A PATH TO UNIVERSAL HEALTHCARE

SUMMARY:

Introduction:
The Affordable Care Act (ACA, Obamacare) was passed into law in 2010 yet we are still far from achieving universal healthcare. The COVID-19 pandemic has made clear how important that goal is to protect public health and prevent suffering. We must act now. This report details some of the barriers to universal healthcare and some specific measures that can be taken on the path to achieve that goal: encouraging Medicaid expansion, strengthening Obamacare, using a proven model to negotiate drug prices, providing a better public option plan, eliminating wasteful tax subsidies, and merging all public insurance into Medicare.

The COVID-19 pandemic has highlighted the need for universal healthcare in this country and the problems with our current system of insurance coverage.

- Prior to passage of the ACA, there were over 44 million Americans without health insurance
- As of 2018, there were just under 29 million uninsured
- As of May 2020, as a result of the COVID-19 pandemic:
  - Almost 27 million people become newly uninsured
  - About half became eligible for Medicaid
  - 8 million became eligible for tax credits under the ACA
  - Almost 6 million were ineligible for any insurance with financial assistance
- When unemployment insurance runs out in January 2021, if unemployment is unchanged for these people, the situation for them depends on where they live:

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<th>In states that expanded Medicaid</th>
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- Although most insurance companies have been waiving coinsurance for most costs related to COVID-19, some gaps in coverage remain, including out-of-network fees, and waivers have expired for almost half. As new cases and hospitalizations increase, millions risk bankruptcy due to the cost of medical care.

Medicaid is the primary stopgap, but gaps in coverage are large
When the ACA became law in 2014, 19 states refused to expand Medicaid
- Since then, 5 of those states eventually decided by legislative or executive action to expand Medicaid
- In 6 additional states, the citizens forced the issue by ballot initiatives that required Medicaid expansion to be adopted
- 8 states still have no plans to expand Medicaid
- In addition, 43 states have had 55 waivers approved to bypass various elements of the original design of Medicaid expansion under the ACA, including work requirements, eligibility and enrollment restrictions, benefit, copay and healthy behavior restrictions and changes in behavioral health provisions
- 27 more waivers across 21 states are pending approval
- Medicaid payments to providers are often low due to state budget restraints, leading to problems with patient access to care

The ACA (Obamacare) has provided insurance for millions, but it is complicated and too expensive for many,
- It has 5 different levels of coverage: bronze, silver, gold, platinum and catastrophic (only allowed for some individuals)
- Increasing levels must cover a larger percentage of the cost of care, but have higher premium costs
- Out-of-pocket costs can still be as high as $8,150 a person
- Premiums can be reduced with tax credits for those with family income from 1 to 4 times the federal poverty level, with lower credits for higher income levels
- Credits can be used in advance, but may need to be paid back if income changes
- In 2019, the average ACA enrollee paid a premium of $87/month even counting subsidies; 70% of the uninsured say they can afford no more than $75/month
- Out-of-pocket costs can also be reduced with subsidies, but only for those with 1 to 2.5 times the federal poverty level and only for those who buy a silver plan
- One-third of patients needed help signing up for Medicaid or ACA coverage
- Two-thirds of those who needed help didn’t understand their options and half found the process too complicated

Public option plans have been proposed as a solution, but are limited
- They have limited ability to control healthcare costs
- They do not relieve the problems of unaffordable premiums and out-of-pocket costs
- They do not address problems with access to care
- They do not address problems with increasing costs of medical care
- There are a confusing number of different proposals

Given these problems, what is the path to universal healthcare?

Details of the 8-point path to Universal Healthcare:
1. Encourage expansion of Medicaid
   a. Change the formula for federal cost sharing
i. Current formula is based on state’s median income  
ii. Instead, base formula on Medicaid enrollment  
b. Eliminate work requirements, which are counterproductive  
c. After transition period, gradually merge Medicaid into Medicare  
i. Eliminates excess administrative costs  
ii. Eliminates barriers to care due to state waivers  
iii. Eliminates barriers to care due to budget restraints  
iv. Allows for care across state borders  
v. Equalizes care around the nation  

2. Strengthen Obamacare by making it more affordable and understandable  
a. Eliminate bronze tier and catastrophic coverage  
b. Eliminate short-term policies  
c. Lower out-of-pocket costs  
d. Provide higher subsidies for premiums and cost-sharing  
e. Provide cost-sharing subsidies for same incomes as subsidies for premiums  
f. Increase funding for customer assistance  

