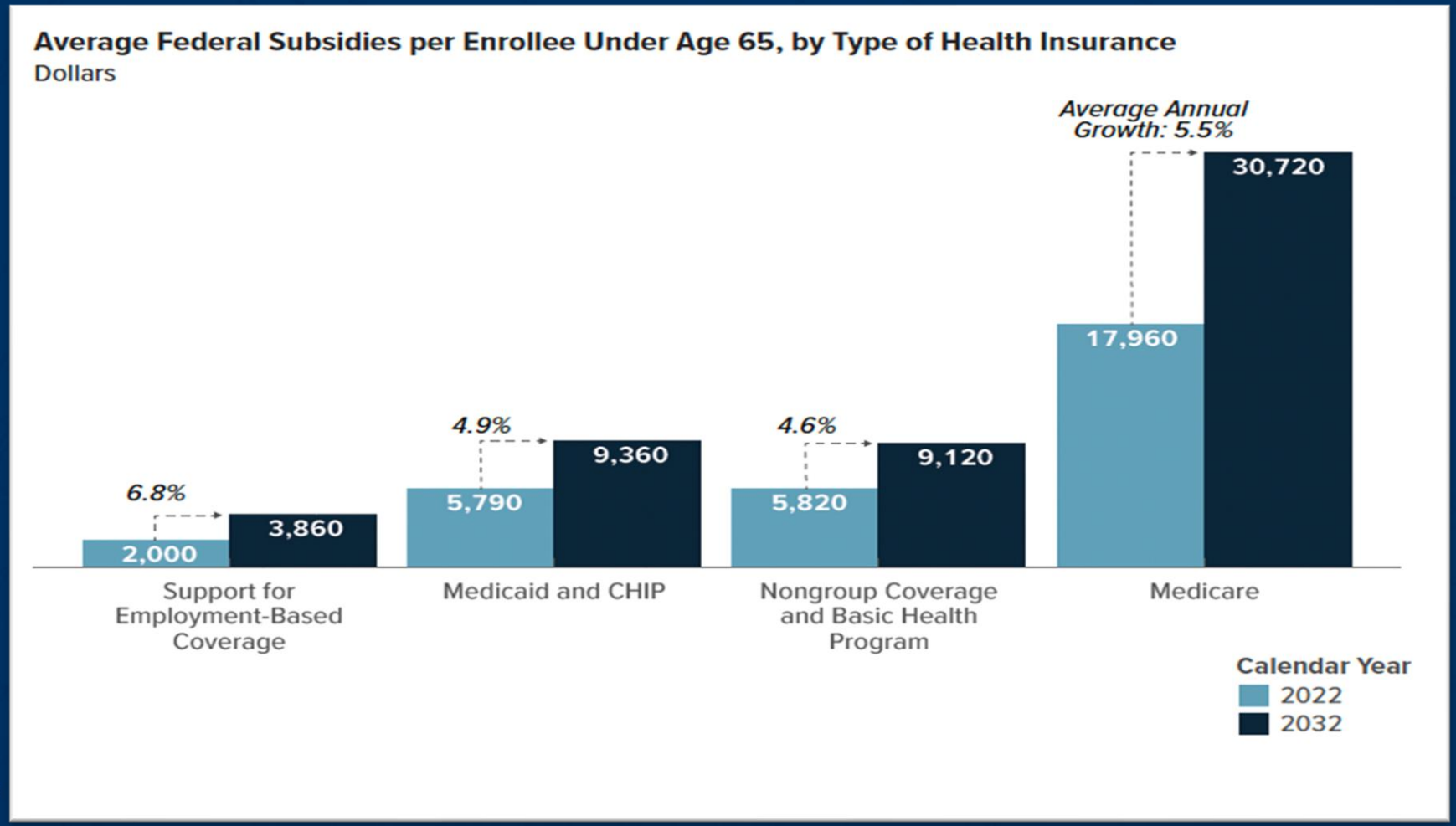
The ESI tax exclusion is cheap (to the federal Treasury) relative to all the alternatives.



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Medicaid 101

- Joint federal-state program
- Federal rules around eligible groups and benefits.
- Federal government provides an open-ended reimbursement of state Medicaid expenditures.
- ACA significantly expanded Medicaid to able-bodied, working-age adults with a much higher federal share of expenditures.

  → 100% reimbursement for 2014-2016, phased down to 90% in 2020 where it is scheduled to remain

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Federal Medicaid reimbursement

- Federal reimbursement = Federal medical assistance percentage (FMAP)
- For the traditional enrollees, the FMAP is a function of state per capita income. Typically, the wealthiest states get a 50% FMAP. The poorest get about a 75% FMAP.
- States often create fake expenditures so they can get federal money without having to put up state dollars. The federal government allows this within certain parameters.
- In economic downturns, Congress often gets money to states by increasing the FMAP.

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Health Insurance Enrollment – Last Decade

TABLE 3

Annual Health Insurance Enrollment Since the ACA Took Effect in 2013

IN MILLIONS OF ENROLLEES

	(Pre ACA) 2013	2014	2015	2016	2017	2018	2019	2020	2021
Individual (non-group)	11.8	16.5	17.6	17.0	15.2	14.2	13.7	14.2	16.2
Difference from 2013		40%	49%	44%	29%	20%	16%	20%	37%
Employer Group	161.2	156.7	157.6	157.6	160.0	159.4	160.3	157.7	156.5
Difference from 2013		-3%	-2%	-2%	-1%	-1%	-1%	-2%	-3%
Medicaid and CHIP	61.1	69.9	72.7	75.0	74.6	72.2	71.2	80.2	86.7
Difference from 2013		14%	19%	23%	22%	18%	17%	31%	42%

SOURCES: Private market data from the National Association of Insurance Commissioners and Mark Farrah Associates; Medicaid and CHIP data from the CMS.

