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KEY DESIGN COMPONENTS AND CONSIDERATIONS FOR ESTABLISHING A SINGLE-PAYER HEALTH CARE SYSTEM

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, D.C., MAY 22, 2019

Serial No. 116–9

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KEY DESIGN COMPONENTS AND CONSIDERATIONS FOR ESTABLISHING A SINGLE-PAYER HEALTH CARE SYSTEM

WEDNESDAY, MAY 22, 2019
HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, D.C.

The Committee met, pursuant to call, at 10:04 a.m., in Room 210, Cannon House Office Building, Hon. John A. Yarmuth [Chairman of the Committee] presiding.

Present: Representatives Yarmuth, Moulton, DeLauro, Doggett, Morelle, Horsford, Scott, Jayapal, Peters, Khanna, Cooper, Schakowsky, Sires, Panetta, Jackson Lee, Womack, Woodall, Johnson, Flores, Stewart, Roy, Meuser, Timmons, Hern, Norman, Burchett, Crenshaw, and Smith.

Chairman YARMUTH. The hearing will come to order.

Good morning, and welcome to the Budget Committee's hearing on "Key Design Components and Considerations for Establishing a Single-Payer Health Care System."

I want to welcome our witnesses with us today from the Congressional Budget Office.

This morning we will be hearing from Mr. Mark Hadley, Deputy Director at CBO. He will make an opening statement.

After his opening statement, he will be joined by Dr. Jessica Banthin and Dr. Jeffrey Kling. Dr. Banthin is the Deputy Assistant Director for Health, Retirement, and Long-Term Care Analysis at the CBO, and Dr. Kling is the Associate Director for Economic Analysis at the Congressional Budget Office.

Members may direct their questions to any of the three witnesses.

Now I yield myself five minutes for the opening statement.

Once again, I would like to welcome our witnesses from the Congressional Budget Office. Thank you for joining us. I appreciate the opportunity to dive into your recent report on single-payer health care systems.

Ensuring access to quality, affordable healthcare remains one of the greatest policy challenges of our time. The Affordable Care Act has given us a great foundation on which to build. Since it was enacted, 20 million more Americans have been able to gain meaningful health coverage. Currently, 89 percent of Americans under 65 are insured, and that's a historic high.

But even with these dramatic gains, 30 million Americans still live without health insurance. And even for those Americans with health insurance, many are underinsured and still struggle with

high deductibles and copays. Too many American families still must make the impossible choice between going to the doctor or putting food on their table, filling their gas tank or refilling a prescription.

We cannot accept this tragic reality as the status quo. Progress must produce more progress. And we must begin to pursue the next wave of health care reforms.

That's why last summer I promised that if I became Chairman of the Budget Committee, we would hold a hearing on single-payer health care.

In January, I requested a CBO report on key policy considerations to lay the groundwork for advancing legislation to expand quality and affordable health coverage. Earlier this month, CBO released this report, and today we will examine its findings.

My goal for this hearing is to work through some of the policy issues laid out in this report, including what eligibility would look like and what benefits could be covered, how the system could be financed, how a single-payer system might affect the price of prescription drugs, what kind of transition period would be needed to allow health care providers and other stakeholders time to prepare.

Major reforms like the ones outlined in this report would mean major consequences for the health of our citizens, as well as the health of our economy. They must be done carefully and methodically but not without urgency. Access to affordable health care isn't just a policy proposal or a political slogan. It is life or death for millions of Americans.

I also hope to review what we as a country spend on health care now and what we get in return, as well as our long-term fiscal outlook with or without major reforms.

Last year, health spending accounted for 18 percent of our economy. We spend upwards of $3.5 trillion annually as a nation on health care, more per person than any other country. Yet, our outcomes are some of the worst among developed nations. Our wasteful and inefficient system has led to skyrocketing prescription drug prices and out-of-pocket costs for consumers, all while insurance companies and CEOs continue to post massive profits.

A single-payer system could expand access to care, decrease our nation's total health care spending, and help grow our economy. The trick is closing the information gap on what single-payer health care truly is so that we can close the health coverage gap for millions of American families.

I know that the advocates here today and across the country have been at the front lines of this fight for years, and I want to thank you for that hard work and dedication.

I have also talked to small business owners and numerous CEOs of Fortune 500 companies. They privately tell me they are all for a single-payer system. They know we are the only country that provides health care the way we do.

Last year, the average U.S. employer spent more than $5,700 for a single employee plan and more than $14,000 for a family health plan. These CEOs know that a system of employer-based coverage puts them at a disadvantage with their global competitors.

There is a consensus among economists that our system of employer-based coverage displaces wages. Relieving employers from

the burden of providing coverage will empower American companies to raise employee wages, expand their businesses, and help to grow our nation's economy.

Given all these reasons, it is incumbent upon us to begin to work through the opportunities and tradeoffs involved in a single-payer system, as well as other ways to achieve universal coverage, many of which have been proposed by Members of this Committee. I strongly believe it is not a matter of if we will have universal coverage, but when. The CBO report and this subsequent hearing are designed to advance that timeline.

Before I close, I would like to request unanimous consent to submit materials from the American Academy of Actuaries, American Hospital Association, Health Over Profit for Everyone, Healthcare Leadership Council, National Association of Health Underwriters, National Nurses United, Partnership for Employer-Sponsored Coverage, and Public Citizen in the hearing record. Without objection, so ordered.

[The information follows:]

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Honorable John Yarmuth
Chairman
Committee on the Budget
U.S. House of Representatives
204-E Cannon House Office Building
Washington, DC 20515

Honorable Steve Womack
Ranking Member
Committee on the Budget
U.S. House of Representatives
204-E Cannon House Office Building
Washington, DC 20515

Dear Chairman Yarmuth, Ranking Member Womack, and distinguished Members of the Committee:

On behalf of the American Academy of Actuaries'[1] Health Practice Council, I appreciate the opportunity to provide the following for the official record of your committee's May 22 hearing regarding considerations for establishing a single-payer health care system.

Earlier this year, the Academy's Health Practice Council published an issue paper, *Expanding Access to Public Insurance Plans*. The paper outlines possible approaches for the implementation of a public health insurance plan, including the establishment of a public health insurance option, Medicare/Medicaid buy-ins, and a single-payer system. We welcome the opportunity to discuss the paper in more detail with you and your staff, as well as with other members of the committee.

We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss further, please contact David Linn, the Academy's senior health policy analyst (202.785.6931; linn@actuary.org).

Sincerely,

Audrey Halvorson, MAAA, FSA
Vice President
Health Practice Council
American Academy of Actuaries

CC: Members of the House Committee on the Budget

[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

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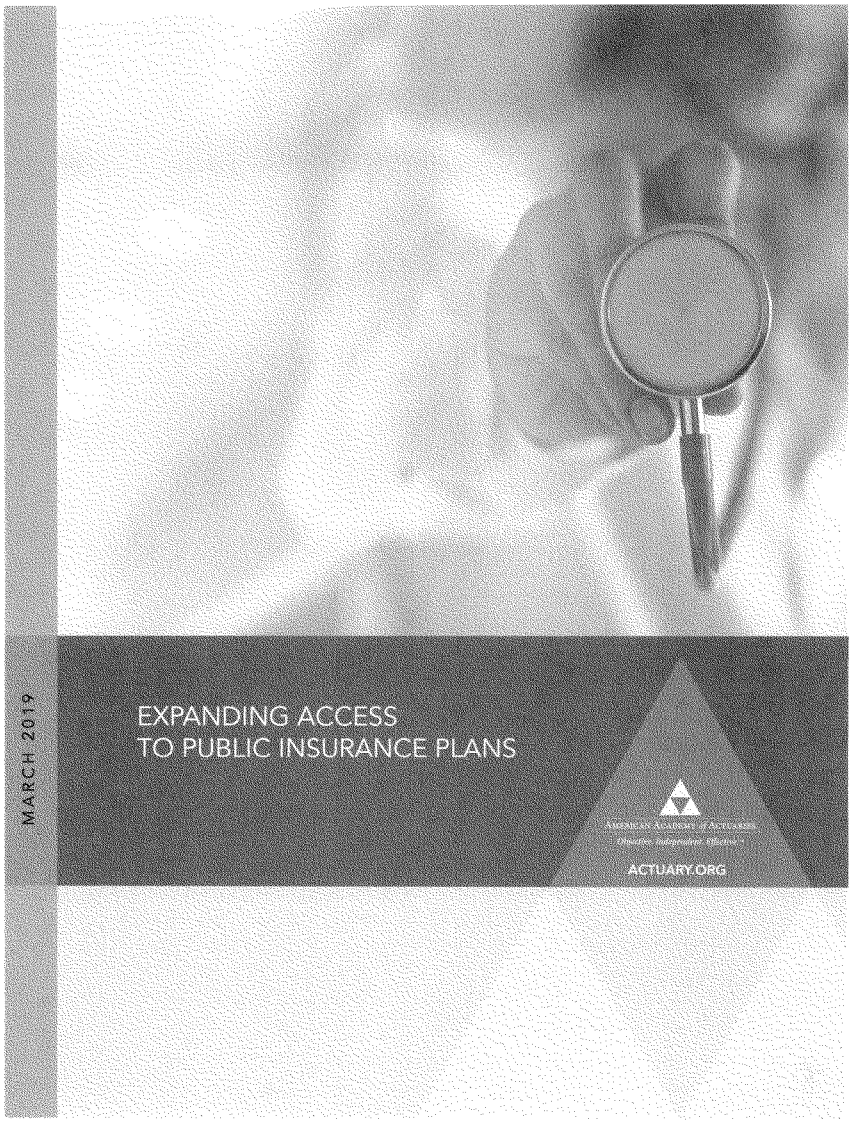
MARCH 2019
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The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

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Expanding Access to Public Insurance Plans

MARCH 2019

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Executive Summary

Proposals to expand access to public health insurance plans are being put forward to provide a way to supplement efforts to strengthen insurance markets under the Affordable Care Act (ACA) or to replace the ACA marketplaces and/or other health insurance programs altogether.

Goals of these proposals vary and include increasing access to affordable coverage, exerting downward pressure on provider prices, increasing plan availability, and reducing the number of uninsured. This issue paper from the American Academy of Actuaries Health Practice Council briefly outlines four approaches aiming to achieve such goals and highlights the key design elements that would need to be specified for an approach to be fully evaluated and implemented. Note that there are not clear lines demarcating these options, and particular proposals could have elements of more than one approach. In addition, different proposals often use different terminology to describe similar approaches. The nomenclature used in this paper attempts to accurately reflect each approach, and could differ from the terms used in particular proposals.

Including a government-facilitated plan in the ACA marketplaces.
Under this option, a government-facilitated or administered health plan would compete with other plans in the ACA marketplaces. The public plan would generally follow the requirements of the ACA marketplaces, including the issue, rating, and benefit coverage rules, and would be part of the single risk pool. The difference would be that the government-facilitated plan would likely use provider payment rates based on Medicare or Medicaid, or some rate between those levels and commercial payment levels.

Creating a Medicaid buy-in.
Under a Medicaid buy-in, all or certain individuals not currently eligible for Medicaid would be able to enroll directly into Medicaid and pay any applicable premiums. It would be administered by states or by private entities such as managed care organizations. Unlike a government-facilitated plan in the ACA marketplaces, it would likely operate outside of the exchange, would not be part of the ACA single risk pool, and would not necessarily be subject to the same rules as ACA plans.

Creating a Medicare buy-in.

Under a Medicare buy-in, all or certain individuals not currently eligible for Medicare would be able to enroll directly into Medicare and pay any applicable premiums. It would have many similarities to a Medicaid buy-in, but rather than being administered by states it would be administered by the federal government or by private entities such as managed care organizations. It would likely operate outside of the exchange, would not be part of the ACA single risk pool, and would not necessarily be subject to the same rules as ACA plans.

Medicare for more or for all.

Rather than creating a Medicare buy-in option, other approaches would more directly expand Medicare. These approaches range from extending Medicare eligibility by lowering the eligibility age (e.g., to age 55), extending Medicare eligibility to all U.S. residents, or extending Medicare eligibility to all and also restructuring the program to provide more comprehensive coverage.

When designing or evaluating a proposal to expand access to public health insurance plans, it's important for the goals of the proposal to be explicit. Regardless of the policy goal, many major and minor design elements need to be specified. These include:

- Who is the eligible population? Would the plan be available to all or would certain subgroups of the population or areas of the country be targeted? Would employers be allowed to enroll their workers in the public plan?
- Would coverage in the plan be an option among other coverage choices or the sole coverage source available?
- How would the program be funded and what entities would bear the financial risk?
- Who would administer the program?
- Would the program rely solely on public coverage (e.g., traditional Medicare) and/or include private plan choices (e.g., Medicaid managed care, Medicare Advantage (MA))?
- What benefits would be covered and what patient cost-sharing would be required?
- If other coverage options are available, would the public plan follow the same rules governing private plans competing for the same enrollees? Would the plan be part of the ACA single risk pool?
- How would provider payment rates be set? Would there be a provider network?
- How would premiums be determined and how would they vary among enrollees? Would premiums and/or cost-sharing be subsidized for low-income enrollees?
- Would the new plan be implemented all at once or phased in over time?

