

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-19

Subject: Covering the Uninsured under the AMA Proposal for Reform
(Resolution 108-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee A
(John Montgomery, MD, MPH, Chair)

1 At the 2018 Annual Meeting, the House of Delegates referred Resolution 108, “Expanding AMA’s
2 Position on Healthcare Reform Options,” which was sponsored by the Medical Student Section.
3 Resolution 108-A-18 asked that our American Medical Association (AMA) remove references in
4 AMA policy to opposing single-payer health care by rescinding Policies H-165.844 and
5 H-165.985; amending Policy H-165.888 by deletion to remove “1(b) Unfair concentration of
6 market power of payers is detrimental to patients and physicians, if patient freedom of choice or
7 physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall
8 within such a definition and, consequently, should continue to be opposed by the AMA. Reform
9 proposals should balance fairly the market power between payers and physicians or be opposed;”
10 and amending Policy H-165.838 by deletion to remove “12. AMA policy is that creation of a new
11 single-payer, government-run health care system is not in the best interest of the country and must
12 not be part of national health system reform.” The Board of Trustees assigned this item to the
13 Council on Medical Service for a report back to the House of Delegates at the 2019 Annual
14 Meeting.

15
16 This report provides background on health care coverage and costs in the US; summarizes potential
17 approaches to cover the uninsured and achieve universal coverage; outlines factors to evaluate in
18 proposals to expand coverage; and presents policy recommendations.

19 20 BACKGROUND

21
22 The health insurance coverage environment in the US for the nonelderly population heavily relies
23 on the provision of employer-sponsored insurance, with nongroup coverage, Medicaid and other
24 public programs covering smaller shares of the population. In 2017, 57 percent of the nonelderly
25 population was covered by employer-sponsored health insurance coverage, with Medicaid and the
26 Children’s Health Insurance Program (CHIP) covering 22 percent, non-group plans covering eight
27 percent, and other public plans covering three percent. Of concern, 27.4 million nonelderly
28 individuals (10 percent) remained uninsured, an increase of 700,000 from 2016.¹

29
30 The income demographic of the uninsured population is concentrated below 400 percent of the
31 federal poverty level (FPL), with 82 percent of the uninsured with income below that threshold in
32 2017. Almost one-fifth of the uninsured population had incomes below the poverty line in 2017,²
33 which in 2019 is \$12,490 for an individual and \$25,750 for a family of four.³ Significantly, more
34 than three-quarters of the nonelderly uninsured had at least one full-time worker in their family.⁴

1 At the same time, \$3.5 trillion was spent on health care in the US in 2017, an increase of 3.9
 2 percent from 2016 – amounting to \$10,739 per person. Hospital care made up 33 percent of total
 3 health care spending, with spending on physician and clinical services amounting to 20 percent,
 4 and retail prescription drugs 10 percent. Overall, health care spending made up 17.9 percent of the
 5 gross domestic product (GDP) in 2017.⁵

6
 7 Health care is financed by a variety of entities in the US, via dedicated taxes and/or general
 8 revenues, or by contributions made to health insurance premiums and out-of-pocket costs. In 2017,
 9 the federal government and households each accounted for 28 percent of health care spending.
 10 Health care spending by private businesses amounted to 20 percent of spending, with state and
 11 local spending following at 17 percent.⁶

12
 13 **MOVING FORWARD: APPROACHES TO COVER THE UNINSURED**

14
 15 The uptick in the uninsured rate, coupled with increasing pressures relating to health care costs, has
 16 caused momentum to build in support of action to cover the remaining uninsured. There have been
 17 two main approaches outlined in legislation and organizational policy proposals to date to improve
 18 the coverage climate in the US. First, legislation and organizational proposals have been put
 19 forward to build upon and fix the Affordable Care Act (ACA) to cover more people. As an
 20 alternative, other proposals have been introduced to use Medicare as the foundation to cover all US
 21 residents, or allow Medicare or Medicaid buy-ins.

22
 23 *The AMA Proposal for Reform*

24
 25 Expanding health insurance coverage and choice have been long-standing goals of the AMA. The
 26 approach to coverage as outlined under the AMA proposal for reform supports health system
 27 reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice,
 28 freedom of practice, and universal access for patients. Notably, the AMA health system reform
 29 proposal has been extensively deliberated by the House of Delegates over the past 20 years. Based
 30 principally on recommendations developed by the Council on Medical Service, beginning in 1998,
 31 the AMA proposal for covering the uninsured and expanding choice advocates for the promotion of
 32 individually selected and owned health insurance using refundable and advanceable tax credits that
 33 are inversely related to income so that patients with the lowest incomes will receive the largest
 34 credits (Policies H-165.920 and H-165.865). Policy H-165.920 also supports and advocates a
 35 system where individually purchased and owned health insurance coverage is the preferred option,
 36 but employer-provided coverage is still available to the extent the market demands it. AMA policy
 37 also underscores that in the absence of private sector reforms that would enable persons with low-
 38 incomes to purchase health insurance, our AMA supports eligibility expansions of public sector
 39 programs, such as Medicaid and CHIP, with the goal of improving access to health care coverage
 40 to otherwise uninsured groups (Policy H-290.974). AMA policy has long supported the creation of
 41 basic national standards of uniform eligibility for Medicaid (Policy H-290.997), and at the
 42 invitation of state medical societies, the AMA will work with state and specialty medical societies
 43 in advocating at the state level to expand Medicaid eligibility to 133 percent FPL as authorized by
 44 the ACA (Policy D-290.979). Addressing a public option, Policy H-165.838 states that insurance
 45 coverage options offered in a health insurance exchange be self-supporting; have uniform solvency
 46 requirements; not receive special advantages from government subsidies; include payment rates
 47 established through meaningful negotiations and contracts; not require provider participation; and
 48 not restrict enrollees' access to out-of-network physicians.