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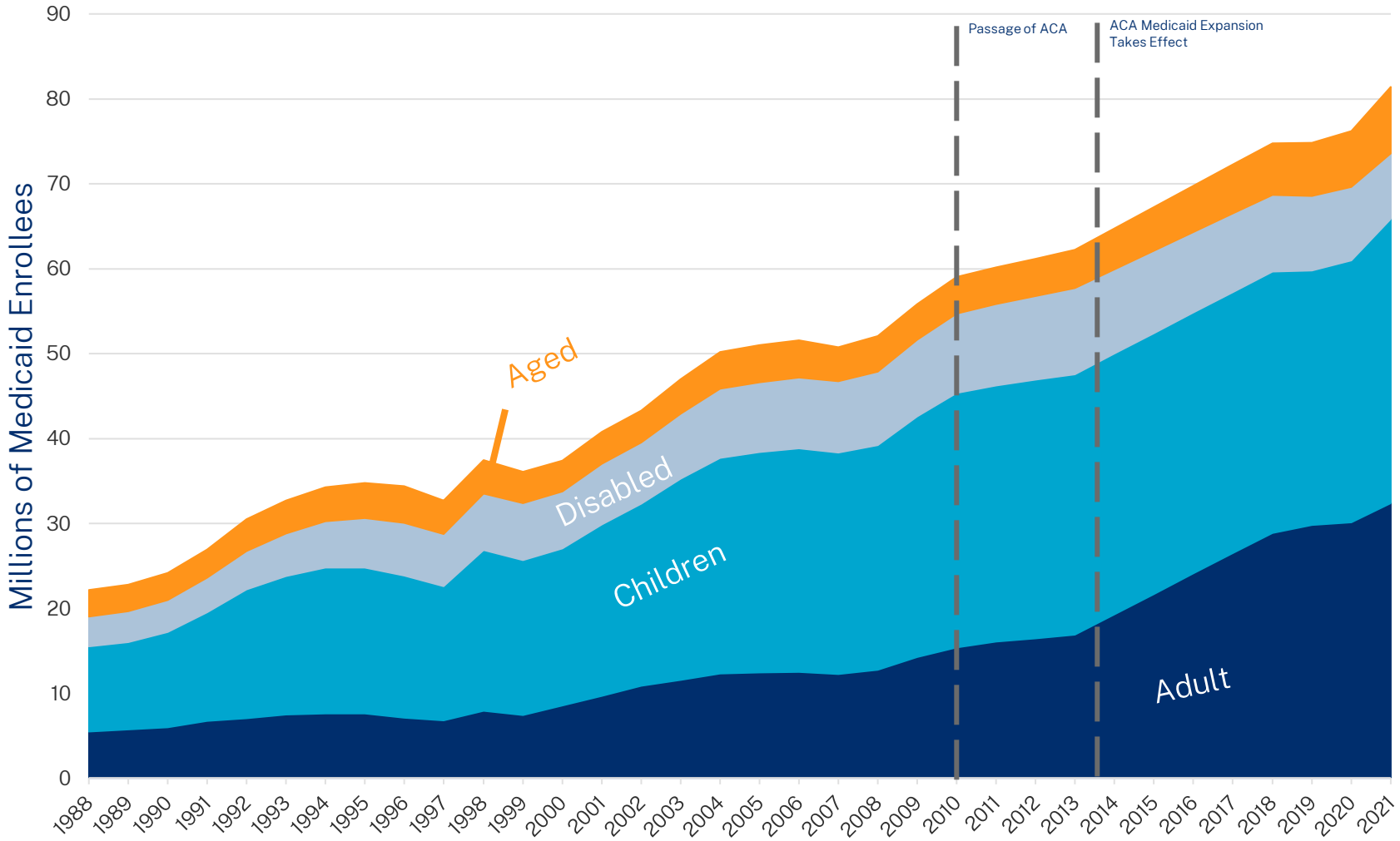
Medicaid Enrollment Has More Than Tripled Over the Last Three Decades