How these details are decided would affect the viability of the plan and the impacts it would have on coverage availability and affordability, not only of the public plan, but also of other coverage sources.

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Expanding Access to Public Insurance Plans

Introduction

Proposals to expand access to public health insurance plans are being put forward as a way to supplement efforts to strengthen insurance markets under the Affordable Care Act (ACA) or to replace the ACA marketplaces and/or other health insurance programs altogether.

Rather than examining particular proposals, this issue paper examines four general approaches for incorporating or expanding public plan availability in the health insurance system—including a government-facilitated plan in the ACA marketplaces, allowing individuals to buy into Medicaid, allowing individuals to buy into Medicare, and expanding Medicare to more or to all. The terms used to describe these various options are often used interchangeably but the approaches would be structured differently and have different impacts depending on the implementation details.

To help clarify these issues, this paper from the American Academy of Actuaries Health Practice Council provides a brief overview of each general approach and identifies the key design features that would need to be specified for an approach to be fully evaluated and implemented. The nomenclature used in this paper attempts to accurately reflect each approach, and may differ from the terms used in particular proposals. Note that there are not clear lines demarcating these options, and particular proposals could have elements of more than one approach.

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Designing and evaluating different proposals

When designing or evaluating a proposal to expand access to public plans, it's important for the goals of the proposal to be explicit. Such goals could include: increasing access to affordable coverage; exerting downward pressure on provider prices, especially in areas with high prices or little provider competition; increasing plan availability, especially in areas with few private insurance options; and reducing the number of uninsured.

Regardless of the policy goal, many major and minor design elements need to be specified. Among the most important is defining the eligible population. Would the plan be available to all or would certain subgroups of the population be targeted? And would coverage in the plan be an option among other choices or the sole choice available? Another primary design element is whether the program would rely solely on public coverage (e.g., traditional Medicare) or whether it would include private plan choices along the lines of Medicaid managed care or Medicare Advantage plans. Similarly, what entity bears the financial risk—the federal government, states, private plans, providers, or some combination? And of course, the funding for the program would need to be specified.

Aside from these more high-level elements, the particulars of how the program would work need to be specified. These design considerations include guidelines for what services are covered and the beneficiary share of the cost of those services, what the enrollment rules are, how provider payment rates are set, how premiums are determined, and how the program is administered.

When evaluating public plan expansion proposals, it's important to assess the impacts on public plan enrollment, premiums and other funding needs, and access to providers. Equally important is to examine the impact on other remaining coverage sources (if any). For example, for proposals that would maintain the health insurance marketplaces and other private health insurance options, it's important to assess the impact of the public plan expansion on those markets: Would marketplace enrollment increase or decrease, would the risk pool profile improve or worsen, would private insurers continue to offer coverage, would employers continue to offer coverage to their workers, and how would premiums be affected?

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Including a government-facilitated plan in the marketplaces

Under this approach, a government-facilitated or -administered health plan (also referred to here as a public plan) would compete with other plans in the ACA marketplaces. The primary difference between the government-facilitated plan and the participating private plans is that the government-facilitated plan would likely use provider payment rates based on Medicare or Medicaid, which can be much lower than the commercial provider payment levels, or some rate between those levels and commercial payment levels. In general, the government-facilitated plan would follow the rules of the ACA marketplaces, including the issue, rating, and benefit coverage rules, and would be part of the ACA single risk pool. To the extent that the same rules are not followed, either the public plan or the private plans could attract a disproportionate share of less-healthy individuals and find it more difficult to compete.

Key design considerations:

Where would the government-facilitated plan operate?

Government-facilitated plans could be made available in all areas or be limited to particular exchanges, depending on the goal of the program. For instance, if a goal is to serve as a fallback option, the government-facilitated plan could be targeted to areas with no or few participating private insurers. If a goal is to address high provider prices, the government-facilitated plan could be targeted to areas with high provider prices. When determining what criteria would be used to determine public plan availability, an assessment should be made as to whether particular options would encourage or discourage private plan participation.

It would also need to be determined whether the government-facilitated plan would operate solely on the ACA exchanges and/or off the exchanges.

Who would be eligible to enroll in the government-facilitated plan? Would employers be allowed to enroll their workers? Would any individuals or groups be automatically enrolled?

Presumably everyone currently eligible for ACA individual market coverage would be eligible to enroll in the government-facilitated plan, as one of the marketplace options. It's possible that in some geographic areas the public plan would be the only marketplace option available. Although this type of a proposed public plan expansion typically focuses on the individual market, it would need to be determined whether small and/or large employers would have access to the government-facilitated plan as well.

Another question is whether anyone eligible would be automatically enrolled in the public plan. Also, if any individuals more typically enrolled in other plans—such as Medicare, Medicaid, or employer-sponsored plans—would instead be targeted for individual market public plan enrollment, or automatically enrolled, the impact on each of the risk pools would need to be considered.

What entity would administer the government-facilitated plan?

A federal or state government entity could administer the public plan. Alternatively, the insurance and administrative tasks could be contracted out to a non-government entity, such as a managed care organization. Such tasks could include developing the plan design, setting premiums, premium collection, claims processing, ensuring regulatory compliance, risk adjustment processing, etc.

How would the program be funded and who would bear the financial risk?

It would need to be decided whether the program would be self-supporting through premiums (and perhaps also the federal government via ACA premium subsidies) or whether the program would have additional federal or state funding. Additional government funding solely for the government-facilitated plan compared with the private marketplace plans would affect premiums and create an unlevel playing field between the public plan and the private plans. Such advantages for the government-facilitated plan could affect marketplace participation among private plans.

Even if premiums are intended to fully fund the program, there could be a financial risk if the premiums turn out to be too low relative to plan costs (or a financial benefit if premiums exceed costs). What entity bears the risk—the federal government, states, and/or managed care organizations—depends on how the public plan is administered and whether there are risk-sharing mechanisms between the federal or state governments and participating managed care organizations.

Would the government-facilitated plan be part of the single risk pool, following the same issue, rating, and benefit coverage rules as private plans?

As long as it follows the same rules as private plans, the government-facilitated plan would most likely be part of the single risk pool. It would be required to cover the same benefits and follow the same issue and rating rules as other plans operating in the marketplaces. As a result, adverse selection concerns between the government-facilitated plan and private plans would be less as compared to having to compete under different rules. Differences in the risk profiles of the public plan and the private plans would be addressed at least partially through the risk adjustment program.

If, however, the government-facilitated plan were to compete under different rules, it could be more difficult to spread risks in the single risk pool and risk adjustment could be difficult to implement. As a result, the viability of plans attracting less-healthy individuals, whether the public plan or private plans, could be at risk.

What provider payment rates would be used in the government-facilitated plan? Would the plan establish a provider network?

The choice of what payment rates are used in the government-facilitated plan—Medicaid, Medicare, commercial, or some level between Medicare, Medicaid, and commercial rates—would affect premiums, the willingness of providers to treat patients with public plan coverage, and the willingness of private plans to participate in the market. The broadness or narrowness of any provider networks would also affect the attractiveness of the plan and the risk profile of enrollees. These tradeoffs would need to be considered. Lower provider payment rates could result in lower premiums for the public plan, potentially offset to some extent by a lower degree of utilization control if managed care organizations don't administer the plan. But in the absence of other mechanisms to encourage provider participation (e.g., mandatory participation for providers participating in Medicare or Medicaid), provider payment rates would need to be high enough to ensure adequate access to care, which could be especially problematic in rural areas with few providers. Another question is whether lower provider payment rates in the government-facilitated plan could provide more leverage to private plans to negotiate lower payment rates. Or whether instead private plans would find it more difficult to compete, potentially leading to their exit from the market.

How would premiums be set?

Assuming no external funding of the public plan (beyond any ACA premium subsidies), premiums would be set (by the administering government entity or a managed care organization) to cover expected claims and administrative costs. As long as the government-facilitated plan follows the ACA issue and rating rules, the premium factors used for the public plan would be the same as for the private ACA plans. Private plans are subject to medical loss ratio (MLR) requirements, limiting the share of premiums available for administration and profit. It would need to be determined whether the public plan would also be subject to the MLR requirement. If plan administration is shared between the federal or a state government and a private entity, it could be difficult to track the administrative expenses and determine the public plan MLR. In addition, it would need to be determined whether other requirements that affect premiums for private insurers would also apply to the public plan, such as health insurer taxes and fees and the need to hold adequate reserves.

How would ACA premium subsidies be affected?

Premium subsidies could be used toward the government-facilitated plan in the individual market, at least for on-exchange plans. Whether or not the premium for the government-facilitated plan is included in the calculation of the benchmark premium (the second-lowest-cost silver-tier plan) could affect subsidy levels, which in turn could affect enrollment dynamics. For instance, if the public plan affects the benchmark premium and results in lower premium subsidies, enrollment could shift from private plans to the lower-premium public plan. However, lower premium subsidies could result in lower enrollment more generally, potentially leading to a worsening of the risk pool.

It would also need to be determined whether individuals not already eligible for premium subsidies (e.g., because of eligibility for Medicaid or employer-sponsored coverage) would remain ineligible for premium subsidies.

Adverse selection and an unlevel playing field

"Adverse selection" describes a situation in which an insurer (or an insurance market as a whole) attracts a disproportionate share of unhealthy individuals. It occurs because individuals with greater health care needs, when given the opportunity, are more likely to purchase health insurance and to purchase health insurance with richer benefits or broader provider networks than individuals with fewer health care needs. Adverse selection can increase premiums for everyone in a health insurance plan or market because it results in a pool of enrollees with higher-than-average health care costs. Adverse selection is a byproduct of a voluntary health insurance market in which people can choose whether to purchase coverage and what coverage to purchase, depending in part on how their anticipated health care needs compare with the insurance premium charged.

Selection can also occur between plans or insurance markets if plans competing to enroll the same participants operate under different rules, often referred to as an unlevel playing field. If one set of plans operates under rules that are more advantageous to healthy or less costly individuals, then healthy or less costly individuals will migrate to those plans; less-healthy or more costly individuals will migrate to the plans more advantageous to them. In other words, plans that have rules more amenable to higher-risk/higher-cost individuals will experience adverse selection. In the absence of an effective risk adjustment program that includes all plans, upward premium spirals could result, threatening the viability of the plans more advantageous to higher-risk individuals.

Numerous rules governing health insurance can affect selection if they differ between competing plans or markets. These include rules regarding insurance issue and rating (e.g., how premiums can vary by age, health status, and geographic area; the presence and timing of open enrollment periods; whether pre-existing conditions can be excluded from coverage); benefit coverage requirements (e.g., essential health benefit requirements; cost-sharing requirements); and health insurer rules (e.g., minimum loss ratio requirements; reserve requirements; reporting requirements).

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Creating a Medicaid buy-in

Medicaid eligibility currently varies by state. In general, the federal government requires that state Medicaid programs cover low-income families (including parents, pregnant women, and children), low-income adults age 65 and older, and low-income individuals with disabilities. States also have the option to extend Medicaid eligibility to additional groups, including families and individuals above the minimum federal standards and otherwise eligible individuals with high medical expenses who have incomes exceeding the eligibility threshold (i.e., medically needy). Medicaid's benefit packages also differ by state, and within states by eligibility category. Medicaid is administered by states, but is jointly funded by the federal government and the states.

Under a Medicaid buy-in, individuals not currently eligible for Medicaid would be able to enroll directly into Medicaid and pay any applicable premiums. It would be administered by states. Unlike a government-facilitated public plan, it would operate outside of the exchange,[1] would not be part of the ACA single risk pool, and would not necessarily be subject to the same rules as ACA plans. How the Medicaid buy-in rules are structured and how they compare to the rules governing ACA plans would affect the enrollment, risk profiles, and premiums in both markets.

Key design considerations:

Where would Medicaid buy-in plans be available?

A Medicaid buy-in plan could be made available on a state-by-state basis, at each state's discretion. If federal funds would be required, the buy-in program would also be subject to federal approval.

Who would be eligible to enroll in a Medicaid buy-in? Would employers be allowed to enroll their workers? Would any individuals or groups be automatically enrolled?

A Medicaid buy-in could be made available to everyone, or be limited to particular groups—for instance individuals of certain ages, individuals without access to employer coverage or ACA subsidized coverage, or individuals with limited incomes. Other eligibility questions include whether the Medicaid buy-in is an option added to current coverage choices or is instead the only source of coverage for individuals eligible, whether certain populations are automatically enrolled in the buy-in plans, and whether employers can purchase buy-in

1 It would be possible for Medicaid buy-in plans to operate within the ACA exchanges. However, those plans would likely have to meet the ACA requirements regarding issue and rating rules, benefit requirements, etc. As a result, those plans could be similar to the government-facilitated plan option approach discussed above.

plans for their employees. The impact on other insurance markets, including the individual and employer group markets, could be larger the more expansively buy-in eligibility is defined.

Aside from eligibility, any enrollment rules would need to be determined. For instance, would there be limited open enrollment periods (and if so, would those coincide with ACA enrollment periods) or could individuals move into and out of the buy-in at any time? The latter could increase adverse selection effects between the buy-in program and other insurance markets.

Would the buy-in include traditional Medicaid coverage and/or coverage through a Medicaid managed care organization (MCO)?