3. Provide a sustainable means for lower drug prices  
a. Remove restraints on negotiating drug prices  
b. Use model with proven success  
i. Allow launch price in first year without restraint on prescription  
ii. Conduct independent assessment comparing new drug with existing treatments  
iii. Negotiate price based on relative cost/benefit and cost in other countries  
iv. No price increases allowed without new assessment  

4. Provide a better public option plan  
a. Should be administered by Medicare to save costs  
b. Should have no deductibles  
c. Gradually eliminate copayment  
d. Gradually increase services provided (medications, dental, hearing, home care, nursing home)  
e. These same improvements should also occur in standard Medicare  

5. Eliminate tax subsidies to encourage enrollment in public option  
a. Eliminate health savings account and flexible spending accounts  
b. Gradually phase out tax exemption for employer sponsored health insurance premiums  
c. These mostly benefit the wealthy  

6. Monitor progress and adjust designs to optimize the likelihood of achieving universal healthcare  
a. Increase spending on consumer assistance to reduce barriers to enrollment due to complexity and confusion  
b. Provider reimbursements may need to be adjusted  
c. Cost control may be limited by multiple payers  

7. Simplify the healthcare system by merging all public insurance into Medicare.  
a. Medicaid, the public option under Obamacare, and Medicare will all be one
b. Administrative costs are lowest

c. If this becomes the dominant form of insurance, after a transition period, a single payer system can be developed that will eliminate barriers and improve cost control

8. Instead of opting-in to Medicare, enrollment will be automatic and simple, eliminating confusion

   a. Everyone will be enrolled in Medicare
   b. Anyone who wants private insurance can keep but only the very best private insurance will be able to compete with Medicare
   c. Providers will only be responsible for billing Medicare; individuals are responsible for billing any private insurance they keep
   d. This will dramatically reduce the administrative burden for providers, saving billions of dollars each year
   e. Private health insurers will continue to receive billions of dollars to process claims for Medicare, as they do now
   f. This will create an efficient, single-payer system—Medicare for All—that will benefit everyone by improving health and productivity and decreasing costs
A PATH TO UNIVERSAL HEALTHCARE
American Council to Advance Medicare for All

The U.S. leads the world in cost of healthcare per person but lags behind in measures of quality health outcomes. The intrinsic problems with the system of healthcare coverage in the U.S. have been highlighted by the failures of that system to provide adequate care during the COVID-19 pandemic, with the potential for 27 million newly uninsured. This has led to an overwhelming majority of citizens, both Republicans and Democrats, to call for the U.S. to join the other developed countries of the world in creating a system of universal healthcare. The Affordable Care Act (ACA, popularly known as Obamacare), which went into effect in 2014, took a major step in that direction, decreasing the number of people without health insurance from over 44 million to under 27 million, until changes enacted by Republicans resulted in an increase in the uninsured by about 1 million over the past two years.

One of the most important aspects of the ACA was the expansion of Medicaid, designed to include all families with household income below 138% of the federal poverty level, with 90% of the cost covered by the federal government. Unexpected resistance by Republican governors and state legislators led to 19 states refusing to expand their Medicaid programs, with the Supreme Court invalidating the ACA regulation that would have stripped those states of any Medicaid funding. However, the value of this component of the ACA in providing for healthcare for those most in need who are unable to obtain it by any other means did not escape the public. Since 2014, five of those states decided by legislative or executive action to expand Medicaid (often after election of a Democratic governor) and in six additional states, the citizens forced the issue by a ballot initiative requiring expansion. Unfortunately, 43 states have had 55 waivers approved to bypass various elements of the original design of Medicaid expansion under the ACA, including work requirements, eligibility and enrollment restrictions, benefit, copay and

4 https://nypost.com/2020/05/14/has-the-coronavirus-crisis-changed-how-americans-feel-about-universal-health-care/
5 https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
8 https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/
healthy behavior restrictions and changes in behavioral health provisions and 27 more waivers across 21 states are pending approval.\(^9\)

The importance of Medicaid expansion is shown by the fate of the newly uninsured as a result of COVID-19. About half became eligible for Medicaid and another 8 million became eligible for tax credits under the ACA. Almost 6 million were ineligible for any insurance with financial assistance. More urgently, when unemployment insurance runs out in January 2021, if unemployment is unchanged for these people, the situation for them depends on where they live\(^3\):

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Although most insurance companies have been waiving coinsurance for most costs related to COVID-19, some gaps in coverage remain, including out-of-network fees, and waivers have expired for almost half.\(^10, 11\) As new cases and hospitalizations increase, millions risk bankruptcy due to the cost of medical care. State governments are in a similar situation. While their budgets are impaired by the economic downturn resulting from business closures related to the pandemic, they are simultaneously strained by increased costs from surging Medicaid rolls.