49
 50 Since the enactment of the ACA, the House of Delegates has been very proactive in and responsive
 51 to the evolving coverage environment to ensure that AMA policy is able to address how to best

1 cover the remaining uninsured. Under the ACA, eligible individuals and families with incomes
 2 between 100 and 400 percent FPL (between 133 and 400 percent FPL in Medicaid expansion
 3 states) are being provided with refundable and advanceable premium credits that are inversely
 4 related to income to purchase coverage on health insurance exchanges. In addition, individuals and
 5 families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in
 6 Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which
 7 leads them to face lower deductibles, out-of-pocket maximums, copayments and other cost-sharing
 8 amounts. At the time that this report was written, 36 states and the District of Columbia have
 9 adopted the Medicaid expansion provided for in the ACA, which extended Medicaid eligibility to
 10 individuals with incomes up to 133 percent FPL.⁷

11
 12 Significantly, the House of Delegates has adopted a multitude of policies that address coverage for
 13 the remaining uninsured in the ACA environment:

- 14
 15 • *8.2 million individuals who are eligible for premium tax credits but remain uninsured.*⁸
 16 Policy H-165.824 supports adequate funding for and expansion of outreach efforts to
 17 increase public awareness of advance premium tax credits, and providing young adults
 18 with enhanced premium tax credits while maintaining the current premium tax credit
 19 structure which is inversely related to income.
 20
- 21 • *1.9 million individuals who are ineligible for premium tax credits due to income higher*
 22 *than 400 percent FPL.*⁹ AMA policy supports expanding eligibility for premium tax
 23 credits up to 500 percent FPL, encouraging state innovation with reinsurance (H-165.824),
 24 and establishing a permanent federal reinsurance program (H-165.842).
 25
- 26 • *3.8 million individuals who are ineligible for premium tax credits to purchase coverage on*
 27 *health insurance exchanges because they have an offer of “affordable” employer*
 28 *coverage.*¹⁰ Policy H-165.828 supports legislation or regulation, whichever is relevant, to
 29 fix the ACA’s “family glitch,” and supports lowering the threshold that determines whether
 30 an employee’s premium contribution is “affordable,” measured by comparing the
 31 employee’s share of the premium to their income.
 32
- 33 • *6.8 million individuals who are eligible for Medicaid or CHIP but remain uninsured.*¹¹
 34 AMA policy supports efforts to expand coverage to uninsured children who are eligible for
 35 CHIP and Medicaid through improved and streamlined enrollment mechanisms and
 36 educational and outreach activities aimed at Medicaid-eligible and CHIP-eligible children.
 37 In addition, Policy H-290.961 opposes work requirements as a criterion for Medicaid
 38 eligibility.
 39
- 40 • *2.5 million individuals with incomes below 100 percent FPL who fall into the “coverage*
 41 *gap” due to their state’s decision not to expand Medicaid.*¹² Policy D-290.979 states that
 42 our AMA, at the invitation of state medical societies, will work with state and specialty
 43 medical societies in advocating at the state level to expand Medicaid eligibility to 133
 44 percent (138 percent FPL including the income disregard) of FPL as authorized by the
 45 ACA.
 46
- 47 • *Individuals who may choose not to get covered resulting from the elimination of the federal*
 48 *individual mandate penalty:* Policy H-165.824 encourages state innovation, including
 49 considering state-level individual mandates, auto-enrollment and/or reinsurance, to
 50 maximize the number of individuals covered and stabilize health insurance premiums
 51 without undercutting any existing patient protections. This policy builds upon Policy

1 H-165.848, which supports a requirement that individuals and families who can afford
2 health insurance be required to obtain it, using the tax structure to achieve compliance. The
3 policy advocates a requirement that those earning greater than 500 percent FPL obtain a
4 minimum level of catastrophic and preventive coverage. Only upon implementation of tax
5 credits or other coverage subsidies would those earning less than 500 percent FPL be
6 subject to the coverage requirement.

7
8 *Building Upon and Improving the Affordable Care Act*

9
10 Legislative and organizational proposals to build upon and fix the ACA, on both the federal and
11 state levels, generally include one or more of the following provisions:

- 12
- 13 • Increasing the amount of and expanding eligibility for premium tax credits, including
14 removing the “subsidy cliff;”
 - 15 • Providing “enhanced” tax credits to young adults;
 - 16 • Increasing amounts of cost-sharing reductions received by individuals who qualify for
17 them;
 - 18 • Extending eligibility for cost-sharing reductions beyond 250 percent FPL;
 - 19 • Establishing a reinsurance program;
 - 20 • Fixing the “family glitch;”
 - 21 • Establishing a state individual mandate and/or auto-enrollment program; and
 - 22 • Restricting the availability of short-term limited duration insurance (STLDI) plans and
23 association health plans.
- 24

25 These proposals are generally targeted at the populations that remain uninsured under the law, as
26 well as to address the reasons individuals are uninsured or underinsured in the current environment.
27 For example, in 2017, 45 percent of uninsured nonelderly adults reported that they were uninsured
28 because the cost was too high.¹³ Increasing the amount of and expanding eligibility for premium
29 tax credits and cost-sharing reductions addresses concerns with both high premiums and cost-
30 sharing requirements.

31
32 *Expanding Medicare or Medicaid to Cover the Uninsured*

33
34 Legislation has also been introduced to use Medicare or Medicaid as vehicles to expand coverage.
35 “Medicare-for-All” legislation has been introduced in the US House of Representatives and the
36 Senate: S 1129, the Medicare for All Act of 2019 (Senator Bernie Sanders, I-VT), and HR 1384,
37 the Medicare for All Act of 2019 (Representative Pramila Jayapal, D-WA). These bills call for the
38 replacement of employer-sponsored insurance, individual market coverage, and most public
39 programs, including Medicaid, Medicare and CHIP, with Medicare-for-All. The new Medicare-for-
40 All program would have no premiums, and in general no cost-sharing, with the exception of S 1129
41 giving the Secretary of Health and Human Services (HHS) the authority to allow for cost-sharing
42 for prescription drugs, up to \$200 per year. The new Medicare-for-All program would cover all
43 medically necessary services in outlined benefit categories, dental and vision services, with
44 coverage of long-term services and supports varying based on the legislation. These proposals
45 would establish a global budget for all health spending. A fee schedule would be established for
46 physicians, guided by Medicare rates.^{14,15,16}

47
48 As an alternative to the traditional Medicare-for-All proposals, “Medicare for America” legislation
49 was expected to be reintroduced this session of Congress at the time that this report was written. Of
50 note, there may be differences between the legislation introduced this Congress and that introduced
51 last Congress. Unlike Medicare-for-All, Medicare for America as introduced during the 115th

