Proposals to reform America’s health-care system dominated the Democratic presidential primaries, and the cost of health care remains one of the top concerns of American voters. Sweeping partisan legislation is unlikely to pass what will be a narrowly divided 117th Congress. Nevertheless, there is likely to be some common ground and scope to:

- Reduce Medicare out-of-pocket drug costs
- Auto-enroll seniors in Medicare Advantage
- Require insurers to renew short-term health-care policies for enrollees who get sick

Prescription drugs are the largest routine medical expense for many seniors, and out-of-pocket expenses amount to 18% of prescription drug spending in the United States. For seniors, high out-of-pocket costs for prescription drugs reflect flaws in the design of Medicare’s Part D prescription drug benefit. Under current payment rules, the federal government picks up more of the cost if manufacturers inflate list prices for drugs—even though this increases out-of-pocket costs for seniors. Leaders of both parties are eager to fix these perverse incentives, by increasing the responsibility of prescription drug plans for Part D costs and directing the government’s savings toward capping Medicare patients’ out-of-pocket costs.

*This issue brief was completed before the inauguration and updated as of January 26.*
Complex health-insurance plans can be difficult for people to choose between without assistance. This is particularly problematic in the case of Medicare, which serves elderly Americans who may feel less comfortable shopping around and for whom the default is significantly inferior to every permitted alternative.

Whereas the default Medicare plan exposes beneficiaries to potentially unlimited out-of-pocket costs, all Medicare Advantage (MA) plans are required to cap out-of-pocket costs at $6,700 per year, and most cap them below this. Whereas unsubsidized enrollees in the default Medicare plan need to pay additional premiums averaging $505 for prescription drug coverage (and half of them fail to enroll in Part D), 84% of beneficiaries can purchase MA plans covering prescription drugs with no additional premium. Most MA enrollees also receive additional dental benefits—typically covering preventive exams, x-rays, and cleanings without out-of-pocket costs.

Medicare beneficiaries enrolled in privately managed MA plans are more likely to receive appropriate preventive care, are more likely to be treated by cost-effective providers, are less likely to be hospitalized, and have a lower mortality rate than those who remain in the default Medicare plan.

Congress should follow the recommendation of scholars from both the left and the right who have advocated altering Medicare program rules, so that newly eligible beneficiaries are enrolled by default in the highest-quality plan in their county. This would, in turn, strengthen the incentive for MA plans to enhance the quality of their coverage.

ACA sought to make affordable coverage available to Americans with preexisting conditions by requiring insurers on the individual market to sell plans at the same price to individuals who sign up before or after they get sick. This caused plans to prove disproportionately attractive to those with the costliest medical needs, driving up premiums and leading millions of healthy Americans to drop coverage altogether.

The Trump administration sought to make available affordable alternatives by eliminating restrictions on Short-Term Limited Duration plans in 2018. Democrats have been concerned that this would risk exposing more Americans to unanticipated gaps in health-insurance coverage while causing ACA
premiums to increase by drawing away low-cost healthier enrollees. Experience demonstrated, however, that the availability of these short-term plans, and their popularity, did not cause ACA premiums to rise. But this lower-cost insurance option has served to increase overall insurance coverage over the past couple of years.

Nevertheless, there is a legitimate and serious concern that individuals, once enrolled in short-term plans, will be unable to renew their policies if they develop a major medical condition. Congress should therefore strengthen consumer protections by requiring such insurance plans to renew coverage indefinitely, regardless of medical risks that policyholders might develop. This would combine the advantages of long-term security of coverage with those of lower premiums for enrollees who sign up before they are ill and maintain continuous coverage.

Read more

Chris Pope, “Fixing Private Health Insurance,” National Affairs, no. 25 (Summer 2020)
Pope, “Continuous Renewable Coverage: Rx for America’s Dysfunctional Health Insurance System,” Manhattan Institute, December 2020
As President Biden assumes office, his administration and the 117th Congress face several pressing tasks. Among them: accelerating the pace of recovery from the pandemic, helping to get schools reopened and students back on track, and restoring safety to the many American cities afflicted by unrest and rising violence. In these briefs, Manhattan Institute fellows offer actionable ideas for the new government—proposals for educational pluralism, executive branch prudence, economic revitalization, evidence-based criminal justice reform, fair and efficient health care, near-term fiscal relief, and long-term fiscal discipline. Each brief contains specific recommendations for Congress or the new administration, along with links to further reading. Taken together, these recommendations represent an agenda for fostering the growth and opportunity that America desperately needs in the wake of the pandemic.