Those eligible for Medicaid or marketplace insurance under the ACA have additional barriers. In a recent survey, about one-third of individuals eligible for either one said they needed help to apply for coverage. Two-thirds of those who needed help didn’t understand their options and half found the process too complicated. Almost one-fifth didn’t have an internet connection at home.\(^12\) Despite this, the current administration has decreased funding for navigators to provide consumer assistance.\(^12\)

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The ACA has its own complexities that limit its accessibility. It has 5 different levels of coverage: bronze, silver, gold, platinum and catastrophic (only allowed for some individuals). Increasing levels must cover a larger percentage of the cost of care but have higher premium costs. In 2019, the average ACA enrollee paid a premium of $87 a month, even counting subsidies; yet 70% of the uninsured say they can afford no more than $75 a month. Premiums can be reduced with tax credits for those with family income from one to four times the federal poverty level, with lower credits for higher income. Credits can be used in advance but may need to be paid back if income changes. Out-of-pocket costs can be as high as $8,150 a person. Out-of-pocket costs can also be reduced with subsidies, but only for those with one to 2.5 times the federal poverty level and only for those who buy a silver plan.

The ACA was designed to ensure that all low-income households would either be eligible for premium-free coverage under Medicaid or receive subsidies to help them afford premiums in the ACA marketplaces. But since states were expected to provide Medicaid to anyone with family income below the federal poverty level, subsidies were only provided for those with income between 100% and 400% of the federal poverty level, leaving a coverage gap for millions. The additional restrictions imposed by Medicaid waivers leaves even more people without Medicaid or ACA subsidies.


The individuals in the coverage gap are mostly low-wage and part-time workers who have limited ability to obtain health insurance through work. The average premium for marketplace insurance without subsidies for either a silver or bronze plan ranges between 30% and 80% of these workers’ monthly wages—far beyond what they can afford. In addition, the non-expansion states are concentrated in the South where low-wage workers are predominantly persons of color. This coverage gap therefore exacerbates the disparities in healthcare access and outcomes seen between white and non-white populations in the U.S.\textsuperscript{14}

The ACA originally included plans for a public option, which would allow individuals to purchase health insurance from a government-run plan instead of a private plan, if they wanted to. There was considerable debate in Congress about how this would be achieved, whether or not and how much money it would save, and what the advantages and disadvantages of it were. In the end, a public option was not included in the ACA.\textsuperscript{15} This has led to renewed interest in public option plans as a way to improve the ACA toward the goal of achieving universal health care. The result has been a confusing array of proposals.\textsuperscript{16}

\textsuperscript{14} Halpin HA and Harbage P. The origins and demise of the public option. Health Affairs 2010; 29:1117-24.

\textsuperscript{15} \url{http://files.kff.org/attachment/Table-Side-by-Side-Comparison-Medicare-for-all-Public-Plan-Proposals-116th-Congress}
Unfortunately, these proposals have unrealistic expectations of administrative savings since profits are a small component of the difference between the cost of private plans and government plans.\textsuperscript{17}

\textsuperscript{17}Congressional Budget Office. Private Health Insurance Premiums and Federal Policy. February, 2016. 
www.cbo.gov/publication/51130
For this reason, none of these plans relieve the problems of unaffordable premiums and out-of-pocket costs, ensuring that healthcare access will still be a problem for many. All have limited ability to control healthcare costs.

With this background, there are some reasonable recommendations that can be made that will help achieve universal healthcare in the U.S.

1. **Encourage expansion of Medicaid.** The current formula for calculating the federal share of each state’s Medicaid costs (formally known as the Federal Medical Assistance Percentage, or FMAP) uses the state’s average per capita income in relation to the national average per capita income. States with lower average per capita income are reimbursed a higher share of their costs but the law limits the range of FMAP to between 50% and 83%. In 2019, the average FMAP was 60% with a range of 50% (13 states) to 77% in Mississippi. (Some additional legislation adds special provisions for the District of Columbia, native Americans, and some specific services.) However, prior to passage of the ACA, there was no requirement that states provide Medicaid to all low-income households. States that have not expanded Medicaid under the ACA, and therefore provide services under prior regulations, have wide latitude to determine eligibility. Some of these states deny