1 Congress would allow large employers to continue providing health insurance to their employees,
2 if they provide gold-level coverage (80 percent of benefits costs covered). Alternatively, they can
3 direct their contributions toward paying for premiums for Medicare for America. If employers
4 continue to offer health insurance to their employees, employees would have the ability to choose
5 Medicare for America coverage instead of their employer coverage. There would also be premiums
6 and cost-sharing under Medicare for America. Premiums would be on a sliding scale based on
7 income, with individuals with incomes below 200 percent FPL having no premium, deductible or
8 out-of-pocket costs. Premiums overall would be capped at no more than 9.69 percent of monthly
9 income. Individuals and families with incomes between 200 and 600 percent FPL would be eligible
10 to receive subsidies to lower their premium contributions, with current Medicare beneficiaries
11 either paying the premium for which they are responsible under Medicare, or that of Medicare for
12 America, whichever is less expensive. Out-of-pocket maximums would also be applied on a sliding
13 scale based on income, with the caps being \$3,500 for an individual and \$5,000 for families.
14 Provider payment under Medicare for America would be based largely on Medicare rates, with
15 increases in payment for primary care, mental and behavioral health, and cognitive services, and
16 the Secretary being given the authority to establish a rate schedule for services currently not paid
17 for under Medicare. Participating providers under Medicare or Medicaid would be considered to be
18 participating providers under Medicare for America. Notably, as a condition of participation in the
19 program, providers would accept Medicare for America rates paid by employer-sponsored
20 insurance plans and Medicare Advantage plans.^{17,18}

21
22 Smaller scale proposals have also been introduced to allow older individuals to buy in to Medicare
23 starting at age 50; establish a public option that would be offered through the exchanges based on
24 Medicare; and allow individuals to buy in to Medicaid. Senator Debbie Stabenow (D-MI) has
25 introduced S 470, the Medicare at 50 Act, and Representative Brian Higgins (D-NY) has
26 introduced HR 1346, the Medicare Buy-In and Health Care Stabilization Act of 2019, which would
27 enable individuals to buy in to Medicare at age 50. Premiums would be based on estimating the
28 average, annual per capita amount for benefits and administrative expenses that would be payable
29 under Parts A, B, and D for the buy-in population. Notably, individuals enrolled in the buy-in
30 would receive financial assistance similar to that which they would have received had they
31 purchased a qualified health plan through the marketplace.^{19,20}

32
33 Senator Brian Schatz (D-HI) and Representative Ben Ray Lujan (D-NM) introduced S 489/HR
34 1277, the State Public Option Act. If enacted into law, the legislation which would give states the
35 option to establish a Medicaid buy-in plan for residents regardless of income. Interestingly, for
36 individuals ineligible for premium tax credits, their premiums cannot exceed 9.5 percent of
37 household income. If these individuals were to enroll in other plans on state ACA marketplaces,
38 their premiums would not be capped as a percentage of their income. In terms of physician
39 payment rates, the State Public Option Act would make permanent a payment increase to Medicare
40 levels for a range of primary care providers.^{21,22} In addition, several states are considering a
41 Medicaid buy-in or public option, including New Mexico, Colorado, Minnesota, New Jersey,
42 Connecticut, Washington and Maine.²³ Some state proposals would use Medicaid provider rates as
43 the basis for payment levels, whereas others would use Medicare or other approaches.

44
45 Legislative proposals have also been put forward in Congress to establish a public option on the
46 exchanges that rely on components of the Medicare program in program structure and to keep plan
47 costs down. The public option, available to individuals and/or small employers eligible to purchase
48 such coverage, would require Medicare participating providers to participate in the public option.
49 Proposals differ in their approaches to provider opt-out provisions, and whether providers in
50 Medicaid would also be required to participate in the public option. Such public option proposals
51 would also base provider payment rates on Medicare, either extending Medicare payment rates or

1 using Medicare rates as a guide to establish payment levels. Individuals who qualify for premium
 2 tax credits and cost-sharing subsidies could use such subsidies to purchase the public option. All
 3 public option proposals would at a minimum cover essential health benefits as required under the
 4 ACA, with some proposals covering more benefits.

5
 6 *International Approaches to Universal Coverage*

7
 8 Countries that have achieved universal coverage show that there is no “one-size-fits-all” approach
 9 to covering the uninsured and health system financing. Health system financing varies from
 10 country to country. While some countries can fall into one overarching financing model, others
 11 may incorporate multiple financing models in their health systems. Such models include a single-
 12 payer system financed through taxes, and employer-sponsored insurance and coverage provided by
 13 nonprofit, private insurers.

14
 15 Many countries finance their health systems generally through taxes, with the government serving
 16 as single-payer. For example, in Denmark, health care is financed predominantly through a national
 17 health tax, equal to eight percent of taxable income. In the United Kingdom, the majority of
 18 financing for the National Health Service comes from general taxation and a payroll tax. Partly as a
 19 result of the level of health care benefits provided by the government, countries with single-payer
 20 systems tend to have higher tax rates and social insurance contributions. Overall, taxes that fund
 21 social insurance programs are often higher in other developed countries than in the United States.

22
 23 Other countries have employer-sponsored insurance and coverage provided through nonprofit,
 24 private insurers. For example, health insurance in Germany is mandatory for all citizens and
 25 permanent residents, and is primarily provided by competing “sickness funds,” not-for-profit,
 26 nongovernmental health insurance funds. Sickness funds are financed by mandatory contributions
 27 imposed as a percentage of employees’ gross wages up to a ceiling. High-income individuals can
 28 choose to opt out and instead purchase substitutive private coverage. Switzerland requires residents
 29 to purchase mandatory statutory health insurance, which is offered by competing nonprofit
 30 insurers. Direct financing for health care providers, predominantly for hospitals providing inpatient
 31 acute care, comes from tax-financed government budgets. Residents pay premiums for statutory
 32 health insurance coverage; premiums are redistributed among insurers by a central fund, adjusted
 33 for risk. In the Netherlands, all residents are required to purchase statutory health insurance from
 34 private insurers. Its statutory health insurance is financed through a combination of a nationally
 35 defined, income-related contribution; a government grant for insured individuals under the age of
 36 18; and community-rated premiums set by each insurer. Such contributions are collected centrally
 37 and allocated to insurers according to a risk-based capitation formula.²⁴