Many states allow or require segments of their Medicaid beneficiaries to enroll in a managed care plan, and in 2016, about two-thirds of Medicaid enrollees were in a comprehensive managed care plan.[2] Such coverage is provided by risk-bearing Medicaid MCOs, which receive capitated rates to cover the costs of Medicaid benefits and associated administrative costs and profit. Would buy-in enrollees have the same options or requirements?

The buy-in population could be very different from the current Medicaid population in terms of their health care needs. Private insurers with expertise in the current Medicaid population, or a particular segment thereof, might not necessarily have expertise in a broader buy-in population. If enrollment in a Medicaid managed care plan is allowed or required in a Medicaid buy-in program, plans for currently eligible Medicaid beneficiaries might need to be distinct from plans for the buy-in population. Would MCOs be allowed to offer managed care plans to the buy-in population but not the currently eligible population, or vice versa?

How would the Medicaid buy-in program be funded?

It would need to be decided whether the program would be self-supporting through buy-in premiums (and perhaps also the federal government via ACA premium subsidies) or whether the program would have additional state or federal funding.

2 Medicaid and CHIP Access Commission, *MACPAC Medicaid and CHIP Data Book*, December 2018. Medicaid managed care enrollment is generally highest among non-disabled children and adults, and lower for disabled and aged beneficiaries.

How would the Medicaid buy-in be administered?

States would administer the program, but could contract with private MCOs to perform insurance and administrative tasks.

What benefits would be covered?

Federal rules require that Medicaid cover a broad range of benefits, including inpatient and outpatient hospital services and physician services, but states are allowed the option to cover additional benefits. As a result, Medicaid benefits vary considerably among states and also vary within states by Medicaid eligibility category. Medicaid mandated benefits include some services not considered part of ACA essential health benefits, and exclude some benefits that are. For instance, prescription drugs and physical therapy are not mandated Medicaid benefits but can be covered as optional benefits. States must offer nursing facility and home health care benefits, and can offer other long-term care services on an optional basis. Long-term care services are not typically covered by private health insurance plans. Because Medicaid is targeted to a low-income population, patient cost-sharing is usually held to a minimum.

It would need to be determined what benefits a Medicaid buy-in would cover. Would they reflect benefits the state currently uses for one or more of its eligibility categories, the ACA essential health benefits, or some other set of benefits? Also, would cost-sharing requirements change from the state's current requirements, which could be lower than those under ACA plans?

How benefits and cost-sharing are defined under a Medicaid buy-in plan and how they compare to those in ACA coverage could affect selection between the Medicaid buy-in plan and ACA coverage.

What would provider payment rates be under a Medicaid buy-in plan?

Provider payment rates would affect buy-in premiums as well as provider willingness to treat buy-in enrollees. Medicaid provider payment rates are often low compared with Medicare and commercial payment rates. If payment rates were set higher than current Medicaid rates, providers could be more willing to participate, but premiums would be higher. Payment rates for any new services covered would also need to be determined. A question is whether lower provider payment rates in the Medicaid buy-in plan could provide more leverage to individual and group market plans to negotiate lower payment rates. Or instead would private plans find it more difficult to compete with the buy-in, potentially leading to their exit from the individual or group market.

How would Medicaid buy-in premiums be set?

A key question is whether Medicaid buy-in premiums would be self-supporting or whether they would be subsidized by the state or federal government (aside from any premium subsidies provided to low-income enrollees through the buy-in program or through ACA premium subsidies, if applicable). If premiums are to be self-supporting, they would need to reflect the expected claims plus administrative costs for the buy-in population; any premiums for current Medicaid beneficiaries likely would be unaffected unless other changes are also made to the current Medicaid program. Even if premiums are intended to fully fund the program, there could be a financial risk if the premiums turn out to be too low relative to plan costs (or a financial benefit if premiums exceed costs). What entity bears the risk—the federal government, states, and/or managed care organizations—depends on how the buy-in plan is administered and whether there are risk-sharing mechanisms between the federal or state governments and participating MCOs.

It would also need to be determined whether and how buy-in premiums would be allowed to vary by individual characteristics, such as age or geographic area. If allowable premium rating factors differ from those in ACA plans, there could be selection effects between buy-in plans and ACA plans. Depending on the buy-in rules, lower-cost people could be better off purchasing buy-in coverage compared with ACA plans or other coverage choices, or vice versa. The buy-in plans would likely not be included in the ACA single risk pool, so there wouldn't be risk adjustment between buy-in plans and ACA plans. Even if it were desired to include buy-in plans in ACA risk adjustment, it could be difficult to do so, especially if the buy-in plans have different benefits and rating rules.

If more than one MCO were to participate in the buy-in program, there may need to be risk adjustment among participating organizations to reflect the risk profiles of different MCOs and reduce incentives for MCOs to avoid high-cost enrollees.

Could individuals use ACA premium subsidies toward a Medicaid buy-in plan?

It would need to be determined whether ACA premium subsidies could be used toward Medicaid buy-in premiums, and if so, whether and how buy-in premiums are used when determining the ACA benchmark plan. The latter could be complicated if buy-in plans cover different benefits or have different actuarial values than ACA plans. Allowing ACA premium subsidies to be used for Medicaid buy-in coverage could reduce enrollment in ACA plans, potentially reducing the viability of the ACA marketplaces. It could also reduce overall enrollment if the buy-in premium was used to determine the ACA benchmark premium and lower ACA premiums subsidies resulted.

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Creating a Medicare buy-in

Medicare eligibility is currently limited to individuals aged 65 and older and individuals younger than 65 meeting certain disability criteria. Under a Medicare buy-in, individuals not currently eligible for Medicare would be able to enroll directly into Medicare and would pay any applicable premiums. It would have many similarities to a Medicaid buy-in, but rather than being administered by states it would be administered by the federal government. It would operate outside of the exchange,[3] would not be part of the ACA single risk pool, and would not necessarily be subject to the same rules as ACA plans. How the Medicare buy-in rules are structured and how they compare to the rules governing ACA plans would affect the enrollment, risk profiles, and premiums in both markets. A Medicare buy-in could also affect the employer group health insurance market if coverage is extended to individuals who would be otherwise covered by employer plans.

Key design considerations:

Where would Medicare buy-in plans be available?

A Medicare buy-in plan could be made available nationwide. The federal nature of the program could make it more difficult to limit a buy-in to particular areas, perhaps unless done as a demonstration project.

Who would be eligible to enroll in a Medicare buy-in? Would employers be allowed to enroll their workers? Would any individuals or groups be automatically enrolled?

A Medicare buy-in could be made available to everyone, or be limited to particular groups, for instance individuals of certain ages (e.g., ages 55-64) or individuals without access to employer coverage. Other eligibility questions include whether the Medicare buy-in would be an option added to current coverage choices or would instead be the only available source of coverage for individuals eligible, whether certain populations would be automatically enrolled in the buy-in plans, and whether employers could purchase buy-in plans for their employees. The impact on other insurance markets, including the individual and employer group markets, could be larger the more expansively buy-in eligibility is defined.

3 It would be possible for Medicare buy-in plans to operate within the ACA exchanges. However, those plans would likely have to meet the ACA requirements regarding issue and rating rules, benefit requirements, etc. As a result, those plans could be similar to the government-facilitated plan approach discussed above.

Aside from eligibility, any enrollment rules would need to be determined. For instance, would there be limited open enrollment periods (and if so, would those coincide with ACA or Medicare enrollment periods) or could individuals move into and out of the buy-in at any time? The latter could increase any selection effects between the buy-in program and other insurance markets.

Would the buy-in include traditional Medicare coverage and/or Medicare Advantage coverage?

Current Medicare beneficiaries have the option of enrolling in traditional Medicare or in a Medicare Advantage plan. Would buy-in enrollees have the same options? Under traditional Medicare, the federal government bears the financial risk, although providers can sometimes share in that risk, for instance through bundled payments or accountable care organizations. Under Medicare Advantage, private plans bear the financial risk, although again, that risk can be shifted to or shared with providers depending on the provider payment arrangement. Under Part D prescription drug plans, private plans and the federal government bear the financial risk, with the latter shouldering much of the catastrophic costs of high-cost beneficiaries through a reinsurance program.

The buy-in population could be very different from the current Medicare population in terms of their health care needs. Private insurers with expertise in the current Medicare population may not necessarily have expertise in the buy-in population. If Medicare Advantage plans are included in the buy-in program, would plans for currently eligible Medicare beneficiaries be distinct from plans for the buy-in population? Would insurers be allowed to offer MA plans to the buy-in population but not the currently eligible population, or vice versa?

How would the program be funded?

It would need to be decided whether the program would be self-supporting through buy-in premiums (and perhaps also the federal government via ACA premium subsidies) or whether the program would have additional federal funding. As long as the buy-in premiums are fully self-supporting, there would be no net impact on the Medicare trust funds. However, state Medicaid budgets could be affected, depending on any changes in state funding responsibility for beneficiaries dually eligible for Medicare and Medicaid.

What entity would administer the buy-in program?

The federal government would administer the buy-in. As with the current Medicare program, some insurance and administrative tasks could be contracted out to private entities, through Medicare Advantage plans or other private contractors.

What is the current Medicare benefit structure?

Under traditional Medicare, benefits are covered by three separate parts. Medicare Part A covers inpatient hospital and post-acute services; Part B covers physician and outpatient hospital services; Part D covers prescription drugs. Each part is subject to different deductibles and coinsurance requirements. Eligible individuals automatically have Part A coverage, but parts B and D are optional. Private MA plans are more integrated and cover all of the services covered by the traditional Medicare program. MA plans (also known as Medicare Part C) can also provide benefits beyond those in traditional Medicare and are available both with and without prescription drug coverage.

Medicare benefits do not cover all of the ACA-required essential health benefits. For instance newborn care and prescription drug coverage is not required. And although MA plans have out-of-pocket limits, traditional Medicare coverage does not. Individuals with traditional Medicare can have supplemental coverage, in the form of an individually purchased Medigap plan or retiree benefits provided from a former employer. And low-income Medicare beneficiaries can have additional benefits and cost-sharing protections through Medicaid and Part D low-income subsidies.

What benefits would be covered?

Many decisions about benefits under a Medicare buy-in would need to be made, including:

- For a traditional Medicare buy-in option, would individuals have to choose both parts A and B? Would Part D coverage also be mandatory under either a traditional Medicare or Medicare Advantage buy-in option?
- Would buy-in benefits be supplemented in order to meet ACA essential health benefit requirements and the needs of a broader eligible population?
- What cost-sharing requirements and/or protections would be included?
- Would supplemental coverage, such as Medigap coverage, be available to buy-in enrollees?
- Would Medicare Advantage special needs plans (SNPs)—which tailor coverage to particular groups, such as those with specific conditions or dually eligible for Medicaid—be available to the buy-in population?

How benefits are defined under a Medicare buy-in plan and how they compare to benefits in ACA coverage could affect selection between the Medicare buy-in plan and ACA coverage. Estimates of the actuarial value of the traditional Medicare program range from 80 percent[4] to 84 percent.[5] These findings suggest that Medicare coverage is in the range of an ACA gold metal tier plan, although differences in underlying benefits can affect such comparisons.

What would provider payment rates be under a Medicare buy-in plan?

Provider payment rates would affect buy-in premiums as well as provider willingness to treat buy-in enrollees. If payment rates were set higher than current Medicare rates, providers could be more willing to participate, but premiums would be higher. Payment rates for any new services would also need to be determined. A question is whether lower provider payment rates in the Medicare buy-in plan compared to commercial coverage could provide more leverage to individual and group market plans to negotiate lower payment rates. Or instead would private plans find it more difficult to compete with the buy-in, potentially leading to their exit from the individual or group markets.

How would Medicare buy-in premiums be set?

A key question is whether Medicare buy-in premiums would be self-supporting or whether they would be subsidized by the federal government or states (aside from any premium subsidies provided to low-income enrollees through the buy-in program or through ACA premium subsidies, if applicable). If premiums are to be self-supporting, they would need to reflect the expected claims plus administrative costs for the buy-in population. Unless there were a specific policy goal to have cross subsidies between the current Medicare population and the buy-in population (or other changes made to the current Medicare program), premiums for current Medicare beneficiaries likely would be unaffected.

The federal government would be at risk if buy-in premiums for traditional Medicare were set too low relative to plan costs (and could benefit if premiums exceed costs). If MA plans are included as a buy-in choice, they would be at financial risk if those premiums were set too low. If a Medicare buy-in program is federally subsidized, there would need to be a structure to allocate the government subsidy, especially if MA buy-in plans are available. Additional subsidies for buy-in plans compared with individual or group market coverage would affect premiums and enrollment, potentially affecting the availability of individual and group market plans.

4 Frank McArdle, Ian Stark, Zachary Levinson, and Tricia Neuman, "How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans? A 2012 Update," Kaiser Family Foundation issue brief, April 2002. The Medicare actuarial value estimate includes prescription drug coverage.
5 Daniel W. Bailey, "Actuarial Value and the Actuarial Value of Original A/B Medicare," *In the Public Interest*, Issue 9, January 2014. The Medicare actuarial value estimate reflects parts A and B only and does not include prescription drug coverage.