Medicaid enrollment driven by growth in able-bodied, working-age adult enrollees



Source: MACStats and CBO

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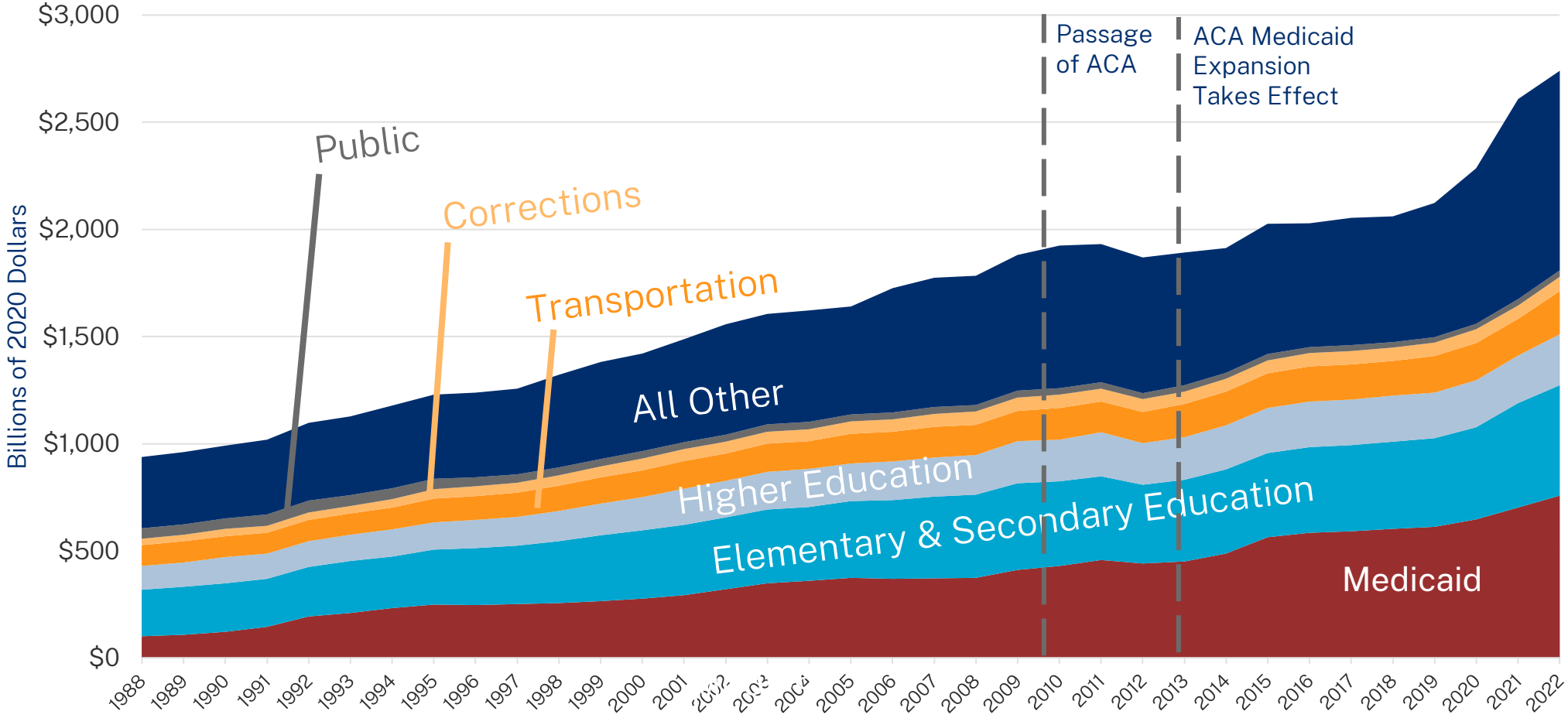
State Spending Explosion Driven by Medicaid

Medicaid Spending Up 500% Over Last Three Decades



Source: National Association of State Budget Officers' Annual Expenditure Reports

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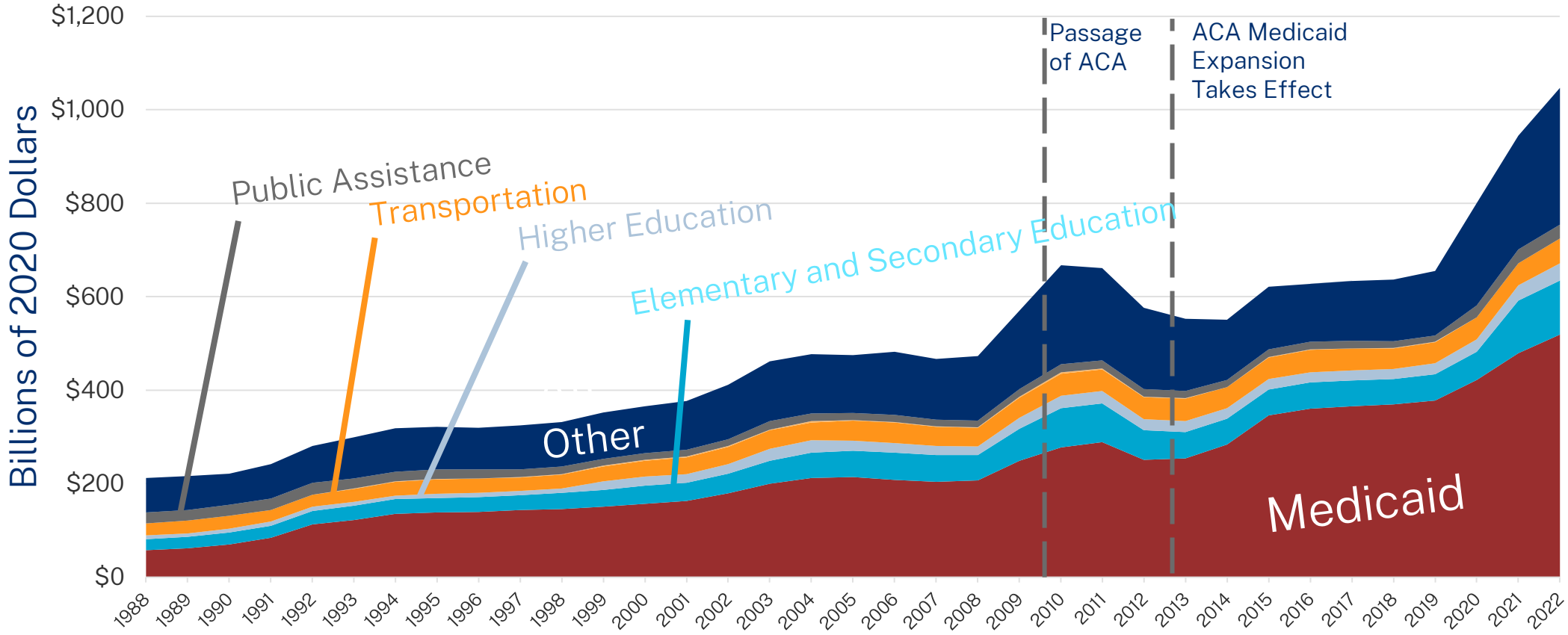
An Explosion of Federal Money To States For Medicaid