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eligibility to anyone without children (except for pregnant women) *regardless of income* since this is what is allowed under minimum federal guidelines.\textsuperscript{19}

![Figure 5: Median Medicaid/CHIP Eligibility Thresholds, January 2013](image)

Even states that have expanded access under the ACA often seek to limit access to the program through various waivers. These may take various forms, such as work requirements, even though these have been shown to be counterproductive.\textsuperscript{20} This is not surprising when you realize that 42\% of Medicaid expenses are for the disabled, 23\% for the elderly and 20\% for children.\textsuperscript{19}


The end result is that states that offer generous benefits to all low-income households may receive significantly lower cost-sharing from the federal government than states that sharply limit benefits because the FAMP is based primarily on the average income in the state, not on the benefits provided.

One solution is to change the formula for FMAP. If instead of basing federal cost sharing solely on a state’s average per capita income, if the FMAP also considered the percentage of those below the national average per capita income who receive Medicaid services, it would better serve the purpose of varying the FMAP, i.e., to ease the burden of care for low-income households more fairly for those states that are required to provide more services to them. An important addition to this is to limit federal waivers that limit eligibility, especially those that are known to be counterproductive, such as work requirements.

Equally important would be the gradual merging of Medicaid into the Medicare program, eliminating entirely the state component so that eligibility requirements, services provided, and reimbursements are eventually equalized across the country. There are several advantages to this. First, the administrative component of healthcare costs would decrease by at least 7%, a savings of billions of dollars a
Second, barriers to care would be removed due to elimination of waivers that vary according to state. Third, additional barriers would be relieved due to elimination of state-by-state restriction of services due to budget restraints (often in the form of reduced reimbursement rates, decreasing the availability of providers). Fourth, access to care across state borders would be enabled, currently a problem for many complex medical problems requiring specialized consultations and for routine problems for patients living in areas near state borders. Last, care provided to individuals on Medicaid would be equalized across the country instead of being subject to the vagaries of state residency.

Several options could be considered for carrying out a gradual transition of Medicaid into Medicare. For example, each year a proportion of states could be offered the option to transfer all Medicaid patients into Medicare, relieving them entirely of the cost of their care. The choice of states could be determined by lottery or, in order to implement the goal of expanding Medicaid more rapidly, the order of states could be determined first by the order in which they opted to expand Medicaid, and then by their FMAP (the lower the FMAP the sooner the offer of transfer to Medicare). Alternatively, each year a percentage of each state’s Medicaid patients could be transferred into Medicare.

2. Strengthen Obamacare by making it more affordable and understandable. The first improvement to make in Obamacare would be to eliminate the bronze tier and the catastrophic coverage option. It is hard enough for consumers to make the best choices when shopping, but healthcare is too complicated to expect individuals to choose what is best for them when unreasonable choices are placed before them. The multiple tiers of coverage in the ACA marketplace are confusing enough, but the bronze tier and catastrophic coverage options offer too little coverage to be of value to anyone but the wealthiest individuals. Yet these are the people who are either unlikely to choose them or who have little need of the cost savings they offer. Low-income individuals are only too likely to take the risk of choosing coverage with low annual premiums in the hope that they will not get sick, ignoring the possibility that they will likely be unable to afford the care they need if they do get sick because their insurance will not cover it. The bronze tier and catastrophic options offer confusion and disappointment without significant benefit to anyone.

Similarly, short-term policies, available in some states, should be eliminated. These policies have a number of limitations, including failure to cover pre-existing conditions, inability to apply for standard Obamacare coverage if you lose coverage during the year until the next open enrollment, limits on covered benefits, limited provider networks, and limits on what is considered cost sharing toward out-of-pocket limits. These limitations are not always well understood by individuals who

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purchase these plans because of their low cost, and they are often unable to afford the cost of care if they get sick.\textsuperscript{22}

Lower out-of-pocket costs are essential to make Obamacare more affordable. Out-of-pocket costs are a major cause of treatment delay and missed care.\textsuperscript{23} In 2016, 16\% of those under 65 were in households that had problems paying medical bills.\textsuperscript{24} Deductibles in particular have a negative effect on access to care and particular attention should be paid to elimination or dramatic reduction of these. Copayments should also be kept to a level that minimizes the likelihood that they will cause individuals to avoid care and reasonable limits should be placed on total annual out-of-pocket costs.