It would also need to be determined whether and how buy-in premiums would be allowed to vary by individual characteristics, such as age or geographic area. If allowable premium rating factors differ from those in ACA plans, there could be selection effects between buy-in plans and ACA plans. Depending on the buy-in rules, higher-cost people could be better off purchasing buy-in coverage than other available coverage, or vice versa. In addition, setting a uniform national buy-in premium could result in high buy-in enrollment in areas with higher ACA premiums and lower enrollment in areas with lower ACA premiums. The buy-in plans would likely not be included in the ACA single risk pool, so there wouldn't be risk adjustment between buy-in plans and ACA plans. Even if it were desired to include buy-in plans in ACA risk adjustment, it could be difficult to do so, especially if the buy-in plans have different benefits and rating rules.

Aside from any risk adjustment between ACA plans and buy-in plans, if private plans participate in the program, there might need to be risk adjustment among buy-in plans to reflect the risk profiles of different buy-in plans and to reduce incentives for plans to avoid high-cost enrollees.

Could individuals use ACA premium subsidies toward a Medicare buy-in plan?

It would need to be determined whether ACA premium subsidies could be used toward Medicare buy-in premiums, and if so, whether and how buy-in premiums are used when determining the ACA benchmark plan. The latter could be complicated if buy-in plans cover different benefits or have different actuarial values than ACA plans. Allowing ACA premium subsidies to be used for Medicare buy-in coverage could reduce enrollment in ACA plans, potentially reducing the viability of the ACA marketplaces. It could also reduce overall enrollment if the buy-in premium was used to determine the ACA benchmark premium and lower ACA premiums subsidies resulted.

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Medicare for more or for all

Rather than creating a Medicare buy-in option, other approaches would more directly expand Medicare. These approaches range from extending Medicare eligibility by lowering the eligibility age (e.g., to age 55), extending Medicare eligibility to all U.S. residents, or extending Medicare eligibility to all and also restructuring the program to provide more comprehensive coverage. The latter two approaches are often referred to as "Medicare for All" or "single payer," and they would replace most or all other sources of coverage. However, the design details of particular proposals could be different and have different implications.

Key design considerations:

Where would Medicare eligibility be extended?

A reduction in the Medicare eligibility age would be made available nationwide. The federal nature of the program would make it more difficult to extend eligibility only to particular geographic areas.

How would Medicare eligibility be extended?

Medicare eligibility could be extended to all regardless of age, or the Medicare eligibility age could be lowered, for instance to age 55. Unlike a buy-in approach, in which Medicare could be one of many insurance coverage options, under a Medicare eligibility change, Medicare would become the primary source of coverage for those eligible, replacing other sources of coverage. Other coverage could potentially be available to supplement Medicare coverage.

Would the Medicare expansion include traditional Medicare coverage and/or Medicare Advantage coverage?

Presumably a change in the Medicare eligibility age would result in newly eligible Medicare beneficiaries having the same choices as current Medicare beneficiaries. That is, they would have a choice of enrolling in traditional Medicare (in which the federal government bears the financial risk) or in a risk-bearing Medicare Advantage plan and/or Part D plan. However, a policy to increase Medicare eligibility to more or to all could also include more structural changes to the Medicare coverage options, including the extent to which private plans remain available and how they compete with traditional Medicare.

The newly eligible population could be very different from the current Medicare population in terms of their health care needs. Private insurers with expertise in the current Medicare population might not necessarily have expertise in the newly eligible population or could evaluate the relative health management opportunities differently for the newly eligible population. But unlike a Medicare buy-in approach, it might be more administratively difficult for Medicare Advantage plans to have separate plans for the currently eligible Medicare beneficiaries and the newly eligible beneficiaries.

How would the program be funded?

Medicare is currently funded by a combination of federal payroll taxes, beneficiary premiums, and general tax revenues. An expansion of Medicare would require additional funding, especially as the current Medicare program is already facing serious financial challenges. Non-Medicare health spending is financed by a range of payers, including individual premiums and out-of-pocket costs, employer premium contributions, and state and federal governments, via taxpayer funds. Financing needs for non-Medicare spending would decline if more of the population becomes covered by Medicare. Therefore, it is important to determine how Medicare would be financed and also the net effect on total health care financing.

To the extent that Medicare would continue to be at least partially financed by beneficiary premiums, it would need to be determined whether and how premiums would vary among enrollees (e.g., by age or income).

What entity would administer the expansion program?

The federal government would administer the expansion. As with the current Medicare program, some insurance and administrative tasks could be contracted out to private entities, through Medicare Advantage plans or other private contractors.

How Medicare is currently financed

Medicare benefits are financed through two trust funds. The Hospital Insurance (HI) trust fund supports Medicare Part A, which covers inpatient hospital care and post-acute care services such as skilled nursing facility care and home health care services. The Supplementary Medical Insurance (SMI) trust fund supports Medicare Part B—hospital outpatient care, doctor visits, lab tests, and medical supplies—and Part D prescription drug coverage. Medicare Advantage plans are paid out of both funds, in applicable proportions.

HI Trust Fund. According to the 2018 Medicare trustees report, payroll taxes comprise 87 percent of HI trust fund revenues. The payroll tax rate is 1.45 percent for both workers and employers; self-employed workers pay 2.9 percent. Workers with incomes exceeding $200,000 ($250,000 for married couples) pay an additional 0.9 percent payroll tax on income exceeding the threshold. Other sources of HI income include a portion of the federal taxes on Social Security benefits, premiums from voluntary enrollees not eligible for premium-free Part A, and interest on trust fund assets. The HI trust fund had built up a surplus of $202 billion at the end of 2017 but is projected to be depleted in 2026. At that time, tax revenues are projected to cover only 91 percent of program costs, with the share declining to 79 percent in 2050.

No current provision exists for general fund transfers to cover HI expenditures in excess of dedicated revenues, so additional revenues would need to be raised, benefits cut, or some combination of the two. Eliminating the HI deficit over the next 75 years would require an immediate 28 percent increase in payroll taxes, an immediate 17 percent reduction in expenditures, or some combination of both. Deferring action would require larger increases in payroll taxes or larger reductions in expenditures to attain long-term trust fund solvency.

SMI Trust Fund. Medicare's SMI trust fund receives nearly three-quarters of its funding from federal general tax revenues. Standard per beneficiary premiums for parts B ($135.50 per month in 2019) and D ($33 per month in 2019) are set to equal one-quarter of coverage costs; high-income beneficiaries pay a larger share of costs. Low-income Part D beneficiaries receive federal premium assistance and pay lower premiums. As a result, beneficiary premiums account for 26 percent of Part B costs and 17 percent of Part D costs. Part D receives 13 percent of its funding from states to reflect the federal assumption of prescription drug costs for dually eligible beneficiaries. Aside from interest on the trust funds, the remaining funding comes from general revenues—72 percent for Part B and 70 percent for Part D.

The SMI trust fund is expected to remain solvent because its financing is reset each year to meet projected future costs. But increases in SMI costs will require increases in beneficiary premiums and federal tax dollars, which will add pressure to the federal budget. SMI general revenue funding is scheduled to increase from 1.6 percent of gross domestic product (GDP) in 2017 to 2.8 percent in 2092.

SMI premium increases similarly will place pressure on beneficiaries, especially when considered in conjunction with increasing beneficiary cost-sharing expenses. The average beneficiary expenses (premiums and cost-sharing) for parts B and D combined currently equal 24 percent of the average Social Security benefit. These expenses are projected to 34 percent of the average Social Security benefit by 2092.

Source: 2018 Medicare Trustees Report

What benefits would be covered?

Many decisions about benefits would need to be made, including:

- Would Medicare benefits be supplemented to meet the needs of a broader eligible population, including benefits covered by Medicaid and employer plans?
- Would traditional Medicare retain its separate parts A, B, and D component structure, or would the benefit design be more integrated, consistent with other types of coverage such as ACA individual market plans and employer coverage?
- What cost-sharing requirements and/or protections would be included?
- Would supplemental coverage, such as Medigap coverage, continue to be available to Medicare enrollees?
- Would Medicaid continue to provide additional benefits and cost-sharing protections to low-income beneficiaries?

Would other coverage options be available?

As noted above, aside from the potential availability of supplemental plans, Medicare would replace other sources of coverage for those eligible for Medicare. As a result, there would not be selection concerns between Medicare and other plans. However, there would be disruption as individuals shift from their existing source of coverage to Medicare. Whether individuals are better off under current coverage sources or Medicare depends on any differences in benefits and cost-sharing requirements, provider networks, premiums, and taxes.

If Medicare extends eligibility only to certain age groups, the risk pools of other sources of coverage would shrink, with premiums reflecting the risk pool composition of the remaining enrollees. To the extent that other coverage sources continue, there might need to be coordination between Medicare and other coverage sources. For instance, if the Medicare eligibility age is lowered (as opposed to being extended to all) it would need to be determined how Medicare would coordinate with active and retired workers with employer coverage. Also, what would happen to coverage for dependents if older workers became eligible for Medicare but the dependents are not yet eligible?

What is a single payer health insurance system?

In general, "single payer" means the health insurance system covers the health care spending for all of a specified population and is financed by the government, typically from tax revenues. Although the term describes how the system is financed, it does not define who employs the health care providers. The term "socialized medicine" differs from "single payer" in that the former refers to a system in which the government not only pays for the medical spending, but also owns the health care facilities and employs the physicians and other health care workers.

The Medicare program is often referred to as a single payer system. Medicare is currently financed through payroll taxes, beneficiary premiums, as well as federal income taxes. Medicare covers medical services for eligible beneficiaries, and care is received from private health care providers. Medicare is not operated completely by the government, however. Private insurers participate through Medicare Advantage and the Part D prescription drug program. About one-third of Medicare beneficiaries were enrolled in MA plans in 2018, and all Medicare Part D coverage is offered by private insurers. In addition, beneficiaries participating in the traditional Medicare program can choose to purchase private Medigap plans that supplement Medicare coverage.

What would provider payment rates be under Medicare?

Under a Medicare for all expansion, it would need to be determined whether payment rates would continue at current Medicare rates. If so, for those beneficiaries currently covered by Medicaid, providers would generally be paid more than under the current system, and for commercially insured patients, provider payments would decrease. Even if on average provider rates remain unchanged, individual providers could be better or worse off, depending on their patient mix. Because total Medicare spending reflects not just provider payment rates but also utilization, one consideration is whether any reduction in provider payment rates would be offset by less utilization control. Payment rates for any new services would also need to be determined. If MA plans continue to be available, it would also need to be determined whether the MA requirement that out-of-network providers are paid Medicare fee-for-service rates would be retained.

In the long run, provider payment rates reflect not only where they were set initially, but also how they grow over time. For most Medicare services, Congress determines how Medicare provider payment rates are increased from year to year, although the secretary of Health and Human Services sets the updates for particular service categories. These updates reflect in part a determination of whether payments cover providers' costs and whether Medicare beneficiaries have adequate access to high-quality providers, as well as a goal of spending Medicare funds efficiently. Setting Medicare payments low can help put pressure on providers to lower their costs and provide care more efficiently. However, if low payments result in reduced access to care or provider financial losses, there could be pressure on Congress to increase rates more rapidly.

How would Medicare expansion premiums be set?

As noted above, standard Medicare parts B and D premiums are set equal to 25 percent of program costs. Higher-income beneficiaries pay higher premiums for parts B and D, and lower-income beneficiaries pay lower premiums for Part D. (Low-income beneficiaries can also have Part B premiums paid by Medicaid.) Premiums can differ for particular MA and Part D plans but are otherwise uniform, with no variation by age, gender, health status, or other factors. Aside from setting overall premiums to meet program financing goals, it would need to be determined whether and how any premiums would vary among beneficiaries. This question becomes more important the lower the Medicare age is set.

Would the transition to an expanded Medicare program be done all at once or phased in?

If an expanded Medicare program is to be phased in rather than implemented all at once, transition rules would be required.

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Conclusion

Many approaches to expanding access to public health insurance plans are being explored as potential ways to increase access to affordable health insurance. To fully evaluate or to implement any of these proposals, many design features would need to be specified. These include: defining where the plan would operate and who would be eligible, whether the public plan would be an optional choice or the sole coverage source available, whether the program would rely solely on public coverage or would also incorporate private plans such as Medicare Advantage plans, what benefits would be covered and what cost-sharing would be required, what providers would be paid, how premiums and other financing would be set, and any transition rules. How these features are decided would affect the viability of the plan and the impacts it would have on coverage availability and affordability—not only of the public plan, but also of other coverage sources.

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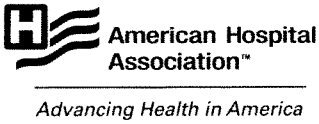

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May 22, 2019

The Honorable John Yarmuth
Chairman
Committee on Budget
United States House of Representatives
204-E Cannon House Office Building
Washington, DC 20515

Dear Chairman Yarmouth,

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the Committee holding this hearing on the Congressional Budget Office's (CBO) Key Design Components and Considerations for Establishing a Single-Payer Health Care System.

America's hospitals and health systems are committed to the goal of affordable, comprehensive health insurance for every American. However, "Medicare for All" is not the solution. Instead, we should build upon and improve our existing system to increase access to coverage and comprehensive health benefits.

Our detailed comments follow.