Federal funds for Medicaid are nearly 7 times greater than Federal funds for Elementary and Secondary Education



Source: National Association of State Budget Officers' Annual Expenditure Reports

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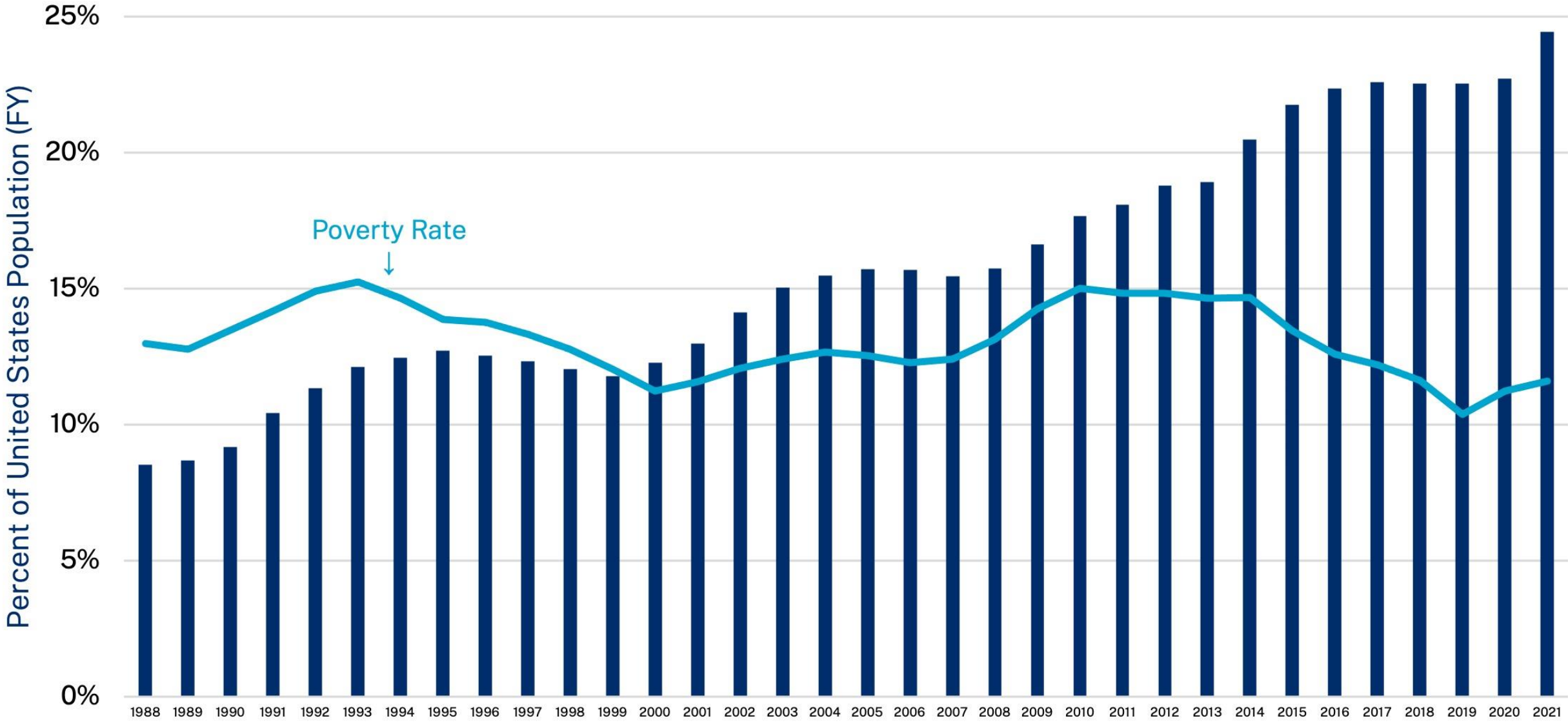
Medicaid is No Longer for the Poor

Enrollment Has Tripled over Last Three Decades as Enrollees Now Double People in Poverty