38
 39 In its analysis of international health systems, the Council noted that private insurance can play a
 40 supplementary and/or substitutive role to public health insurance options. Based on the country,
 41 premiums for private coverage can be paid by individuals and/or employers, unions or other
 42 organizations. Supplementary insurance, available in several countries, covers services that are
 43 excluded or not fully covered in the statutory plan, which could include prescription drug, dental
 44 and/or vision coverage. It can also build off the statutory coverage provided to improve coverage
 45 and can provide increased choice of or faster access to providers. For example, private health
 46 insurance in Australia and Norway offers more choice of providers, as well as expedited access to
 47 nonemergency care. Substitutive insurance is duplicative of coverage offered in the statutory plan,
 48 and could be available to populations not covered by or those who opt out of the statutory plan. In
 49 Germany, many young adults with higher incomes take advantage of substitutive private health
 50 insurance, because health insurers offer them coverage for a more extensive range of services, as
 51 well as lower premiums.²⁵

1 The role of patient out-of-pocket payments in contributing to health care financing varies from
 2 country to country. In Canada, there is no patient cost-sharing for publicly insured physician,
 3 diagnostic and hospital services. In the United Kingdom, there is limited cost-sharing for publicly
 4 covered services. In countries where for many services patients have no cost-sharing, patients may
 5 have out-of-pocket responsibilities for outpatient prescription drugs, dental care and vision care. In
 6 many cases, vulnerable groups in these countries are either exempt from or face lower prescription
 7 drug copayments.²⁶

8
 9 Residents of Switzerland have similar types of cost-sharing exposures as privately insured
 10 individuals in the US. Insured adults are responsible for deductibles for statutory health insurance
 11 coverage, which can be lower, closer to \$235, or higher, more than \$1,900, depending on patient
 12 choice. After the deductible is met, individuals pay 10 percent coinsurance for all services, up to an
 13 annual maximum of approximately \$550 for adults, with the cap for children being roughly half of
 14 that for adults. Low-income individuals are eligible for premium subsidies, and regional
 15 governments or municipalities cover the health insurance expenses of individuals receiving social
 16 assistance benefits or supplementary old age and disability benefits.²⁷

17
 18 Overall, several other countries, while requiring deductibles and/or copayments, also impose caps
 19 on cost-sharing, which limit patient out-of-pocket responsibilities. There are also exemptions from
 20 cost-sharing for vulnerable populations. For example, in Germany, there is an annual cap on cost
 21 sharing for adults equal to two percent of household income; the cap is equal to one percent of
 22 household income for chronically ill individuals. In Sweden, annual out-of-pocket payments for
 23 health care visits are capped below \$200.²⁸

24
 25 Finally, approaches to paying providers vary, and are not wholly dependent on a country's health
 26 care financing model. Physicians can be salaried, or be paid via fee-for-service and capitation.
 27 Payments to physicians can also depend on whether patients have registered with and/or received a
 28 referral from their primary care physician. Physician fee schedules can be regulated or set by
 29 national, regional or local health authorities, negotiated between national medical
 30 societies/physician trade unions and the government, or negotiated/set by sickness funds or health
 31 plans. Physicians in some countries can also receive performance-based payments. Patient out-of-
 32 pocket payments contribute varying levels to physician payment, depending on cost-sharing
 33 responsibilities.

34
 35 **CONSIDERATIONS IN EVALUATING PROPOSALS TO EXPAND COVERAGE**

36
 37 *Coverage Impacts*

38
 39 None of the legislative proposals to expand coverage highlighted in this report have been formally
 40 scored by the Congressional Budget Office to assess their impacts on coverage. That being said,
 41 proposals that would establish a single-payer system that would enroll all US residents into a single
 42 plan would be expected to lead to universal coverage. The coverage impacts of other proposals to
 43 expand coverage via a public plan available to all lawfully present individuals in the US would
 44 depend on whether individuals are able to opt out of the coverage, and what other provisions are
 45 included to maximize coverage rates. Some proposals would achieve universal coverage for legal
 46 residents, but not for undocumented individuals. Others, including public option proposals, would
 47 be expected to increase coverage, but at much lower rates.

48
 49 The coverage impacts of proposals that aim to build upon and fix the ACA will depend on whether
 50 provisions to improve upon and/or expand premium tax credits and cost-sharing reductions;
 51 improve access to premium tax credits and cost-sharing reductions for those who find their

1 employer-sponsored coverage unaffordable; and/or establish a federal reinsurance program are
 2 coupled with mechanisms to maximize coverage rates, such as meaningful individual mandate
 3 penalties or an auto-enrollment mechanism. Also, additional states expanding their Medicaid
 4 programs would positively impact coverage rates, as 2.5 million of the nonelderly uninsured have
 5 incomes below 100 percent FPL and fall into the “coverage gap” due to their state’s decision not to
 6 expand Medicaid.²⁹ Of note, certain policy options to improve the ACA have been evaluated to
 7 assess their potential impacts on overall coverage rates. For example, researchers from RAND
 8 Corporation modeled the impact of increasing the generosity of premium tax credits and extending
 9 eligibility for premium tax credits beyond 400 percent FPL, and concluded that implementing those
 10 policy options would increase the number of total insured by 2.4 million people in 2020. In
 11 addition, RAND modeled the impact of a generous reinsurance program, estimated to lead to an
 12 additional 2 million individuals having health insurance coverage in 2020.³⁰

13
 14 The Urban Institute also estimated the coverage impacts of reform proposals to build upon and fix
 15 the ACA, including:

- 16
- 17 • Reinstating the ACA’s individual mandate penalties and cost-sharing reduction payments
 18 and prohibiting the expanded availability of STLDI plans;
- 19 • Expanding Medicaid eligibility in all remaining states, with full federal financing of the
 20 Medicaid expansion for all states; and
- 21 • Improving marketplace assistance, including the enhancement of the ACA’s premium tax
 22 credit and cost-sharing subsidy schedules; tying ACA financial assistance to gold instead
 23 of silver level coverage; and establishing a permanent federal reinsurance program.
- 24