THE IMPORTANCE OF HEALTH COVERAGE

Meaningful health care coverage is critical to living a productive, secure and healthy life. Studies confirm that coverage improves access to care; supports positive health outcomes, including an individual's sense of their own health and wellbeing; incentivizes appropriate use of health care resources; and reduces financial strain on individuals and families.[i] Coverage has broader community benefits as well, from ensuring adequate resources to maintaining critical health care infrastructure to being associated with decreased crime. We, therefore, appreciate Congress' focus on opportunities to close the remaining coverage gaps and achieve comprehensive health coverage for every American.

Despite recent coverage gains, approximately 9 percent of the U.S. population remains uninsured, a number that has increased over the past two years. The remaining uninsured tend to be young adults, disproportionately Hispanic, and workers in lower-income jobs. Many of the uninsured are likely eligible for but not enrolled in subsidized coverage, including through Medicaid, the Health Insurance Marketplaces or their employers. For example, millions of the lowest income uninsured could be covered if all states expanded Medicaid.

MAY 2019 CBO REPORT

We appreciate the CBO looking at the possible components of a single-payer system and their potential impact on health care in the United States. As the report makes clear, establishing a single-payer system would be a "major undertaking that would involve substantial changes in the sources and extent of coverage, provider payment rates, and financing methods of health care in the United States."

The report notes there are several potential ways that providers could be paid under a single-payer system, including fee-for-service, bundled payments, global budgets or capitated payments. The report also notes there are multiple ways payments could be determined, including administered rates and negotiated rates. The report raises the point that this change in provider payments would have "important implications" for "providers' revenues." We detail additional information on the potential impact to hospitals and health systems below.

Similar to considerations raised in the report, we believe close attention needs to be paid to payments that are made to hospitals that have a higher percentage of low-income patients and to graduate medical education (GME) payments. This funding provides essential financial assistance to hospitals that care for our nation's most vulnerable populations and provide critical community services, such as trauma and burn care. Additionally GME funding ensures there are an adequate supply of well-trained physicians.

The CBO report details possible implications of paying providers Medicare rates in a single-payer system and states "such a reduction in provider payment rates would probably reduce the amount of care supplied and could also reduce the quality of care." The instability of changes to the health care system with a "Medicare for All" type system could have the unintended impact of jeopardizing access to care for everyone. We would urge caution in moving forward with any system that would decrease availability of care or add to the length of time for availability of service – particularly in rural or undeserved areas.

GOVERNMENT-RUN, SINGLE-PAYER MODEL IS THE WRONG APPROACH

While the AHA shares the objective of achieving health coverage for all Americans, we do not agree that a government-run, single-payer model is right for this country. Such an approach would upend a system that is working for the vast majority of Americans, and throw into chaos one of the largest sectors of the U.S. economy.

Indeed, payment under existing public programs, including Medicare and Medicaid, historically reimburse providers at less than the cost of delivering services. For example, Medicare paid only 87 cents for every dollar spent by hospitals caring for Medicare patients in 2017 – a shortfall of $53.9 billion. Chronic underpayment can lead to access issues for seniors as some providers, especially physicians, may limit the number of Medicare patients they take or stop seeing them altogether. Indeed, hospitals and health systems only are able to stay open today to the extent commercial coverage makes up for the losses sustained providing care to beneficiaries of public programs. Congress' own advisory group, the Medicare Payment Advisory Commission (MEDPAC), reported in its March 2018 report that hospitals had a negative 9.6 percent Medicare margin in 2016, on average, and projects that hospital Medicare margins will decline to negative 11 percent in 2018, the lowest such margin ever recorded.

Results from a recent study give some idea of the financial impact a single-payer program based on Medicare rates could have on the health care system. The study found that a proposal to create a government-run, Medicare-like health plan on the individual exchange could create the largest ever cut to hospitals – nearly $800 billion – and be disruptive to the employer-sponsored and non-group health insurance markets, while resulting in only a modest drop in the number of uninsured as compared to the 9 million Americans who would gain insurance by taking advantage of building upon the existing public/private coverage framework. This coverage proposal would enroll significantly fewer people than a single-payer model, and yet the reimbursement cuts would be catastrophic.

Even if the proposed single-payer program increased reimbursement rates above Medicare's rates, our members' experience suggests that the government does not always act as a reliable business partner. Delays in payment and retroactive changes to reimbursement policies leave providers at risk of inadequate payment. Politicization means that providers cannot always trust that the rules of today will be the rules of tomorrow, which presents a challenging – if not impossible – environment for large, complex organizations. Recent examples of the uncertainty of working with government include the defunding of critical elements of the Health Insurance Marketplaces, including outreach and education, and raids on the Medicare and Medicaid programs to offset spending on other priorities.

We also are deeply concerned that a single-payer model would seriously distract from the important delivery system reform work underway. Hospitals and health systems have invested billions of dollars in technology and delivery system reforms to improve care, enhance quality and reduce costs. Moving to a single-payer model could stymie these efforts by, at best, diverting attention and, at worst, being deemed irrelevant if the government can simply ratchet down provider rates to achieve spending objectives.

Finally, moving to a single-payer model would be highly disruptive not only to health coverage, but also to the broader economy. Approximately 90 percent of Americans are currently enrolled in comprehensive coverage with high rates of satisfaction. Not only would this move more than 250 million people into some new form of coverage, it could radically alter the coverage of the more than 55 million people currently enrolled in the

Medicare program, including the tens of millions who have voluntarily opted to enroll in Medicare Advantage, which would no longer exist.

WAYS TO PROMOTE BETTER CARE FOR AMERICA

Health coverage is too important to risk such levels of disruption. The better path to achieving comprehensive coverage for all Americans lies in continuing to build on the progress made over the past decade. To advance our objective of covering all Americans, we support:

- Continued efforts to expand Medicaid in non-expansion states, including providing the enhanced federal matching rate to any state, regardless of when it expands. This would give newly expanded states access to three years of 100 percent federal match, which would then scale down over the next several years to the permanent 90 percent federal match.

- Providing federal subsidies for more lower- and middle-income individuals and families. Many individuals and families who do not have access to employer-sponsored coverage earn too much to qualify for either Medicaid or marketplace subsidies and yet struggle to afford coverage. This is particularly true for lower-income families who would be eligible for marketplace subsidies except for a "glitch" in the law that miscalculates how much families can afford. We support both expanding the eligibility limit for federal marketplace subsidies to middle-income families and fixing the "family glitch" so that more lower-income families can afford to enroll in coverage.

- Strengthening the marketplaces to improve their stability and the affordability of coverage by reinstituting funding for cost-sharing subsidies and reinsurance mechanisms and reversing the expansion of "skinny" plans that siphon off healthier consumers from the marketplaces, driving up the cost of coverage for those who remain.

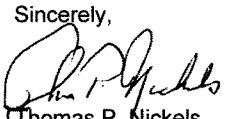
- Robust enrollment efforts to connect individuals to coverage. The majority of the uninsured are likely eligible for Medicaid, subsidized coverage in the marketplace or coverage through their employer. We need an enrollment strategy that connects them to – and keeps them enrolled in – coverage. This requires adequate funding for advertising and enrollment efforts, as well as navigators to assist consumers in shopping for and selecting a plan.

We also must ensure the long-term sustainability of Medicare, Medicaid and other programs that so many Americans depend on for coverage.

CONCLUSION

The AHA appreciates the Committee holding this hearing and we look forward to working with Congress on this important issue. We believe we should come together and build upon and improve our existing system to increase access to coverage and comprehensive health benefits.

Sincerely,



Thomas P. Nickels
Executive Vice President

Cc: The Honorable Steve Womack

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[1] American Hospital Association, "The Importance of Coverage," November 2018. https://www.aha.org/system/files/media/file/2019/04/report-coverage-overview-2018.pdf

May 19, 2019
Dear Chairman Yarmuth;

We are writing about the May 22nd Budget Committee Hearing on the CBO Report "Key Design Components and Considerations for Establishing a Single-Payer Health Care System," which was completed at your request of 01/08/19.

We are very concerned that you did not ask the CBO to do a report based on HR 1384, and instead, asked the CBO to address the issue in a general overall manner, entirely ignoring that Representative Jayapal's bill (HR 1384) was only weeks away from being introduced into the House. You asked the CBO to consider 8 questions. The CBO Report expands your 8 general questions into a total of 18 very specific questions that they propose must be answered to analyze a singlepayer system.

We strongly urge you to focus the CBO's testimony and the committee's discussion on HR 1384, and that you use HR 1384 to answer each of the 18 questions posed in the CBO Report. The CBO staff is unelected. Representative Jayapal and 108 other elected members of Congress have already signed on to HR 1384. We see no reason for the committee to waste time, energy, and taxpayer money on stepping backward in time to repeat the decades of studies and analyses that have culminated in the existing HR 1384.

Included here are the 18 CBO questions and brief answers based on the components of HR 1384. Please focus on questions 11, 12, 16, 17, and 18 in particular, which are the ones that address questions about cost containment, provider rates, and financing. These will counter repeated claims by opponents of any single-payer system, who attempt to create the impression that the only (or primary) way single-payer legislation will cut costs is by slashing doctor and hospital income. As you may, or may not know, that is not true of HR 1384. It is primarily the significant streamlining of our current system's complex, layered administration that will reduce costs by hundreds of billions of dollars annually.

For any healthcare bill to succeed in universal coverage of all medical necessities, it must achieve sustainable affordability, and there are 4 essential elements for achieving that: only one payer, budgets for individual institutions (hospitals, nursing homes, etc.), uniform fee schedules for practitioners, and price controls on drugs... all of which are in HR 1384!

In the attached file are all the questions addressed in the CBO Report, with answers specific to HR 1384 for each question. Again, we strongly urge you to use this hearing to review all the components of HR 1384 specifically.

Thank you,
Steering Committee of HOPE (Health Over Profit for Everyone)

QUESTIONS POSED BY THE CBO REPORT

1. How would a system be administered?
Under HR 1384 it would be administered by the federal government.

2. Would it include a standardized IT infrastructure?
Yes, a standardized IT infrastructure would be used.

3. Who would be eligible, and how would the system verify eligibility?
Under Section 102, the bill states:

> *(a) In General.—Every individual who is a resident of the United States is entitled to benefits for health care services under this Act. The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under this Act.*

Under Section 105, the bill states:

> *The Secretary shall provide for the issuance of a Universal Medicare card that shall be used for purposes of identification and processing of claims for benefits under this program. The card shall not include an individual's Social Security number.*

4. How would people enroll?
Under Section 105, the bill states:

> *(a) In General.—The Secretary shall provide a mechanism for the enrollment of individuals eligible for benefits under this Act. The mechanism shall—*
> *(1) include a process for the automatic enrollment of individuals at the time of birth in the United States (or upon establishment of residency in the United States);*
> *(2) provide for the enrollment, as of the dates described in section 106, of all individuals who are eligible to be enrolled as of such dates, as applicable; and*
> *(3) include a process for the enrollment of individuals made eligible for health care services under section 102(b).*
> *(b) Issuance Of Universal Medicare Cards.—In conjunction with an individual's enrollment for benefits under this Act, the Secretary shall provide for the issuance of a Universal Medicare card that shall be used for purposes of identification and processing of claims for benefits under this program. The card shall not include an individual's Social Security number.*

5. Could people opt out?
Yes, but they would still pay their share of taxes for coverage.

6. What services would the system cover and would it cover long-term services and supports?
Under HR 1384 Improved Medicare for All, every medically necessary service, device, and drug would be covered as well as all long-term care services and supports, both inhome and institutional.

7. How would the system address new treatments and technologies?
The same as traditional Medicare does now.... based on medical evidence that something new is significantly better than existing treatments & technologies.

8. What cost sharing, if any, would the plan require?
NONE. ZERO!

9. What role would private health insurance have?
Private insurance would be able to cover anything not covered by the public plan.

10. What role would current public programs have?
All benefits of all other public healthcare programs would be rolled into the Improved Medicare for All system. However, all VA and IHS members would have the option to continue under their respective programs, which are already government-funded programs. Tricare will be rolled into the Improved Medicare for All program. Medicaid will be rolled into the Medicare for All program, which will completely cover all benefits now covered by Medicaid.

11. How would the system pay providers and set provider payment rates?
HR 1384 would pay FFS for individual practitioners taking into account traditional Medicare rates in setting fee schedules.
The bill states:

> *"In establishing payment amounts for items and services under the fee schedule established under paragraph (1), the Secretary shall take intoaccount—(A) the amounts payable for such items and services under title XVIII of the Social Security Act; and (B) the expertise of providers and value of items and services furnished by such providers."*

Soft global budgets will be negotiated with institutions (hospitals, nursing homes, etc.) Regional directors will use traditional Medicare rates as a comparative payment system in negotiating budgets with each individual institution.
The bill states:

> *"The regional director, on a quarterly basis, shall review whether requirements of the institutional provider's participation agreement and negotiated global budget have been performed, and shall determine whether adjustments to such institutional provider's payment are warranted. This review shall include consideration for additional funding necessary for unanticipated items and services for individuals with complex medical needs*
> *or market-shift adjustments related to patient value. A regional director may negotiate changes to an institutional provider's global budget, including any adjustments to address unforeseen market-shifts related to patient volume."*

Budgets for capital and operations will be separated to ensure capital spending is done on the basis of patient need instead of provider preference.