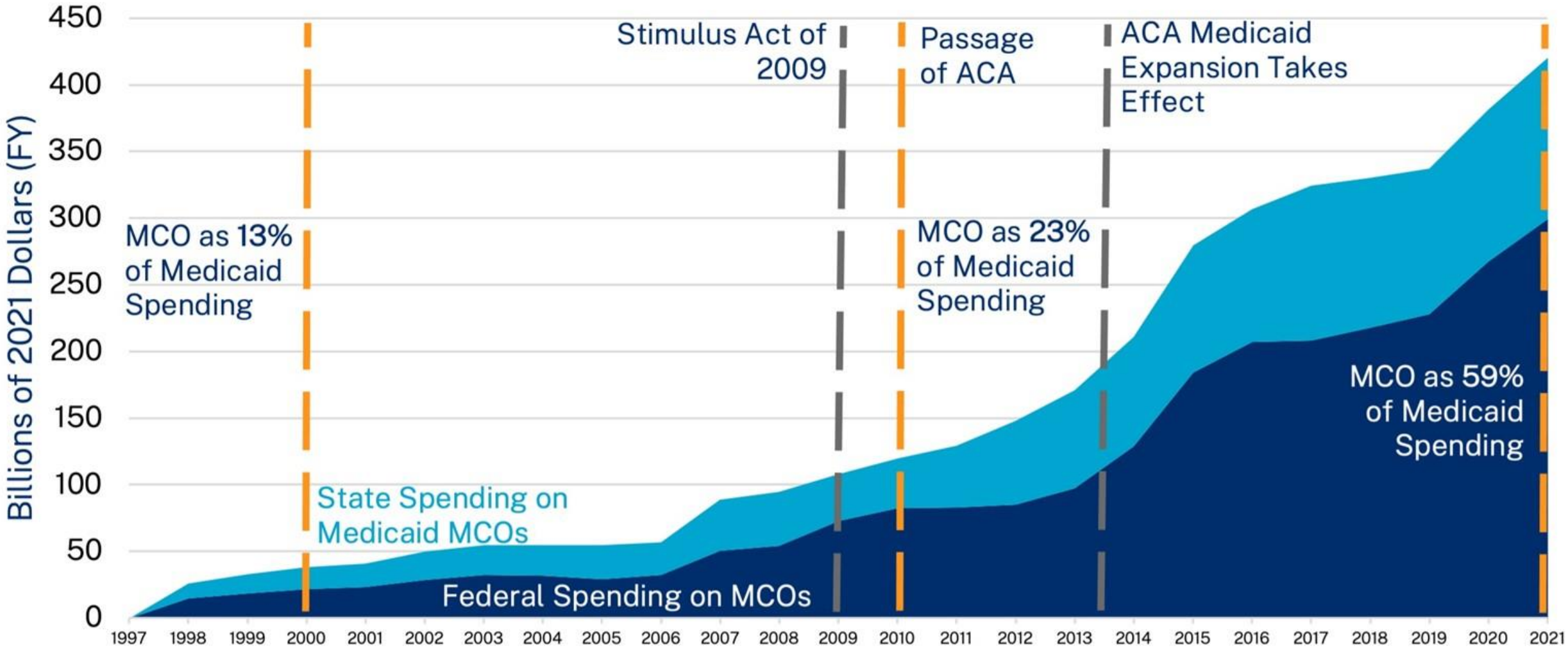


Source: MACStats - Medicaid and CHIP Databook 2021 Edition, Census Bureau, Centers for Medicare & Medicaid Services

Medicaid Improper Payments & Public Health Emergency

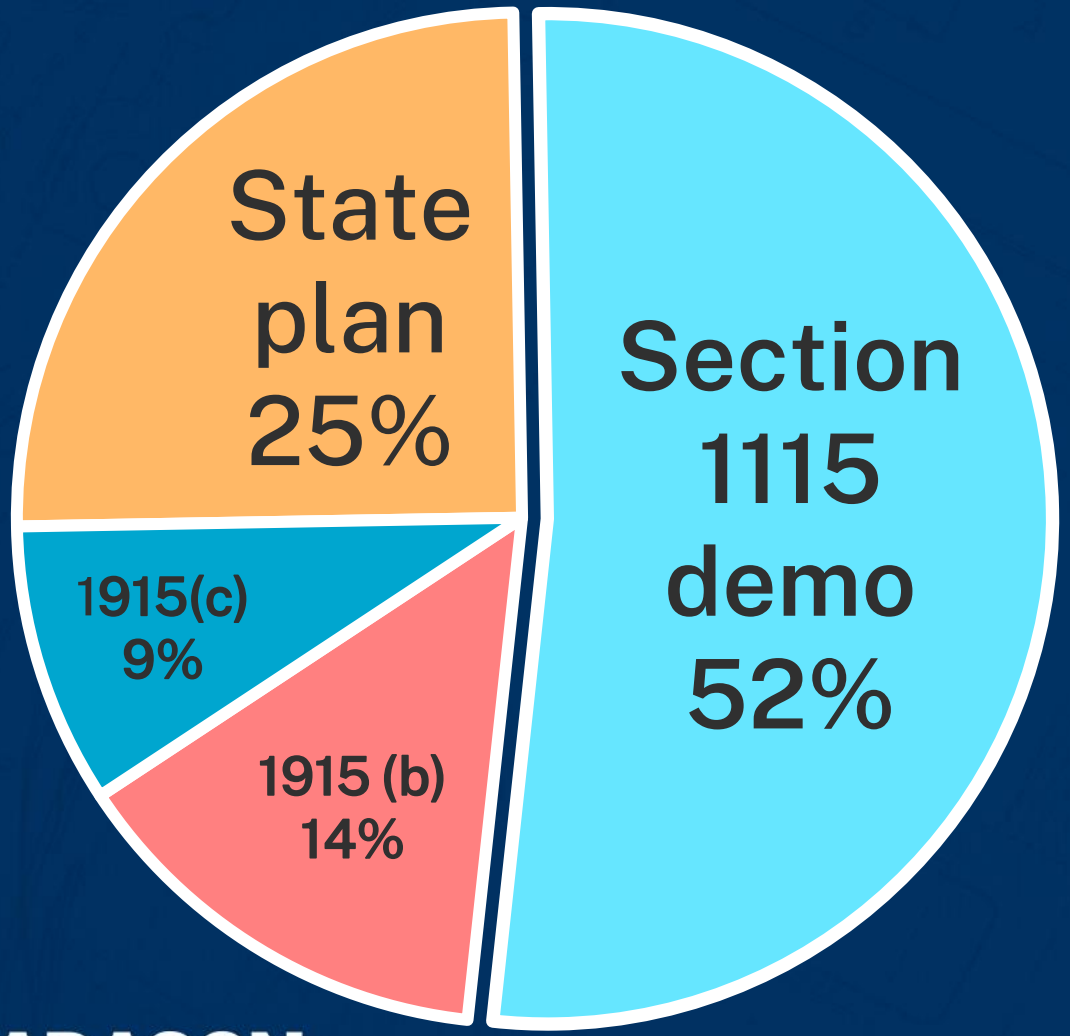
- Pre-pandemic, Medicaid's improper payment rate exceeded 20% (federal spending of $100 billion annually).
- The improper payment rate was driven by the failure of states to ensure that only eligible people were enrolled.
- Families First Coronavirus Relief Act raised states' FMAPs so long as states took no steps to remove anyone from Medicaid regardless of whether people were still eligible.
- There's likely between 15-20 million people enrolled in Medicaid who are not eligible.