25 The Urban Institute assumed that 32.2 million nonelderly people would be uninsured in 2020. If
 26 these proposals to build upon and fix the ACA were enacted into law, the Urban Institute projected
 27 that number would drop to 21.1 million people in 2020 – a decrease of 11.1 million.³¹

28
 29 *Patient Choice of Health Plan*

30
 31 The ability of and degree to which patients would be able to choose their health plan would vary
 32 greatly under proposals put forth to cover the uninsured. Some Medicare-for-All proposals would
 33 not allow individuals with employer-sponsored coverage to keep their coverage; other proposals,
 34 including Medicare for America and proposals that build upon the ACA, would, to varying
 35 degrees. Depending on the proposal that builds upon Medicare to cover all US residents, patient
 36 choice of health plan would depend on whether the structure of the public plan is indeed a singular
 37 public plan in which everyone enrolls, or if it would follow a structure similar to Medicare
 38 Advantage. Under Medicare buy-in proposals, individuals starting at age 50 would have a choice
 39 between their existing mode of coverage and buying in to Medicare. Medicaid buy-in and other
 40 public option proposals are generally adding another plan to pick from on the marketplaces. The
 41 Council notes that if Medicaid buy-in and other public options are able to offer coverage at much
 42 lower premiums than existing marketplace plans, that could impact the size of premium tax credits
 43 available to individuals, which are pegged to the second lowest cost silver plan on the marketplace.
 44 If premium tax credit amounts are lower, individuals may have a choice of health plan, but may be
 45 able to afford fewer coverage options on the marketplaces.

46
 47 *Scope of Benefits*

48
 49 The scope of benefits under proposals introduced to cover the uninsured vary in terms of
 50 comprehensiveness of benefits and cost-sharing. Medicare-for-All proposals that have been
 51 introduced at the time that this report was written would cover medically necessary services in

1 outlined benefit categories, dental and vision services, and long-term services and supports.
2 Generally, there would be no cost-sharing for these services, with the exception of S 1129, the
3 Medicare for All Act of 2019, introduced by Senator Sanders, which would give the Secretary of
4 HHS the authority to allow for cost-sharing for prescription drugs, up to \$200 per year. Medicare
5 for America would cover benefits determined to be medically necessary, including long-term
6 services and supports for the elderly and individuals with disabilities, with cost-sharing
7 responsibilities varying by income. Under the Medicare buy-in proposal for older individuals
8 starting at age 50, such individuals would be entitled to the same benefits under Medicare Parts A,
9 B and D as current Medicare beneficiaries. Public option proposals, including Medicaid buy-ins,
10 generally follow the ACA's essential health benefits requirements, with cost-sharing dependent on
11 income.

12 *Impacts on Patient Access*

13
14
15 Proposals to expand health insurance coverage can be expected to vary also in their impacts on
16 patient access to care. Overall, increased demand for services would depend on how many
17 individuals would become insured under the proposal. In addition, patient demand for services
18 would vary based on the level of cost-sharing required under the proposal in question. For example,
19 under traditional Medicare-for-All proposals, cost-sharing would generally be eliminated, which
20 would be expected to lead to an increased utilization of medical services, as well as those services
21 not typically covered under traditional health insurance (e.g. dental, vision, hearing). On the other
22 hand, individuals use less care if cost-sharing is higher. As such, if patients were still responsible
23 for a certain level of cost-sharing, the effect on demand for services would be expected to be more
24 modest.

25
26 Provider supply and participation in any new public health insurance option can be expected to be
27 impacted by the level at which providers are paid (e.g., Medicare or some variation thereof,
28 Medicaid, new negotiated rates). For Medicare and Medicaid buy-in proposals as well as others
29 that would create a public option, requiring provider participation could also impact whether
30 providers continue to participate in traditional Medicare and/or Medicaid, potentially impacting
31 current beneficiary access to care. In assessing the Medicare for All Act of 2017 as introduced by
32 Senator Bernie Sanders, a working paper released by the Mercatus Center at George Mason
33 University stated that "it is not precisely predictable how hospitals, physicians, and other health
34 care providers would respond to a dramatic reduction in their reimbursements under M4A, well
35 below their costs of care for all categories of patients combined."³² In addition, RAND Corporation
36 recently analyzed a single-payer plan for the state of New York, and an assumption incorporated
37 into its modeling was that "providers reduce supply of services when payment levels decrease or
38 financial risk increases."³³ Another RAND report assessing national health spending estimates
39 under Medicare-for-All stated that "providers' willingness and ability to provide health care
40 services including the additional care required by the newly insured and those benefiting from
41 lower cost sharing would likely be limited."³⁴

42
43 Of concern to the Council are those proposals that would greatly increase demand for services,
44 while containing provisions expected to negatively impact provider supply. In detailing its methods
45 for assessing the presidential campaign proposal of Senator Sanders in 2016, Urban Institute stated
46 that "the Sanders plan would increase demand for health services by eliminating individuals' direct
47 contributions to care (i.e., by eliminating deductibles, copayments, and coinsurance), but not all
48 increased demand could be met because provider capacity would be insufficient."³⁵ The Mercatus
49 Center study of the Medicare for All Act of 2017 stated that while some practices and facilities
50 would be able to continue to operate, others would not, "thereby reducing the supply of health care
51 services at the same time M4A sharply increases health care demand. It is impossible to say

1 precisely how much the confluence of these factors would reduce individuals' timely access to
 2 health care services, but some such access problems almost certainly must arise."³⁶ RAND's report
 3 on national health spending estimates under Medicare-for-All stated "[t]he extent and distribution
 4 of unmet care would depend on providers' payer mix under current law and their responses to
 5 Medicare-for-All payment levels. For example, some providers may elect to not participate in a
 6 Medicare-for-All plan (and instead enter in private contracts with individuals, an arrangement
 7 permitted in some single-payer bills), providers may alter when they retire, and potential medical
 8 students and trainees could change their career choices. As a result, some patients might experience
 9 longer wait times for care or face unmet needs."³⁷