12. How would the system purchase and determine the prices of prescription drugs?
The federal government would negotiate with pharmaceutical companies for the lowest prices, as the VA does now, but with even greater impact due to the vastly increased size of the federal portion of the market. The negotiated price would be based on comparative clinical and cost effectiveness, budget impact of providing coverage, number of similarly effective drugs, and total revenues from global sales obtained by the manufacturer for such drug. In the event of an unsuccessful negotiation at an appropriate price, the federal government would authorize the use of any patent or clinical trial data for purposes of manufacturing such drug for sale under the Medicare for All program.

13. Who would own the hospitals and employ the providers?
Hospitals and other providers would be privately owned and operated as they are now.

14. Could providers offer services that the public plan covers, to private-pay patients?
Providers who participate in the public plan cannot offer services covered by the public plan to patients paying privately. Providers who do not participate in the public plan may provide services covered by the public plan, but only if the patient understands and signs a contract stating that they understand that they could receive this service under the public plan for free, and that this contract is not made or signed in an emergency situation.

15. Could providers "balance bill" patients?
Not if they are a participating provider. For non-participating providers their services would be fully privately paid, so they can bill patients, but it would not be accurate to call it "balance" billing.

16. How would the system contain healthcare costs?
The streamlining of administration into a single payer (the federal government) will eliminate the unnecessary costs inherent in investor-owned companies with their multiple layers of bureaucracies, such as redundancies of offices, staffs, paperwork, competitive salaries and bonuses for CEOs, investor profits, and marketing. The savings from eliminating these will more than offset any need to reduce reimbursement rates, and will also eliminate current provider costs for multiple payer billing and other insurance-related billing activities that now require large clerical staffs and large amounts of practitioners' time. Costs will also be contained by the use of soft global budgets for all institutions, including hospitals.

17. Would the system use global budgets or utilization management?
HR 1384 would set up soft global budgets for individual hospitals and other institutions. Large chains of hospitals, clinics, nursing homes, etc. would not be treated as one entity, and a separate budget would be set up with each hospital or institution within any such chain.

In this bill, global budgeting does not mean setting up one budget for an entire geographic region. Regional directors will negotiate soft global budgets with each individual institution, including hospitals, nursing homes, etc. Hospitals and other institutions will be monitored to make sure they are not spending money unnecessarily. However, the risk of cost overruns will not be shifted onto the provider. This will eliminate the incentive for providers to limit access to services, or quality of services, which is a problem inherent in shifting risk onto providers, as is now done through "capitation payment" and "Value-Based Payment" methods. The US does not have a problem of overuse of services, and utilization management such as capitation and Value-Based Payment methods have not proven to cut costs and have resulted in increased discrimination against the most needy patients and the providers who serve them. So HR 1384 does not include "utilization management."

18. Would the government finance the system through premiums, cost sharing, taxes, or borrowing?
HR 1384 would finance all healthcare through taxes. Because the total cost of healthcare will be lower than the current system, the new taxes will merely replace a larger amount currently being spent by households and businesses on private insurance premiums and out-of-pocket costs. We strongly advocate that the taxes be progressive, so that corporations and the ultra-wealthy will pay their fair share, and those who are low income or poor will pay little or no healthcare taxes. There will be no premiums, deductibles, copays, coinsurance, or any other form of cost sharing. All existing federal, state, and local government healthcare revenues would be shifted into Medicare for All, providing about two thirds of necessary funding. The final one third would be provided by new federal taxes, which would be more than offset for roughly 95% of households by the savings from the elimination of all premiums and out-of-pocket spending by individuals, employers, and employees. This would result in a significant annual savings for the average household.

May 22, 2019

The Honorable John Yarmuth
Chairman
U.S. House Budget Committee
402 Cannon House Office Building
Washington, D.C. 20515

The Honorable Steve Womack
Ranking Member
U.S. House Budget Committee
2412 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Yarmuth and Ranking Member Womack:

As the committee prepares to conduct a hearing on "Key Design Components and Considerations for Establishing a Single-Payer Health Care System," I am writing on behalf of the Healthcare Leadership Council (HLC) to express significant concerns regarding a single payer healthcare system.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

Like you, HLC believes all Americans should have access to affordable coverage of high-quality healthcare. However, a single payer healthcare system such as Medicare-For-All is not a practical solution. In fact, polling shows Americans are not seeking a radical overhaul of our healthcare system, nor would they be better off should it occur.

The most striking aspect of a single payer healthcare system is not what it gives to millions of working families and individuals, but what it takes away. It forces everyone, no matter how much they value their current health coverage, to give up that coverage and enter into a one-size-fits-all system and would significantly increase everyone's taxes.

Healthcare is currently in a period of evolution, transitioning from a fee-for-service system to one that emphasizes value, improved outcomes, elevated population health, and greater cost-efficiency. To halt this progress in order to create a massive new government-run structure, with still-unknown financing provisions, would serve the interests of neither taxpayers nor patients. HLC believes that Congress should continue improving and building upon the current healthcare system instead of pursing a single payer system that would set back patient-centered health innovation instead of advancing it. These improvements could include:

- Establishing a permanent health reinsurance program to help lower premiums for all consumers in the individual insurance market.
- Encouraging states to establish their own reinsurance programs, perhaps through state waivers in which the reinsurance program is partially funded by federal pass-through savings.
- Revising federal assistance to help more people afford coverage through premium tax credits in addition to cost-sharing protections to help lower-income consumers' access medical care.
- Increasing federal funding for outreach and awareness to encourage consumers to purchase and maintain health insurance coverage.
- Fixing the family glitch in which the cost to add family members to an individual's employer-sponsored health insurance is not considered when determining "affordability."
- Offering employers and consumers more choices for their coverage, increasing competition in the market place (e.g., value-based insurance designs).
- Modernizing health plans that are linked to health savings accounts.

Thank you for the opportunity to share our concerns regarding a potential implementation of a single payer healthcare system. HLC looks forward to continuing to collaborate with you on this important issue. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org.

Sincerely,

Mary R. Grealy
President

May 20, 2019

Representative John Yarmuth, Chairman
House Committee on Budget
204-E Cannon House Office Building Washington, DC 20515

Representative Steve Womack, Ranking Member
House Committee on Budget
507 Cannon House Office Building Washington, DC 20515

Dear Chairman Yarmuth and Ranking Member Womack:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. The members of NAHU work on a daily basis to help millions of individuals and employers of all sizes purchase, administer and utilize health insurance coverage. Our expertise lies in the technicalities of health-plan purchasing and administration and the real-world challenges consumers face therein. NAHU members are exceptionally well-versed on the coverage options that businesses of all sizes and individual consumers have available to them, as well as the plan choices they ultimately make.

Our expansive knowledge of health insurance markets and the consumers served by these markets leads us to oppose H.R. 1384, the Medicare for All Act of 2019, and all proposals to implement a government-run, one-size-fits-all healthcare system. This type of legislation would threaten the existing coverage of more than 180 million Americans, stripping them of their current plans and replacing their insurance with less choice and control over doctors, treatments and coverage, and higher taxes, longer wait times and lower quality of care.

The current healthcare system provides Americans with more personal choices than anywhere else in the world when it comes to insurance, doctors and treatments, while ensuring treatment if life or health is in danger. And more than 180 million Americans have access to healthcare coverage through their employers, with the average employer paying more than 70% of the cost of each employee's coverage. Enacting single-payer healthcare would threaten this choice, regardless of the scope of the proposal, from incremental approaches such as a public option or Medicare or Medicaid buy-in, to a more sweeping federal takeover of the entire healthcare system to implement a single standardized government-run plan.

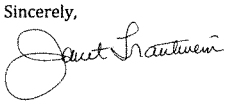
Medicare for All would be prohibitively expensive. Any single-payer system would need to be funded by raising taxes on hard-working Americans by billions of dollars every year. Current estimates put the cost

of implementing such a plan at around $32 trillion, with an average annual tax increase of $24,000 per household. Despite the increase in taxes, these programs would provide lower quality of care than what American patients receive, as evident by current government-run programs in the U.S. with worse quality outcomes than private plans. And patients would face long wait times for treatment and have less access to medical specialists and experts.

We believe that every American deserves access to affordable, quality health coverage, but Medicare for All would not provide that. We believe Congress should focus on bringing down costs by promoting more choice and competition for all Americans, no matter where they get their insurance. When the free market and public programs work together to bring down the cost of care, we can expand access to high-quality care for every American.

As Congress considers proposals to reform the healthcare system, I urge you to consider the detriment that single-payer could have on the current system and the more than 180 million Americans with private insurance coverage. I encourage you to work on solutions that build on the strength and stability of the employer-provided health coverage that millions of Americans rely on today. I look forward to hearing from you on this important issue. If you have any questions about our comments, or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,



Janet Stokes Trautwein
Chief Executive Officer
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Testimony of National Nurses United
Before the House Budget Committee
Hearing on "Key Design Components and Considerations for Establishing a Single-Payer Health Care System"

May 22, 2019

National Nurses United ("NNU"), the largest union representing registered nurses ("RNs") in the United States, submits this testimony in support of the Medicare for All Act of 2019, H.R. 1384. With over 155,000 registered nurse members across the country, NNU proudly endorses the Medicare for All Act of 2019 and we urge the Committee to support H.R. 1384. NNU members, as registered nurses, care for people in their most difficult hours, when they are sick, injured, and dying. We witness the personal impacts of a flawed health care system in our hospitals and clinics every single day. Our primary responsibility is to protect the health and wellbeing of our patients by providing safe, therapeutic care at the bedside, but this is made increasingly difficult by our country's broken health care system.

Under our current multi-payer system that is dominated by insurance, hospital, and pharmaceutical corporations, the basic health needs of tens of millions in the United States go unmet while health corporations soak-up billions of health care dollars. Today, the United States spends more money on health care than any other nation in the world, wasting hundreds of billions of dollars each year on unnecessary administrative costs, huge profit margins, and inefficiencies in our current system. The patchwork system of private for-profit insurers necessitates over $200 billion per year in administrative-related activities, and represents 20 to 30 percent of U.S. health care costs.[1] Despite spending more money on health care than any other country, our county ranks at or near the bottom on many international health indicators, including on such critical barometers as average life expectancy, infant mortality, maternal mortality, and death from preventable diseases.[2]

As the House Budget Committee considers key design components of a single-payer healthcare system, NNU urges Committee members not to lose sight of the fundamental ethical question of equity underpinning the task of health care system design. Even though Medicare for All will save the country trillions of dollars, preoccupation with the financial costs of Medicare for All should not distract us from the real impact of national health policy decisions can have on our lives. A question that the late health economist Uwe Reinhardt first posed to health policy pundits in 1997 is pertinent here:

> As a matter of national policy, and to the extent that a nation's healthcare system can make it possible, should the child of a poor American family have the same chance of avoiding preventable illness or of being cured from a given illness as does the child of a rich American family?[3]

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[1] Edward R. Berchick, Emily Hood, and Jessica C. Barnett. U.S. Census Bureau. "Health Insurance Coverage in the United States: 2017." U.S. Census Bureau (Sept. 2018).

[2] Organization for Economic Cooperation and Development. "Health at a Glance 2017." OECD Publishing (2017); Organization for Economic Cooperation and Development. "OECD Health Statistics 2018." OECD Stat (Updated Nov. 2018).

[3] Reinhardt, Uwe. "Wanted: A Clearly Articulated Social Ethic for American HealthCare." *JAMA* (Nov. 1997), Vol. 278:17, pp.1446-1447.

Dr. Reinhardt, by posing this question, asks us to place our ethical goals and principles into the foreground when considering health care system design.[4] This question should remind the Committee that all health care system design choices—whether on benefits, coverage, provider participation, cost sharing, or cost containment—are all ethical choices that may have a human price beyond dollars and cents. If the answer to Dr. Reinhardt's question is a resounding 'yes', then the Medicare for All Act of 2019 is the health care system that can ensure this principle of equity is fulfilled.

Despite the fact that we—as nurses—believe that our ethical starting point must be one of health equity for all, the Medicare for All program also would create huge cost-savings for the country through a series of measures. The two leading studies on the costs and savings of Medicare for All each find that the program would result in overall savings in national health expenditures. Robert Pollin and his colleagues at the University of Massachusetts Amherst found that Medicare for All would result in $5.1 trillion in savings on national health spending over 10 years.[5] Similarly, Charles Blahous of the Mercatus Institute of George Mason University found that Medicare for All would result in $2.1 trillion in savings over 10 years in national health expenditures.[6] Both Blahous' and Pollin's findings demonstrate that savings captured by Medicare for All would far exceed any increases in costs. Medicare for All would simplify our health system and cut administrative costs significantly. By improving payment systems to hospitals and other providers and by reducing the costs of prescription drugs through leveraged negotiations as a single-payer, the Medicare for All program would save the country trillions of dollars while also guaranteeing improved, quality health care to every person living in the United States.