Medicaid Managed Care Organization (MCO) Spending Growth Soared After Affordable Care Act



Note: Includes Prepaid Ambulatory Health Plans and Prepaid Inpatient Health Plans
Source: CMS FMR 1997-2021, Health Management Associates

Medicaid section 1115 waivers



- More than half of Medicaid funding approved on a case-by-case basis as a “demonstration project” under Section 1115
- Theoretically “budget neutral,” but as interpreted by admin (Liberals seeking to undermine further)
- Biden admin actively using expand coverage to “health related social needs” (a.k.a. – not health care)

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MEDICARE 101

Demetrios Kouzoukas — Director, Medicare Reform Initiative, Paragon Health Institute

Alec Aramanda — Professional Staff Member, U.S. House of Representatives Committee on Energy & Commerce

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What is Medicare?

- Federal health entitlement program targeted to the elderly (aged 65+), disabled, and those with end-stage renal disease (ESRD or kidney disease) or ALS (Lou Gehrig's disease)

- Medicare is a mandatory program, so its spending by law occurs without regular congressional appropriation or authorization

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What is Medicare?

- 1965: Congress creates Medicare (Parts A and B) to cover higher health expenses of the elderly
- 1972: The Social Security Amendments of 1972 expand Medicare to the disabled and those with ESRD
- 1982 and 1983: The Tax Equity and Fiscal Responsibility Act (TEFRA) and the Social Security Amendments of 1983 develop a prospective payment system (PPS) for hospital care and allow the contracting of private health maintenance organizations (HMOs)
- 1989: The Omnibus Reconciliation Act of 1989 implements Resource-Based Relative Value Scale (RBRVS) as part of a physician fee schedule
- 1997: The Balanced Budget Act of 1997 establishes Part C (Medicare+Choice) along with a "sustainable growth rate" for physician payment
- 2003: Medicare Modernization Act (MMA) creates Part D; Part C becomes Medicare Advantage
- 2010: Affordable Care Act (ACA) expands Medicare demonstrations, raises taxes, cuts payments to providers and Part C and D plans, and creates Independent Payment Advisory Board (later repealed)
- 2015: Medicare Access and CHIP Reauthorization Act (MACRA) replaces "sustainable growth rate" with merit-based incentive payment system and alternative payment model bonuses for physicians
- 2022: Inflation Reduction Act (IRA) overhauls Part D cost-sharing and imposes price controls
- 2020-2023: COVID-19 public health emergency leads to Medicare administrative flexibilities, like expanding telehealth

What is Medicare?

- About 60 million beneficiaries in 2022
- $980 billion in 2022 outlays ($770 billion net outlays)
- Accounts for about 21% of national health expenditures and 10% of federal budget

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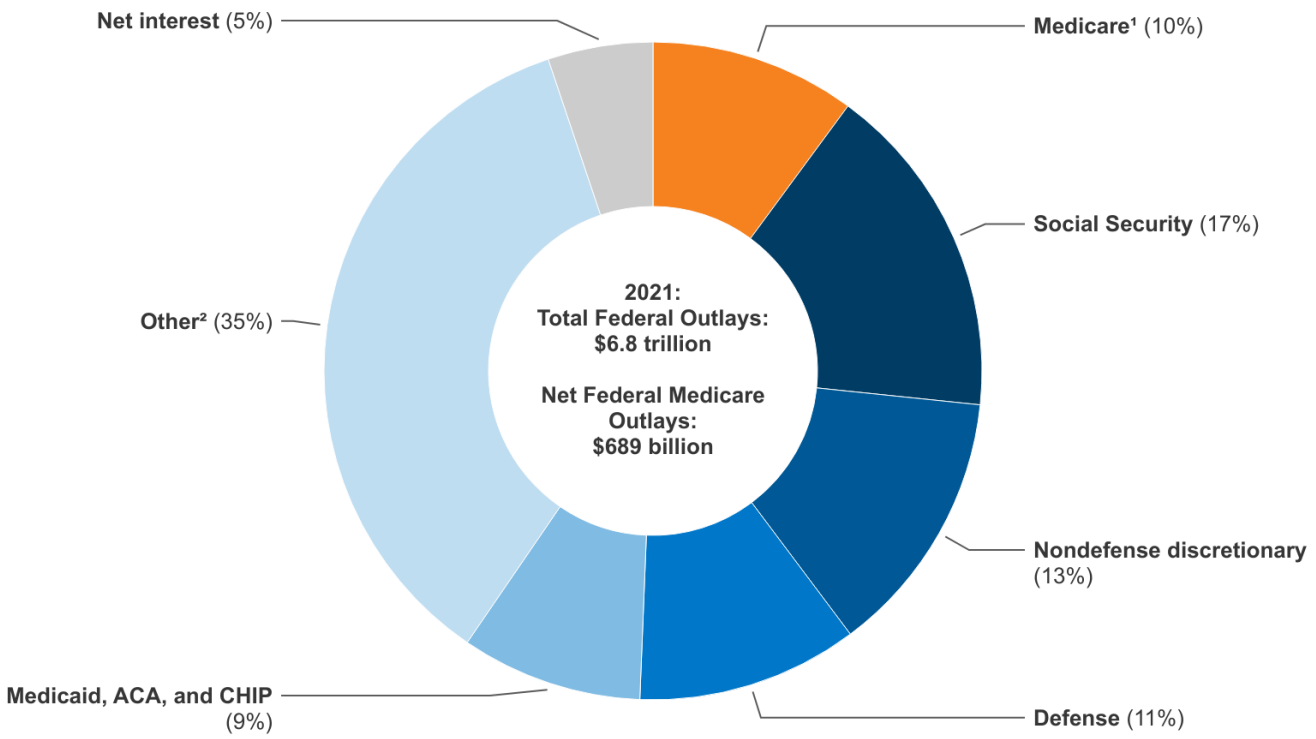
What is Medicare?