10
 11 Concerns regarding wait times also echo data comparing health systems of different countries. For
 12 example, while 51 percent of patients in the United States were able to get an appointment the
 13 same or next day, that number falls to 49 percent in Sweden and 43 percent in Canada, and is 57
 14 percent in the United Kingdom. Only six percent of patients in the US had a wait time of two
 15 months or longer to access a specialist, whereas wait times to see a specialist were significantly
 16 longer in countries with systems classified in the study as national health service and single-payer.
 17 Thirty-nine percent of patients in Canada had wait times of two-months or longer to see a
 18 specialist, with 19 percent of patients in the United Kingdom and Sweden facing such specialist
 19 wait times. Health systems in countries classified to be "insurance-based" (e.g. Germany,
 20 Switzerland, Netherlands, France) have more comparable wait times to the US.³⁸

21
 22 *Other Impacts on Physician Practices*

23
 24 Health reform proposals that have been introduced have the potential to impact physicians and their
 25 practices in a multitude of ways, based on factors that include practice size and specialty; physician
 26 employment status; geography; and the payer mix of patients. As previously noted, transitioning
 27 the entire US population to a plan that pays Medicare rates, or has rates closely tied to that of
 28 Medicare, is expected to negatively impact practices that cannot cover their costs of care based on
 29 Medicare rates. Importantly, the Council notes innovation and practice enhancements can be
 30 undermined if practices were solely to rely on Medicare payment rates, therefore stifling delivery
 31 reform that promises to lower costs and improve care while maintaining access. Some Medicaid
 32 buy-in proposals raise similar concerns, especially those that use Medicaid payment rates in the
 33 buy-in program. On the other hand, proposals to build upon and fix the ACA would maintain the
 34 variety in the potential payer mix for physician practices.

35
 36 The choices physicians currently have in their practice of medicine would be more limited under
 37 proposals that would enroll all US residents in a single public health insurance plan. That being
 38 said, it will be important to monitor if supplemental or substitutive private insurance would be
 39 allowed in such proposals, which would either replace the statutory coverage, or build off of the
 40 statutory coverage provided to improve coverage and provide increased choice of or faster access
 41 to providers. The Council notes that there may be an additional opportunity for physicians to
 42 participate in a parallel private market if it is allowed under such proposals.

43
 44 Requirements for provider participation must be assessed in any proposal that would establish a
 45 public option or allow individuals to buy into Medicare or Medicaid. Such proposals assume
 46 physician participation in these plans if they participate in traditional Medicare and/or Medicaid.
 47 Under such proposals, if there is no provider opt-out provision, physicians would be expected to
 48 differ in their willingness to continue their participation in the existing traditional Medicare and
 49 Medicaid programs, as well as in their decisions on whether to accept new patients. Any proposal
 50 that ties physician participation in Medicare and/or Medicaid to a new public insurance option
 51 would also have the potential to significantly impact the payer mix of physician practices. The

1 Council notes that Policies H-285.989 and D-383.984 oppose “all products” clauses or linking a
2 physician’s participation in one insurance product to that physician’s participation in any other
3 insurance product.

4
5 Health reform proposals that drastically impact physician practice payer mix could also impact
6 practice efficiency. While proposals that build upon the ACA would continue the practice of
7 physicians interacting with a variety of health plans, transitioning all US residents into one public
8 health insurance plan could mean that physicians only interact with one plan, with the same
9 benefits package and payment rates, as well with one set of rules governing the use of utilization
10 management practices.

11 *Cost and Financing*

12
13
14 The Council notes that none of the outlined legislative proposals to expand coverage have been
15 formally scored by the Congressional Budget Office to assess their costs. That being said, think
16 tanks and other entities have provided estimates of certain proposals. Medicare-for-All proposals
17 that cover a comprehensive set of benefits with no cost-sharing are expected to incur the largest
18 increases in federal spending. Recent analyses of Medicare-for-All proposals have been based on
19 the Medicare for All Act of 2017 as introduced by Senator Sanders, his 2016 Medicare-for-All
20 presidential campaign proposal, or a general Medicare-for-All proposal that would provide
21 comprehensive health coverage, including long-term care benefits, with no-cost sharing. Of note,
22 none of these analyses specifically measure the effects of S 1129, the Medicare for All Act of 2019,
23 introduced by Senator Sanders in April of 2019. These analyses, published by the Urban Institute,
24 the Mercatus Center at George Mason University, Kenneth Thorpe of Emory University and
25 RAND Corporation, projected that Medicare-for-All proposals would require a large increase in
26 federal spending. However, there are important differences among the analyses; as a result, they are
27 not directly comparable. First, while Mercatus estimated the effects of the Medicare for All Act of
28 2017 as introduced, Urban Institute and Kenneth Thorpe evaluated Senator Sanders’ 2016
29 presidential campaign proposal. As a result, the Mercatus Center assumed a four-year phase in of
30 Medicare-for-All, but did not include an expansion in long-term services and supports – both
31 differences between the 2017 version of the legislation and the campaign proposal. RAND, on the
32 other hand, provided estimates of a more generic Medicare-for-All proposal. Of note, all of these
33 studies made their cost projections over different time periods. The studies also did not have the
34 same assumptions of the level at which providers would be paid under Medicare-for-All.^{39,40}

35
36 The Mercatus Center estimated that the Medicare for All Act of 2017 would increase federal
37 spending by approximately \$32.6 trillion from 2022 to 2031, assuming a four-year phase-in period
38 beginning in 2018.⁴¹ The Urban Institute projected that federal spending under the 2016
39 presidential campaign proposal would increase by \$32 trillion between 2017 and 2026.⁴² The
40 estimate of the campaign proposal put forth by Kenneth Thorpe was lower – closer to \$25 trillion
41 over the period from 2017 to 2026.⁴³ After the release of the Mercatus Center estimate, the Urban
42 Institute noted that its estimates would differ if it were to standardize the assumptions between the
43 two estimates. For example, Urban stated that if its estimate were over the same period as the
44 Mercatus Center, and still included expansion of long-term services and supports, its estimate
45 would be closer to \$40 trillion.⁴⁴ RAND Corporation estimated that Medicare-for-All would
46 increase federal health spending in 2019, rather than projecting a 10-year estimate, by 221 percent,
47 from \$1.09 trillion to approximately \$3.5 trillion.⁴⁵

48
49 All analyses estimating the cost of Medicare-for-All note that it would necessitate a complete
50 change in how health care is financed in the US. Nearly all current national spending on health care
51 by households, private businesses, and state and local governments would shift to the federal