Too many Americans—as individuals, families, businesses, and taxpayers—have been driven past their breaking point as a result of soaring health insurance costs. Health insurers, as market-driven corporations, enrich themselves by imposing harsh limitation in coverage and through perpetually increasing insurance premiums, deductibles, and co-pays. Private insurers deny between 11 percent to 24 percent of all claims for care,[7] and they restrict patient choice through narrow provider networks, limited drug formularies, and other barriers to care.[8] More than 40 percent of all U.S. adults under the age of 65 forego needed medical care, and 30 percent fail to fill a prescription or take less than the

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[4] Dr. Reinhardt continues to ask policy-makers this basic question about our ethical goals and principles on health care and health equity. Just last week, he posthumously published a book reasserting these same questions onto current health care debates. See Reinhardt, Uwe. *Priced Out: The Economic and Ethical Costs of American Health Care*. Princeton University Press (May 2019).

[5] Pollin, Robert, et al. "Economic Analysis of Medicare for All." Political Economy Research Institute (PERI), University of Massachusetts Amherst (2018), at p. 3, available at https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all.

[6] Blahous, Charles. "The Costs of a National Single-Payer Healthcare System." Mercatus Center, George Mason University (2018), available at https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf, at 7 (summing Blahous' projected national health Expenditures for 2022-2031 from Table 2).

[7] U.S. Government Accountability Office. "Private Health Insurance: Data on Application and Coverage Denials." GAO-11-268 (Mar. 2011), available at https://www.gao.gov/new.items/d11268.pdf.

[8] *See* Grisat, Michelle. "Medicare for All vs. All the Healthcare that Each Can Afford." National Nurses United & The Sanders Institute (Jun. 2017), available at https://medicare4all.org/wp-content/uploads/MedicareForAll-Report-TSI-NNU.pdf.

recommended dose.[9] One third of U.S. adults say that, in the past year, they have had to choose between paying for food, heating, housing, or health care.[10] The inability to pay medical bills continues to be a leading cause of personal bankruptcy, with 66.5 percent due to medical debt and job loss due to illness.[11] Of those whose illnesses led to bankruptcy, 75.7 percent had insurance at the onset of their illness.[12]

Even though the Patient Protection and Affordable Care Act enacted important improvements that have enabled more Americans to enroll in health insurance, out-of-pocket health costs continue to increase and many people remain severely underinsured. These reform efforts temper, but do not resolve the fundamental problems embedded in the market-driven system of health care delivery. The rate of uninsured U.S. adults has risen in the past four years to nearly 30 million.[13] An estimated 41 million more are underinsured,[14] meaning that they have insurance but cannot obtain the care they need because they cannot afford their co-payments or deductibles.

Moreover, the ever-rising cost of health care and its discriminatory characteristics contribute to the growing national chasm in wealth inequality and health disparities. Of those uninsured, 59 percent are people of color.[15] African-Americans suffer higher death rates than whites at an earlier age due to heart disease, diabetes, cancer, HIV, and infant mortality,[16] and African-American women are three to four times more likely than white women to die in childbirth.[17] High costs and poor health outcomes persist because access to insurance is not the same as guaranteed health care for all. Our country must do better.

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[9] West Health Institute and NORC at the University of Chicago. "Americans' Views of Healthcare Costs, Coverage, and Policy." (Mar. 2018), available at https://www.westhealth.org/wp-content/uploads/2018/03/WHI-Healthcare-Costs-Coverage-and-Policy-Issue-Brief.pdf.

[10] *Id.*

[11] Himmelstein, David, et al. "Medical Bankruptcy: Still Common Despite the Affordable Care Act." *American Journal of Public Health*, (2019) Vol. 109 (3), available at https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304901.

[12] Himmelstein, David, Elizabeth Warren, Deborah Thorne, Steffie Woolhandler. "Illness and Injury as Contributors to Bankruptcy." *Health Affairs* (2005).

[13] Kaiser Family Foundation. "Key Facts about the Uninsured Population." (Dec. 2018), available at https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[14] Collins, Sara, Munira Gunja, and Michelle Doty. "How Well Does Insurance Coverage Protect Consumers from Health Care Costs?" *Commonwealth Fund* (Oct. 2017), available at https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_oct_collins_underinsured_biennial_ib.pdf. Other studies estimate that up to 85 million people in the United States are underinsured. Pollin, Robert et al. "Economic Analysis of Medicare for All." Political Economy Research Institute (PERI), (Nov. 2018), available at https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all.

[15] Kaiser Family Foundation. "Key Facts about the Uninsured Population." (Dec. 2018) available at https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[16] U.S. Department of Health and Human Services. Office of Minority Health. "Infant Mortality and African Americans." (Last Updated Nov. 2017), accessed on April 26, 2019, available at https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23; Cunningham, Timothy et al. "Vital Signs: Racial Disparities in Age-Specific Mortality Among Blacks or African Americans — United States, 1999–2015." *Morbidity and Mortality Weekly Report* (May 5, 2017), available at https://www.cdc.gov/mmwr/volumes/66/wr/mm6617e1.htm; American Cancer Society. "Cancer Facts & Figures for African Americans 2019-2021." *Amer. Cancer Society*, 2019.

[17] Centers for Disease Control and Prevention. CDC Public Health Grand Rounds. "Meeting the Challenges of Measuring and Preventing Maternal Mortality in the United States." Presented on Nov. 14, 2017, available at https://www.cdc.gov/grand-rounds/pp/2017/20171114-maternal-mortality.html.

The Medicare for All Act of 2019 improves and expands the overwhelmingly successful and popular Medicare program, so that every person living in the United States has guaranteed access to health care. Medicare benefits would be improved so that all comprehensive health services are covered, including dental, vision, prescription drugs, women's reproductive health, and long-term services and supports. It would require no out-of-pocket costs for patients for any services, and would give all patients the freedom to choose the doctors, hospitals and other providers they wish to see.

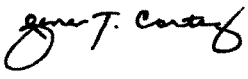
Importantly, "gatekeeper" obstacles to receiving care—like insurance pre-authorization requirements, lifetime or annual limits, or network restrictions—would be eliminated under the Medicare for All Act of 2019. Health care choices would be a decision between you and your doctor and would no longer be a decision made by insurance company administrators. Similarly, the benefits under the program would be completely portable across the United States. There would no longer be gaps in coverage if you change jobs or move. And our health care would no longer be subject to the unpredictable network changes or the ability of your employer to annually negotiate a health plan.

Medicare for All is the only solution to the health care crisis in our country. On behalf of National Nurses United, we urge the Committee to support the Medicare for All Act of 2019, H.R. 1384.

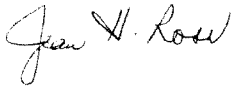
Sincerely,

Bonnie Castillo, RN
Executive Director
National Nurses United

Deborah Burger, RN
Co-President
National Nurses United



Zenei Cortez, RN
Co-President
National Nurses United



Jean Ross, RN
Co-President
National Nurses United

ATTACHMENTS

1. Medicare for All Act of 2019: Summary
2. Issue Brief, Medicare for All Act of 2019: Eliminating Health & Health Care Disparities
3. Issue Brief, Medicare for All Act of 2019: Program Design
4. Issue Brief, Medicare for All Act of 2019: Global Budgets & Other Reimbursements
5. Issue Brief: Medicare for All Act of 2019: Cost & Savings Analyses
6. Issue Brief: Medicare for All Act of 2019: Canada, Taiwan & U.S. Comparison
7. Issue Brief, Medicare for All Act of 2019: Frequently Asked Questions
8. National Nurses United, Report on Medicare for All

ATTACHMENT 1: Medicare for All Act of 2019: Summary

Today's health care system fails to provide quality, therapeutic health care as a right to all people living in the United States. Nearly 30 million Americans are uninsured, and at least 40 million more are underinsured, meaning that they cannot afford the costs of their copays and deductibles. The United States spends more money per capita on health care than any other major nation, yet the quality of our health care is much worse: life expectancy in the United States is lower, while our infant and maternal mortality rates are much higher. We waste hundreds of billions of dollars every year on unnecessary administrative costs, while health care industry executives measure success in profits, instead of patient care.

The current health care system in the United States is ineffective, inefficient, and outrageously expensive. It is time to remove the profit motive in health care, to resolve the inefficiencies, and to guarantee quality, therapeutic health care to every person living in the United States.

The Medicare for All Act of 2019, H.R. 1384 improves and expands the overwhelmingly successful and popular Medicare program, so that every person living in the United States has guaranteed access to health care with comprehensive benefits.

COMPREHENSIVE BENEFITS AND FREEDOM OF CHOICE

- The legislation provides comprehensive health care coverage, including all primary care, hospital and outpatient services, prescription drugs, dental, vision, audiology, women's reproductive health services, maternity and newborn care, long-term services and supports, prescription drugs, mental health and substance abuse treatment, laboratory and diagnostic services, ambulatory services, and more.
- Patients will have complete freedom to choose the doctors, hospitals, and other providers they wish to see, without worrying about whether a provider is "in-network."

NO PREMIUMS, COPAYS, OR DEDUCTIBLES

- Enrollment in Medicare for All would not require any premiums or deductibles. Upon receiving care, patients would not be charged any copays or other out-of-pocket costs.

LONG-TERM SERVICES AND SUPPORTS FOR PEOPLE WITH DISABILITIES AND OLDER AMERICANS

- Long-term services and supports will be fully covered by the Medicare for All program.
- The legislation requires that the program presume that recipients of all ages and disabilities will receive long-term services and supports through home and community-based services unless the individual chooses otherwise.

REDUCING HEALTH CARE SPENDING AND IMPROVING CARE

- Medicare for All would simplify the health care system by moving to a single-payer model. This will reduce the hundreds of billions of dollars wasted on the administration

of the current inefficient multi-payer system, allowing providers to focus on patient care instead.

- The legislation would prevent health care corporations from overcharging for the costs of their services and profiting off illness and injury. The legislation prevents providers from using payments from the program for profit, union-busting, marketing, or federal campaign contributions.
- The Medicare for All program would provide global budgets to all institutional providers to help contain the exorbitant costs present in the system today, and will allow the public to know where our health care dollars are being spent.

REDUCING THE COSTS OF PRESCRIPTION DRUGS

- The United States currently pays the highest prescription drug costs in the world. This legislation would allow Medicare to negotiate drug prices, as other countries do, to substantially lower the costs of prescriptions drugs.
- The legislation authorizes Medicare to issue compulsory licenses to allow generic production if a pharmaceutical company refuses to negotiate a reasonable price.

TRANSITION

- The transition to Medicare for All would occur in two years.
- One year after the date of enactment, persons over the age of 55 and under the age of 19 would be eligible for the program.
- Two years after the date of enactment, all people living in the United States would be eligible for the program.
- The legislation provides funding to help commercial insurance industry workers transition to other employment.

CARE FOR VETERANS AND NATIVE AMERICANS

- This legislation preserves the ability of veterans to receive their medical benefits and services through the Veterans Administration, and of Native Americans to receive their medical benefits and services through the Indian Health Service.

ATTACHMENT 2: Medicare for All Act of 2019: Eliminating Health and Health Care Disparities

Despite spending more on health care per capita than any other country in the world,[1] the United States has extreme health and health care disparities among racial and ethnic populations.[2] These disparities typically impact African Americans, American Indians, and Alaskan Natives the hardest, with the Latinx and immigrant communities also experiencing significant disparities.[3] H.R. 1384, the Medicare for All Act of 2019 (Act), contains provisions that address these disparities.[4]

Unlike our current market-driven system, the Act would guarantee quality, therapeutic health care for all individuals in every community in the United States, including our medically underserved rural and urban areas. It begins to address the structures that drive income, racial, and ethnic inequality in our health and healthcare by providing comprehensive health care benefits to all without regard to the ability to pay—with no deductibles, copayments, or other out-of-pocket costs. This would remove the financial and administrative barriers to care created by private insurers seeking to extract profit at the cost off of our health.

Currently, many low-income and minority communities face overcrowded hospitals and clinics, hospital closures, and shortages of nurses, doctors, and other health care professionals. H.R. 1384 would ensure that our safety-net and critical access hospitals, both rural and urban, are sufficiently resourced and that our communities are staffed with sufficient nurses, doctors, and other providers to promote good health where possible and provide therapeutic care where needed.

The Act would end our tiered system of health care by directing funds based on human need and explicitly targeting health care disparities. The national health budget, allocated regionally, includes separate funding for day-to-day operating expenses such as wages, medical supplies, overhead; capital expenses such as renovating facilities or building new ones as well as major equipment purchases; and special projects that address needs in medically underserved and health professional shortage areas.[5] Each of

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[1] Organization for Economic Cooperation and Development. "How Does the United States Compare?" (2017). Accessed April 26, 2019. https://www.oecd.org/unitedstates/Health-at-a-Glance-2017-Key-Findings-UNITED-STATES.pdf

[2] Caruso, Dominic F., David U. Himmelstein, Steffie Woolhandler, MD. "Single-Payer Health Reform: A Step Toward Reducing Structural Racism in Health Care." *Harvard Public Health Review* (2015). Accessed April 26, 2019. http://harvardpublichealthreview.org/single-payer-health-reform-a-step-toward-reducing-structural-racism-in-health-care/

[3] *Id.*

[4] H.R. 1384 contains several sections related to funding that are discussed and cited below. It also contains robust non-discrimination language (Section 104) and detailed reporting requirements on health and health care disparities based on race, ethnicity, gender, geography, and socioeconomic status so that funding can be directed where needed (Sections 401 and 502).

[5] The national health budget in H.R. 1384 also includes funding for quality assessment, health professional education, and other expenditures. See Section 601.

these budget components takes health care disparities into account, particularly the funding for capital expenses and special projects.