Figure 2

In 2021, Medicare Spending Accounted for 10% of the Federal Budget



NOTE: All amounts are for federal fiscal year 2021. ¹Consists of mandatory Medicare spending minus income from premiums and other offsetting receipts. ²Includes spending on other mandatory outlays minus income from offsetting receipts. ACA is Affordable Care Act. CHIP is Children's Health Insurance Program.
SOURCE: KFF analysis of federal spending from Congressional Budget Office, The Budget and Economic Outlook, 2022 to 2032 (May 2022).

KFF

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Medicare Part A

- Hospital insurance (HI) program funded by payroll taxes in HI Trust Fund
- Covers inpatient hospital, nursing, hospice, and home health care services
- $1,600 deductible per benefit in 2023 and $0 monthly premiums (usually)

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Medicare Part B

- Supplemental Medical Insurance (SMI) funded by general revenues and premiums via SMI Trust Fund
- Largely covers physician, outpatient, and drug administration services
- $164.90 standard monthly premium and $226 annual deductible
- Beneficiaries can opt out of Part B but may face late enrollment penalties later

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Original Medicare

- Parts A and B are also called Original Medicare
- CMS administers and sets reimbursement rates for Original Medicare
- Original Medicare pays for covered services from any participating provider, usually on a fee-for-service (FFS) basis
- Most FFS beneficiaries have supplemental coverage to cover cost-sharing (e.g., private Medigap plans)

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Medicare Part C

- Also called Medicare Advantage (MA)
- Administered by private insurance plans who receive fixed payments from bidding process
- Plans must cover Part A and B benefits and may offer lower costs or supplemental benefits not covered in Original Medicare (e.g., dental, vision, and hearing)
- In 2022, roughly 48% of beneficiaries enrolled in MA

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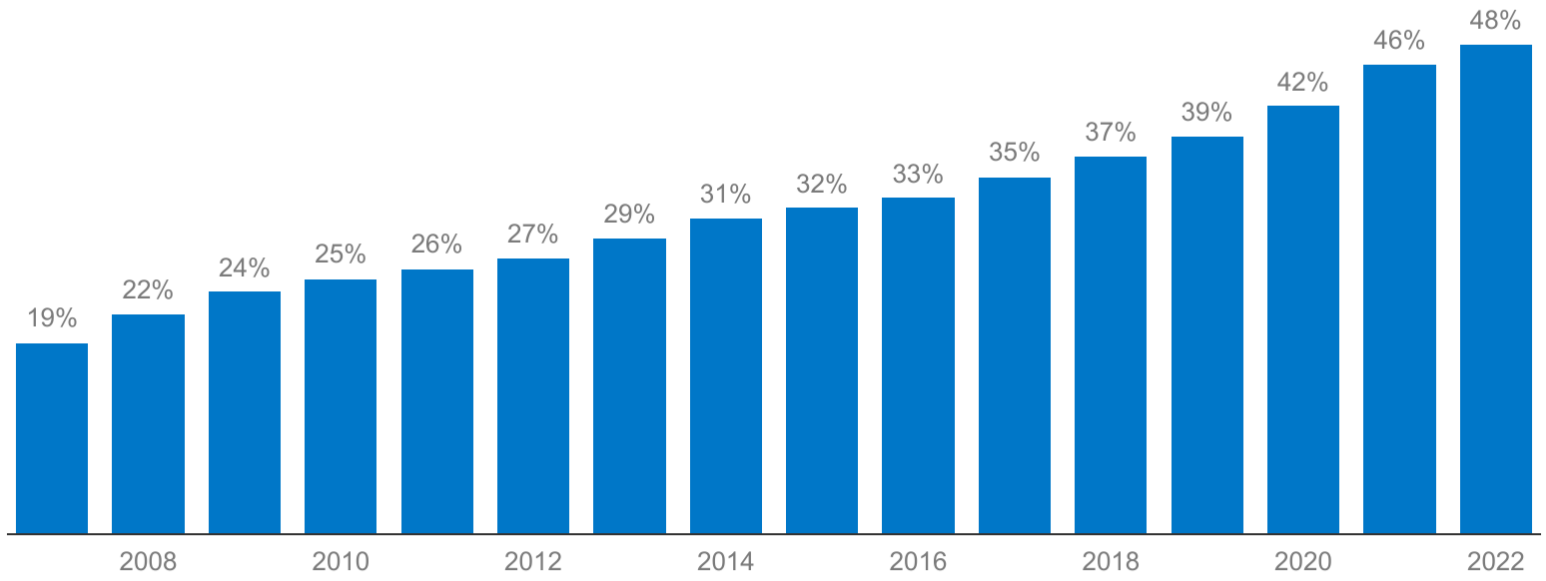
Medicare Part C

Figure 1

Total Medicare Advantage Enrollment, 2007-2022

Medicare Advantage Penetration Medicare Advantage Enrollment



NOTE: Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 58.6 million people are enrolled in Medicare Parts A and B in 2022.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2022; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018-2020; and Medicare Enrollment Dashboard 2021-2022.