It is also important to provide higher subsidies for premiums and cost sharing. Instead of subsidizing only those individuals with income below a certain level, the suggestion that premium subsidies be provided for anyone for whom the premium exceeds a certain percentage of household income (e.g., 8\%) is more reasonable. This has the advantage of achieving the goal of affordability without setting an arbitrary level of income for eligibility. It also allows for changing needs as premiums vary according to the marketplace. A similar method could be used for cost sharing, comparing the annual limits on cost sharing to the household income. To reduce the burden of cost sharing, these subsidies should be based on the gold tier instead of the silver tier, as is currently done.

Finally, the ACA marketplace is confusing and not easy to navigate. It is not always clear to individuals whether they are eligible for Obamacare or for subsidies or how to get subsidies. Not everyone has internet access—an essential tool—or internet skills. And not everyone who needs Obamacare is fluent in English. These problems have been recognized from the outset. The ACA required that marketplaces operated by the states or the federal government must have Navigator programs that help consumers apply for coverage and financial assistance. However, since 2017, the administration has reduced Navigator funding in 32 federal marketplace states from $63 million to $10 million. This


despite the fact that about 7 million people required consumer assistance in 2020.\textsuperscript{25} Funding for the Navigator program should be restored and increased.

\textbf{Figure 2}

\textbf{Reasons Consumers Sought Help Applying For Health Coverage}

Percent who say each of the following is a reason they sought help with the health insurance/Medicaid application or renewal process (multiple responses allowed):

- Didn’t understand health coverage options: 62%
- Process was too complicated to complete on your own: 52%
- Don’t have internet at home: 18%
- Technical problems with website: 18%
- Need help in another language: 15%

\textit{NOTE: Asked among those who say they received help with health insurance or Medicaid application or renewal from someone other than a family member or friend. “Need help in another language” was only asked of Spanish speakers.}

\textit{SOURCE: KFF Consumer Assistance Survey (March 26-April 14, 2020). See topline for full question wording.}

\textbf{3. Provide a sustainable means for lower drug prices.} Currently, Medicare is not allowed to negotiate directly with drug companies on prices. Instead, negotiations are conducted between insurance companies or pharmacy benefit manufacturers and the drug companies. Often, the result is prices that benefit intermediaries instead of patients or Medicare.\textsuperscript{26} Meanwhile, prescription drug costs increased 50% as a portion of total personal health care spending from the 1990s to 2015, while drug profits increased to about three times that of the largest 500 non-drug companies in the world. And the federal government has been spending steadily on drug research, while drug companies have been putting their research and development money largely into development—bringing a drug to market.\textsuperscript{27} It is time to remove restraints on negotiation of drug prices to lower the burden of cost on the government and individuals. It is clear that this can be done without harming the profitability of the drug industry (which is very profitable) or affecting innovation (which is primarily sponsored by the federal government).


\textsuperscript{26} Bump B. Audit: CVS failed to pass on rebates. Albany Times Union. 6/13/2019.

A sensible way to accomplish this would be to use a model that has been proven successful elsewhere. Germany has been using a system of negotiation that allows a considerable degree of freedom for drug companies, yet also constrains prices to a reasonable level.\footnote{Robinson JC. Lower prices and greater patient access—lessons from Germany’s drug-purchasing structure. New England Journal of Medicine 382:2177-2179, 2020.} Notably, Germany has costs about one-third lower than the U.S., duplicating spending at this level could save the U.S. about $100 billion a year.\footnote{Organization for Economic Cooperation and Development, Pharmaceutical spending. \url{https://data.oecd.org/healthres/pharmaceutical-spending.htm}}

The details of the plan include allowing the drug company’s launch price in first year without any restraint on prescription for medically necessary use. During this time an independent commission conducts and compares the new drug with existing treatments. After the review is completed, Medicare negotiates a price based on the relative cost/benefit and the cost in other countries. If a price cannot be agreed upon, it goes to binding arbitration. Price increases are not allowed without a new assessment and a new round of negotiations.

Since generic drugs have also caused increasing problems with unwarranted price increases, they should be included in this model for negotiation.\footnote{Special Committee on Aging, United States Senate. Sudden spikes in off-patent prescription drugs: The monopoly business model that harms patients, taxpayers, and the U.S. health care system. December, 2016. \url{https://www.collins.senate.gov/sites/default/files/DP%20Report.pdf}} Generic price increases should not be allowed without a cost/benefit assessment and demonstration of need.