1 government. How these entities fare after a transition to Medicare-for-All would ultimately depend
 2 on the pay-fors of the proposal. For example, in introducing the Medicare for All Act of 2019,
 3 Senator Sanders also released a white paper that laid out potential funding options, which included:

- 4
- 5 • Creating a 4 percent income-based premium paid by employees, exempting the first
- 6 \$29,000 in income for a family of four;
- 7 • Imposing a 7.5 percent income-based premium paid by employers, exempting the first \$2
- 8 million in payroll to protect small businesses;
- 9 • Eliminating health tax expenditures;
- 10 • Making the federal income tax more progressive, including a marginal tax rate of up to
- 11 70 percent on those making above \$10 million, taxing earned and unearned income at the
- 12 same rates, and limiting tax deductions for filers in the top tax bracket;
- 13 • Making the estate tax more progressive, including a 77 percent top rate on an inheritance
- 14 above \$1 billion;
- 15 • Establishing a tax on extreme wealth;
- 16 • Closing the “Gingrich-Edwards Loophole;”
- 17 • Imposing a fee on large financial institutions; and
- 18 • Repealing corporate accounting gimmicks.⁴⁶
- 19

20 Transitioning to the Medicare for America proposal, the Council notes that while the exact cost of
 21 the legislation is not yet known, it is expected to be significant, but cost less than the
 22 aforementioned Medicare-for-All proposals due to differences in plan premiums and cost-sharing
 23 requirements, and the role of employers. Of note, the sponsors of the bill put forward the following
 24 options to pay for the proposal as introduced during the 115th Congress:

- 25
- 26 • Sunsetting the Republican tax bill;
- 27 • Imposing a 5 percent surtax on adjusted gross income (including on capital gains) above
- 28 \$500,000;
- 29 • Increasing the Medicare payroll tax and the net investment income tax;
- 30 • Increasing the excise taxes on all tobacco products, beer, wine, liquor, and sugar-sweetened
- 31 drinks; and
- 32 • Incentivizing states to make maintenance of effort payments equal to the amounts they
- 33 currently spend on Medicaid and CHIP.⁴⁷
- 34

35 The cost of proposals to build upon the ACA depends on the comprehensiveness of the proposal,
 36 and whether provisions are coupled with a mechanism to maximize coverage rates, such as an
 37 individual mandate or auto-enrollment system, as well as restrictions on short-term limited duration
 38 plans and association health plans. RAND Corporation estimated the impact on the federal deficit
 39 in 2020 of some potential proposals to improve coverage in the individual market under the ACA:

- 40
- 41 • Providing young adults with enhanced premium tax credits: \$1.1 billion;
- 42 • Increasing the generosity of premium tax credits: \$6.4 billion;
- 43 • Extending eligibility for premium tax credits beyond 400 percent FPL: \$9.9 billion;
- 44 • Increasing and extending eligibility for premium tax credits: \$18.8 billion; and
- 45 • Establishing a reinsurance program: Savings of \$2.3 billion to \$8.8 billion depending on
- 46 generosity.⁴⁸
- 47

48 The Urban Institute also estimated the impact of proposals to build upon and fix the ACA on
 49 federal spending on acute health care for the nonelderly in 2020:

- 1 • Reinstating the ACA’s individual mandate penalties and cost-sharing reduction payments
2 and prohibiting the expanded availability of STLDI plans: Savings of \$11.4 billion;
- 3 • Expanding Medicaid eligibility in all remaining states, with full federal financing of the
4 Medicaid expansion for all states (when added to the previous bullet): \$68.1 billion; and
- 5 • Improving marketplace assistance, including enhancing the ACA’s premium tax credit and
6 cost-sharing subsidy schedules; tying ACA financial assistance to gold instead of silver
7 level coverage; and establishing a permanent federal reinsurance program (added to the
8 two previous bullets): \$131 billion.⁴⁹

9
10 The cost of public option proposals, as well as Medicare and Medicaid buy-ins, depends on several
11 factors. First, the rate upon which provider payments are based will impact the cost, whether
12 provider rates are tied to Medicare or a variation thereof, Medicaid, or another payment mechanism
13 entirely. The cost of such proposals will also depend on whether they would be required to be
14 financially self-sufficient and not depend on the traditional Medicare or Medicaid programs for
15 parts of their financing. It will be paramount to assess the impact of any proposal that builds upon
16 the Medicare program, or relies on Medicare program financing in part, on the solvency of the
17 Medicare Trust Fund.

18
19 DISCUSSION

20
21 The AMA has long supported health system reform alternatives that are consistent with AMA
22 policies concerning pluralism, freedom of choice, freedom of practice, and universal access for
23 patients. To expand coverage to all Americans, the AMA has advocated for the promotion of
24 individually selected and owned health insurance; the maintenance of the safety net that Medicaid
25 and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market
26 demands it. On the whole, the AMA proposal for reform recognizes that many individuals are
27 generally satisfied with their coverage, but provides affordable coverage options to those who are
28 uninsured or are having difficulties affording coverage options, including employer-sponsored, for
29 which they are eligible.

30
31 While the ACA has made great strides in covering the uninsured, the Council is concerned with the
32 recent uptick in the uninsured rate, as well as future coverage impacts of zeroing out the federal
33 individual mandate penalty, the expanded provision of STLDI, and other proposals put forward that
34 could likely undermine the progress made to date. That being said, the ACA is not broken, but it is
35 imperfect. Instead of abandoning the ACA and threatening the stability of coverage for those
36 individuals who are generally satisfied with their coverage, the Council believes that now is the
37 time to invest not only in fixing the law, but improving it. Improving the ACA appropriately targets
38 providing coverage to the uninsured population, rather than upending the health insurance coverage
39 of most Americans. Modifications to the law could also improve the coverage options for many
40 who are underinsured and/or cite costs as a barrier to accessing the care they need. In addition,
41 focusing the efforts of our AMA on improving the ACA helps promote physician practice viability
42 by maintaining the variety in the potential payer mix for physician practices. Importantly, the
43 Council is concerned about the cost of proposed Medicare-for-All proposals, and how the
44 proposals’ pay-fors would impact patients and physicians.