KFF

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Medicare Part D

- Private prescription drug coverage from standalone prescription drug plans (PDPs) or MA prescription drug (MA-PD) plans
- Financed by premiums (25.5% of program costs, more if income exceeds $97,000 in 2023), general revenues, and state funding
- The Inflation Reduction Act imposed significant price controls and cost-sharing changes

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Medicare Payment Systems

- Statute requires annual rulemaking for FFS payment rates, often by facility type (e.g., inpatient/outpatient hospital, post-acute care, clinical lab services, etc.)
- CMS must calculate rate updates with external data (e.g., wage index or market basket updates). This is a very formulaic process
- Some areas of discretion: coverage for new technology (e.g., pass-through payments), “equitable adjustment,” and policy riders

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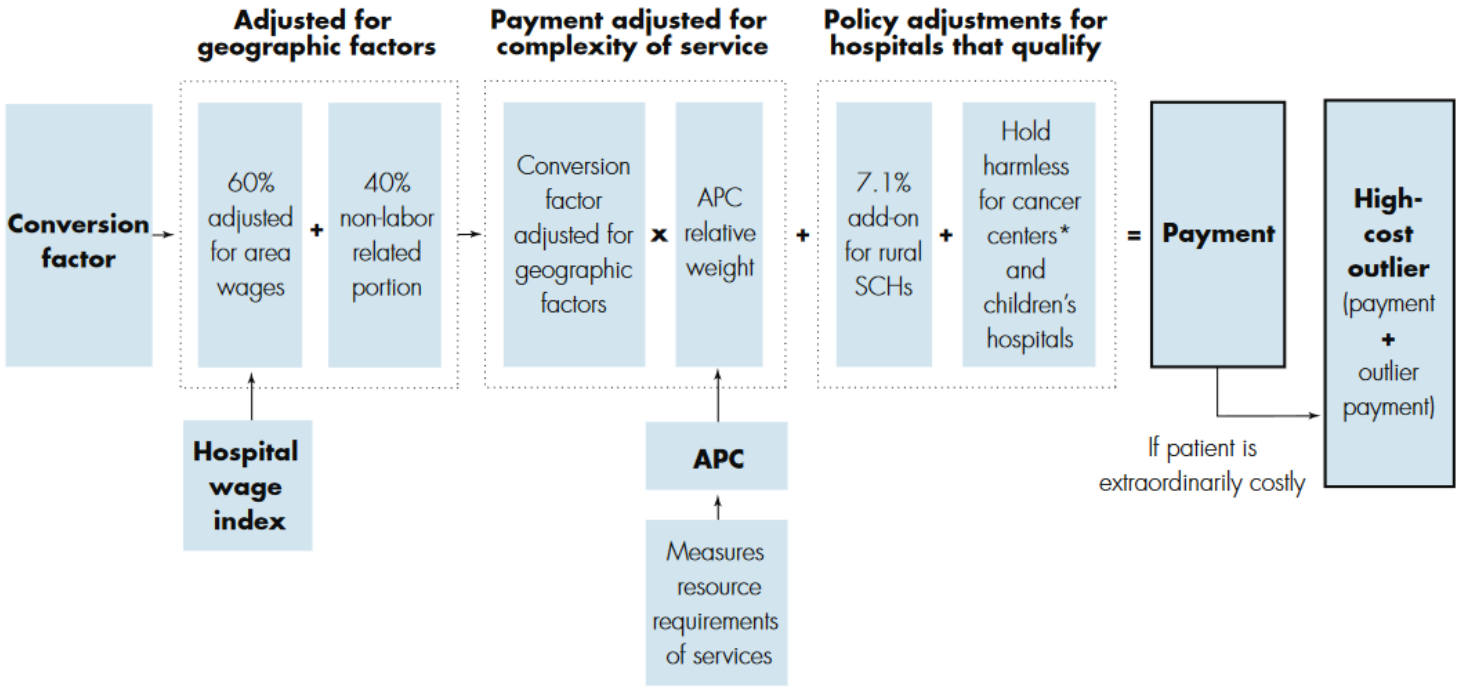
Medicare Payment Systems

Figure 1 Hospital outpatient services prospective payment system



Note: APC (ambulatory payment classification), SCH (sole community hospital). The APC is the service classification system for the outpatient prospective payment system.
*Medicare adjusts outpatient prospective payment system payment rates for 11 cancer centers so that the payment-to-cost ratio (PCR) for each cancer center is equal to the average PCR for all hospitals minus 1 percentage point.

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Policy Process in Medicare

- Medicare is largely run through notice-and-comment rulemaking governed by laws like the Administrative Procedure Act and Congressional Review Act or executive branch policies like E.O. 12866
- CMS may also test policies through demos and models (e.g., within its Innovation Center)
- Numerous other administrative actions are also not codified in rulemaking (e.g., MA rate notices, 1135 waivers, subregulatory guidance)

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Policy Process in Medicare

1. CMS publishes its planned regulations for the upcoming year in OMB's Unified Agenda
2. Regulations are drafted by CMS staff with input from policy staff and offices like OGC, then go through OMB/HHS clearance
3. CMS publishes a proposed rule then a final rule after a notice-and-comment period

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Policy Process in Medicare

- Payment rules come out at different times throughout the year
- Fiscal year rules (e.g., IPPS/LTCH, SNF) are usually proposed in the spring, finalized in the summer, and come into effect on October 1
- Calendar year rules (e.g., OPPS/ASC, PFS) are usually proposed in the early summer, finalized in fall and come into effect January 1

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