4. **Provide a better public option plan.** There was considerable debate about possible inclusion of a public option in Obamacare to allow individuals to choose an insurance plan sponsored by the government.\footnote{Halpin, HA and Harbage, P. The origins and demise of the public option. Health Affairs 29(6):1117-1124, 2010.} In the end, the bill did not include a public option. There are now a number of bills before Congress to add a public option in an attempt to improve Obamacare. However, these bills have a confusing array of different proposal that leave many problems unsolved. They generally have limited approaches to controlling healthcare costs and modest proposals for dealing with unaffordable premiums and out-of-pocket costs.
There is value to the concept of a public option, however, and a better public option plan should be made available that would capitalize on this potential. The most important potential feature of a better public option plan is that it should be administered by Medicare. This would save billions of dollars in administrative costs (on average 2-3% vs. 11.5% of total healthcare expenditures). Second, the public option plan should have no deductibles, and copayments should be gradually eliminated. These out-of-pocket costs deter needed care resulting in minimal net cost savings, when considering the increased cost of caring for patients who delay care. Third, the public option plan should gradually increase the services provided, starting with medications and then adding dental, hearing, home care, and nursing home services. These additional services will provide enormous benefits and can be financed from savings gained by reduced administrative costs, savings on drugs, and reduced use of more expensive services.


33 See detailed analysis of costs and savings related to provision of increased services in the Medicare for All Plan proposed by the American Council to Advance Medicare for All, https://www.acamfausa.org/
These same improvements should also be added to standard Medicare. The improvements to access to care will offset the additional costs. Of note, 27% of Medicare beneficiaries do not have Part D drug coverage.\textsuperscript{34}

5. **Eliminate tax subsidies to encourage enrollment in public option.** In order to ensure the success of the public option plan, enrollment must be encouraged so that costs, subsidies and premiums can remain affordable. If only the sickest people enroll in the public option, costs will be too high. In order to encourage enrollment, current tax subsidies for employer-sponsored plans that predominantly favor the wealthy should be eliminated. Health savings accounts and flexible spending accounts are used together with high-deductible health insurance plans. They offer the greatest benefit to those with high incomes in the highest income tax brackets. Lower income individuals may choose these plans and then find they have difficulty paying their healthcare expenses. These tax-exempt plans should be eliminated. Tax exemptions for employer sponsored health insurance premiums also benefit the wealthy more than those with lower income due to their higher tax brackets. They should be gradually phased out. By eliminating these unfair tax breaks that are not available to those who are unable to get insurance from their employers, enrollment in public option plans will be more attractive.

6. **Monitor progress and adjust designs to optimize the likelihood of achieving universal healthcare.** The success in achieving universal healthcare will depend on the success of Medicaid expansion and merging into Medicare, the level of benefits provided in the public option and the improved subsidies under Obamacare. Many of the policies outlined are complex and it should not be assumed that initial plans will attain desired goals. Provider reimbursements may need to be adjusted; Medicare’s administrative budget may need to be increased to improve the accuracy of claims processing; subsidies will need to be monitored to ensure that costs are not hindering enrollment; funding for outreach and consumer assistance may need to be increased. Yet it must be recognized that even with these efforts, cost control and effective achievement of universal healthcare may be limited by multiple payers.

7. **Simplify the healthcare system by merging all public insurance into Medicare.** Instead of having a public option administered by Medicare in each state on the marketplace exchanges, anyone who wants to opt-in to the public option will be enrolled in Medicare. Medicare will then include anyone currently on Medicare, Medicaid or eligible for Obamacare and choosing the public option. Administrative costs would be even lower and cost-saving programs would be more efficiently managed. If the public option is a success and the combined

Medicare program becomes the dominant form of insurance, private insurance would have a much less important role than it does today.

8. **After a transition period, instead of opting-in to Medicare, enrollment would be automatic and simple, eliminating confusion.** Everyone would be enrolled in Medicare as their primary insurance. Anyone who wants private insurance can keep it, but only the very best private insurance would be able to compete with Medicare. Providers would only be responsible for billing Medicare. This would dramatically reduce the administrative burden for providers, saving billions of dollars in costs each year. Private health insurers could continue to receive billions of dollars to process claims for Medicare, as they currently do. Savings would be maximized and disruption to the industry would be minimized. This will create an efficient, single-payer system—Medicare for All—that will benefit everyone by improving health and productivity and decreasing costs.

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35 See detailed analysis of our Medicare for All plan at: [https://www.acamfausa.org/](https://www.acamfausa.org/)