45
46 The AMA proposal for reform, based on AMA policy, is still the right direction to pursue in order
47 to cover the uninsured, and is cognizant that, in this environment, the ACA is the vehicle through
48 which the AMA proposal for reform can be realized. As such, by putting forward new proposals to
49 build upon and fix the ACA, as well as reaffirming existing policies adopted by the House of
50 Delegates, the AMA proposal for reform as follows has the potential to make significant strides in
51 covering the remaining uninsured and providing health insurance to millions more Americans:

- 1 • Premium tax credits would be available to all individuals without an offer of “affordable”
2 employer coverage.
- 3 • Individuals currently caught in the “family glitch” and unable to afford coverage offered
4 through their employers for their families would become eligible for ACA financial
5 assistance based on the premium for family coverage of their employer plan.
- 6 • To help people currently having difficulties affording coverage, the threshold used to
7 determine the affordability of employer coverage would be lowered, which would make
8 more people eligible for ACA financial assistance based on income.
- 9 • The generosity of premium tax credits would be increased to improve premium
10 affordability, by tying premium tax credit size to gold-level instead of silver-level plan
11 premiums, and/or lowering the cap on the percentage of income individuals are required to
12 pay for premiums of the benchmark plan.
- 13 • Young adults facing high premiums would be eligible for “enhanced” tax credits based on
14 income.
- 15 • Eligibility for cost-sharing reductions would be increased to help more people with the
16 cost-sharing obligations of the plan in which they enroll.
- 17 • The size of cost-sharing reductions would be increased to lessen the cost-sharing burdens
18 many individuals with low incomes face, which impacts their ability to access and afford
19 the care they need.
- 20 • A permanent federal reinsurance program would be established, to address the impact of
21 high-cost patients on premiums.
- 22 • State initiatives to expand their Medicaid programs will continue to be supported. To
23 incentivize expansion decisions, states that newly expand Medicaid would still be eligible
24 for three years of full federal funding.
- 25 • To maximize coverage rates, the AMA would continue to support reinstating a federal
26 individual mandate penalty, as well as state efforts to maximize coverage, including
27 individual mandate penalties and auto-enrollment mechanisms.
- 28 • To improve coverage rates of individuals eligible for either ACA financial assistance or
29 Medicaid/CHIP but who remain uninsured, the AMA would support investments in
30 outreach and enrollment assistance activities.
- 31 • States would continue to have the ability to test different innovations to cover the
32 uninsured, provided such experimentations a) meet or exceed the projected percentage of
33 individuals covered under an individual responsibility requirement while maintaining or
34 improving upon established levels of quality of care, b) ensure and maximize patient
35 choice of physician and private health plan, and c) include reforms that eliminate denials
36 for pre-existing conditions.

37
38 Importantly, the Council stresses that our AMA proposal for reform provides a strong policy
39 foundation to use in evaluating health reform proposals as they get introduced in the coming years,
40 regardless of whether they are tied to the ACA. As such, the Council does not support the policy
41 rescissions proposed in referred Resolution 108-A-18. While the Council continues to believe that
42 AMA should not support single-payer proposals, there is the potential for other health reform
43 proposals to be put forward in the future that could be consistent with AMA policy. The Council
44 underscores that the AMA will continue to thoughtfully engage in discussions of health reform
45 proposals, which will vary greatly in their structure and scope. Opposing single-payer proposals
46 does not preclude that engagement, nor mean that the AMA will not evaluate health reform
47 proposals that are introduced. Ultimately, our AMA, guided by policy, will continue forward in its
48 efforts to advocate for coverage of the uninsured.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 108-A-18, and that the remainder of the report be filed.

- 5
6 1. That our American Medical Association (AMA) support eliminating the subsidy “cliff”,
7 thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty
8 level (FPL). (New HOD Policy)
9
10 2. That our AMA support increasing the generosity of premium tax credits. (New HOD Policy)
11
12 3. That our AMA support expanding eligibility for cost-sharing reductions. (New HOD Policy)
13
14 4. That our AMA support increasing the size of cost-sharing reductions. (New HOD Policy)
15
16 5. That our AMA reaffirm Policy H-165.828, which supports legislation or regulation, whichever
17 is relevant, to fix the Affordable Care Act (ACA’s) “family glitch”; and capping the tax
18 exclusion for employment-based health insurance as a funding stream to improve health
19 insurance affordability. (Reaffirm HOD Policy)
20
21 6. That our AMA reaffirm Policy H-165.842, which supports the establishment of a permanent
22 federal reinsurance program. (Reaffirm HOD Policy)
23
24 7. That our AMA reaffirm Policy H-165.824, which supports providing young adults with
25 enhanced premium tax credits while maintaining the current premium tax credit structure
26 which is inversely related to income; encourages state innovation, including considering state-
27 level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of
28 individuals covered and stabilize health insurance premiums without undercutting any existing
29 patient protections; and supports adequate funding for and expansion of outreach efforts to
30 increase public awareness of advance premium tax credits. (Reaffirm HOD Policy)
31
32 8. That our AMA reaffirm Policy D-290.979, which states that our AMA, at the invitation of state
33 medical societies, will work with state and specialty medical societies in advocating at the state
34 level to expand Medicaid eligibility to 133 percent [(138 percent federal poverty level (FPL)
35 including the income disregard)] FPL as authorized by the ACA. (Reaffirm HOD Policy)
36
37 9. That our AMA reaffirm Policy H-290.965, which supports extending to states the three years
38 of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
39 (Reaffirm HOD Policy)
40
41 10. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which
42 support educational and outreach efforts targeted at those eligible for Medicaid and Children’s
43 Health Insurance Program, as well as improved and streamlined enrollment mechanisms for
44 those programs. (Reaffirm HOD Policy)
45
46 11. That our AMA reaffirm Policy D-165.942, which advocates that state governments be given
47 the freedom to develop and test different models for covering the uninsured, provided that their
48 proposed alternatives a) meet or exceed the projected percentage of individuals covered under
49 an individual responsibility requirement while maintaining or improving upon established
50 levels of quality of care, b) ensure and maximize patient choice of physician and private health

1 plan, and c) include reforms that eliminate denials for pre-existing conditions. (Reaffirm HOD
2 Policy)

Fiscal Note: Less than \$500

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