Funding of Provider Operating Expenses

- H.R. 1384 explicitly includes "efforts to decrease health care disparities in rural or medically underserved areas" as one factor in determining operating expenses.[6] Such efforts could include funding for additional staff, extended operating hours, and additional supplies.

Funding of Provider Capital Expenses

- Health care providers must apply for, and the HHS Secretary must approve, funding to renovate or build new health care facilities or to purchase major equipment. The Secretary prioritizes funding "to improve service in a medically underserved area ... or to address health disparities among racial, income, or ethnic groups, or based on geographic regions".[7]
- In contrast, current private funding for renovating or building new health care facilities and purchasing major equipment generally is based on whether, and how quickly, the expense will be recouped based on the revenue it generates. Thus, privately owned or funded organizations, even those that are not-for-profit, typically favor investing in affluent suburban and urban neighborhoods with low numbers of uninsured.
- Publicly-funded facilities—such as health care provided by safety net hospitals and clinics—have been seriously underfunded leaving many minority, low-income, and rural communities with overcrowded facilities or no facilities at all. Under the Act, funding for capital expenses will be allocated based on need—with the express aim of reducing, and ultimately eliminating, health care disparities—rather than on maximizing revenue. This creates a strong foundation for publicly-funded health care facilities.

Funding of Special Projects

- Special projects funding is used exclusively "for the construction of new facilities, major equipment purchases, and staffing in rural or medically underserved areas ... including areas designated as health professional shortage areas ...".[8]
- Medically underserved areas are geographically defined areas with a shortage of primary care services as well as sub-groups of people living within these areas including people who are homeless, low-income, Medicaid-eligible, Native American, or migrant farm workers. Medically underserved areas are designated based on the Index of Medical Underservice (IMU) which is calculated based on four criteria: the ratio of providers to the population, the

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[6] H.R. 1384, Sec. 611(b)(2)(G)(ii).
[7] H.R. 1384, Sec. 614(c)(2).
[8] H.R. 1384, Sec. 601(a)(7).

percentage of the population with income below the federal poverty level, the percentage of the population over the age of 65, and the infant mortality rate.[9]

- Health professional shortage areas—areas that have a shortage of primary care providers, mental health practitioners, or dentists—are primarily rural and low-income urban areas, but also include specific population groups within a geographic area such as those described above, and facilities such as state mental hospitals, federally qualified health centers, Indian health facilities, and tribal hospitals.[10]
- In addition to purchasing new equipment and building or renovating health care facilities, special projects funds could be used to provide scholarships for medical education, loan repayment or in exchange for practicing in rural or medically underserved areas or areas with a shortage of health care professionals, additional compensation to attract and retain health care professionals, and other programs.

By redirecting money to care based on need, that currently is diverted to profit and high administrative costs in our complex multi-payer billing system, the Act ensures that everyone living in the United States receives the care they need.

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[9] Health Resources and Services Administration (HRSA). "Medically Underserved Areas and Populations (MUA/Ps)." *U.S. Department of Health & Human Services* (Reviewed Oct. 2016). Accessed April 25, 2019. https://bhw.hrsa.gov/shortage-designation/muap.

[10] Health Resources and Services Administration (HRSA). "Health Professional Shortage Areas." *U.S. Department of Health & Human Services* (Reviewed Oct. 2016). Accessed April 25, 2019. https://bhw.hrsa.gov/shortage-designation/hpsas.

ATTACHMENT 3: Medicare for All Act of 2019: Program Design

How does the Medicare for All Act of 2019, H.R. 1384, answer the program design questions posed by the Congressional Budget Office's May 2019 report?

This issue brief adopts the question-based format to conform to the Congressional Budget Office's May 2019 report, "Key Design Components and Considerations for Establishing a Single-Payer Health Care System," which is being presented at the May 22, 2019, House Budget Committee hearing.[1]

How would the government administer a single-payer health plan?

- **Federal Governance.** The Secretary of the U.S. Department of Health and Human Services (Secretary) would oversee the Medicare for All Program (Program) at the federal level and would be responsible for developing policies, procedures, and regulations to carry it out. In so doing, the Secretary would consult with a broad range of entities including federal agencies, professional organizations, and labor unions. Program accountability measures include requiring the Secretary to provide annual reports to Congress and audits by the U.S. Comptroller General every 5 years.[2]
- **Regional Administration.** The Secretary would establish regional offices and appoint regional directors as well as deputy directors to represent American Indian and Alaska Native tribes in each region. The Secretary would incorporate the existing offices of the Centers for Medicare & Medicaid Services (CMS) where possible. The regional directors would be responsible for performing health care needs assessments, recommending changes in provider payments, and establishing quality assurance mechanisms in their respective regions. Finally, the Secretary would appoint a beneficiary ombudsman to receive complaints and grievances and provide assistance to individuals entitled to Program benefits.[3]

Who would be eligible for the plan, and how would people enroll?

- **Two-year eligibility phase-in.** The Program has a two-year transition period. In the first year, persons over the age of 55 and under the age of 19 would be eligible for the Program, and in the second year, all people living in the United States would be eligible.[4]
- **Enrollment.** The Program would include a mechanism for automatic enrollment at birth and upon immigration into the U.S. or attainment of qualified resident status.

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[1] Congressional Budget Office. "Key Design Components and Considerations for Establishing a Single-Payer Health Care System." CBO Publications (May 1, 2019), available at https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf.

[2] H.R. 1384 §§ 401-404.

[3] H.R. 1384 §§ 401-404.

[4] H.R. 1384 § 106.

Eligible individuals would be able to enroll for benefits and obtain a Medicare card in order to receive services under the Program. The Program could build on the current Medicare enrollment system.[5]

What health care services would the plan cover?

- **Universal benefits.** Current Medicare benefits would be expanded and improved in order to provide comprehensive health care coverage to all Program enrollees.[6]
- **Comprehensive benefits.** The benefits would include all primary care, hospital and outpatient services, prescription drugs, dental, vision, audiology, women's reproductive health services, maternity and newborn care, long-term services and supports, prescription drugs, mental health and substance abuse treatment, laboratory and diagnostic services, ambulatory services, and more.[7]

What cost sharing, if any, would the plan require?

The plan prohibits cost sharing for all covered benefits. No premiums, deductibles, coinsurance, copayments or balance billing are allowed.[8]

What role would private health insurance have?

The bill allows private health insurance coverage only for benefits that are not covered under the Program, but prohibits private health insurance coverage for covered benefits. Because the Program provides comprehensive benefits and provides comprehensive coverage, private health insurance is expected to have only a small role (e.g., non-medically necessary cosmetic care or for international tourists).[9]

What role would other public programs have?

After the two-year transition period, all those receiving health care coverage through Medicare, Medicaid, the State Children's Health Insurance Program, or health exchanges established under the Patient Protection and Affordable Care Act would be covered by the Medicare for All Program. These programs would sunset. School-related health programs and existing medical benefits or services under the Department of Veteran Affairs and the Indian Health Service would be maintained, though veterans and Native Americans would also be entitled to full Program benefits.[10]

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[5] H.R. 1384 § 105.
[6] H.R. 1384 §§ 201, 204.
[7] H.R. 1384 §§ 201, 204.
[8] H.R. 1384 § 202.
[9] H.R. 1384 § 107.
[10] H.R. 1384 §§ 901, 902.

What rules would participating providers follow?

To become a participating provider under the Program, the provider must be eligible to participate and must enter into a participation agreement with the Secretary, which includes, as described below, disclosure requirements and other checks on provider participation.[11]

- **Provider qualifications.** Providers are qualified to participate in the Program if they have the requisite license from the state in which they practice and meet minimum provider standards adopted by the Program, including adequate facilities, safe staffing, and patient access. Providers are only eligible to be participating providers for care that they provide directly to individuals.[12]
- **Private contracting limitations.** Participating providers are prohibited from entering into private contracts for covered services with individuals eligible for Program benefits. If a provider furnishes covered services through a private contract, they will be ineligible from participating in the Program for two years. Participating providers may enter into private contracts with individuals who are ineligible to enroll in the Program and may enter into contracts with any individual for noncovered services. Disclosure requirements are established for private contracts.[13]
- **Prohibitions on discrimination.** Providers are prohibited from denying benefits, reducing benefits, or otherwise discriminating against patients based on race, color, national origin, age, disability, marital status, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy).[14]
- **Prohibition on balance billing.** Participating providers are prohibited from balance billing or otherwise charging a Program enrollee for any covered benefit.[15]
- **Checks on upcoding and other reimbursement inflation**. To ensure that coding and billing practices are not being manipulated to inflate provider reimbursement, participating providers are required to disclose any patient or procedure coding or classification system that they use. Additionally, participating providers are prohibited from using any coding or classification system to establish financial incentives or disincentives for doctors or other health care professionals or that may otherwise interfere with clinical practice.[16]
- **Provider duty of ethics and prohibitions on financial interests that interfere with clinical practice**. The bill establishes a requirement for participating physicians, hospitals, and other health care providers to advocate for and act in the exclusive interest of patients. This means that participating providers

[11] H.R. 1384 § 301.
[12] H.R. 1384 § 302.
[13] H.R. 1384 § 303.
[14] H.R. 1384 §§ 104, 301(b).
[15] H.R. 1384 § 202(b), 301(b).
[16] H.R. 1384 § 301(b)(1)(G).

shall not have any financial interest or relationship that impairs that provider's ability to care to patients.[17]

In order to implement the provider duty of ethics, the bill would:

- Prohibit providers from entering bonus, incentive payment, profit-sharing, or compensation-based arrangements related to utilization of services or the financial results of any health care provider, and requires providers to disclose financial interests or relationships with other providers to the Secretary.
- Prohibits providers or their board members from serving on the board of or receiving compensation, stock, or other financial investments in any other entity that furnishes items and services (including pharmaceuticals and medical devices) to the provider.

➢ **Data reporting requirements.** Participating providers are required to furnish information necessary for establishing reimbursements, quality review, and other data reporting, including current data reported under Medicare or state programs, data on costs, quality, outcomes, health equity, and financial data.[18]

➢ **Application of existing anti-fraud and abuse statutes.** The bill applies existing Medicare and Medicaid measures against provider fraud and abuse to the Program, including prohibitions on self-referrals.[19]

➢ **Whistleblower protections**. The bill establishes whistleblower protections for participating providers and individuals that report potential violations of the Act.[20]

➢ **Separation of Operating Funds and Capital Funds.** To ensure that providers are using operating funds for health care benefits, Program funds for operating expenditures and capital expenditures are disbursed through separate mechanisms, and providers are prohibited from comingling operating funds with capital funds.[21]

➢ **Prohibited Uses of Reimbursements**. To ensure that provider reimbursements are used for the provision of benefits under the Program, the bill prohibits program funds from being used for:

- Compensation for any institutional provider employee, contractor, or subcontractor above existing compensation caps establishing for federal contractors under the Bipartisan Budget Act of 2013.[22]
- Marketing.[23]
- Profit or net revenue.[24]

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[17] H.R. 1384 § 301(b)(2).
[18] H.R. 1384 §§ 301(b), 401(b)(1).
[19] H.R. 1384 § 411.
[20] H.R. 1384 § 301.
[21] H.R. 1384 §§ 611, 614(c).
[22] H.R. 1384 § 611(b)(5).
[23] H.R. 1384 § 614(b)(1).
[24] H.R. 1384 § 614(b)(2).

- Incentive payments, bonuses, or other compensation based on patient utilization or other financial measures.[25]
- Union-busting consultants.[26]
- Federal campaign contributions.[27]

Who would own the hospitals and employ the providers?

Hospital ownership and provider employment would be unchanged. Thus, most of the health care delivery system would remain in the private sector.

How would a single-payer system pay providers and set payment rates?

- **National Health Budget.** The Secretary would establish a national health budget that would be allocated regionally. Regional allocations would include payments for the region's providers, capital expenditures, special projects, health professional education, administrative expenses, and prevention and public health activities.
- **Institutional Providers & Global Budgeting.** Institutional providers—including hospitals, skilled nursing facilities, federally qualified health centers, home health agencies, and independent dialysis facilities—would negotiate an annual lump sum global operating budget with the regional director which would be paid on a quarterly basis.[28] The global operating budget would be based on:
  - the historical volume of services in the previous 3-year period and provider capacity,
  - the actual expenditures as compared to other providers within the region and to established normative payment rates,
  - projected changes in volume and type of items and services to be furnished,
  - employee wages,
  - education and prevention programs, and
  - other relevant factors and adjustments.

  Each regional director would review institutional providers' performance on a quarterly basis and determine whether adjustments to the budget are needed, including additional funding needed for unanticipated care for individuals with complex medical needs or for changes in the market.
- **Individual Providers & Group Practices.**[29]
  - **Fee Schedule.** Individual providers, including those in medical group practices, would be paid fee-for-service based on a national fee schedule established by the Secretary. The fee schedule would take into account the prevailing rates under

[25] H.R. 1384 § 614(b)(3).
[26] H.R. 1384 § 614(b)(4).
[27] H.R. 1384 § 614(b)(5).
[28] H.R. 1384 §§ 611-615.
[29] H.R. 1384 §§ 611-615.

Medicare, provider expertise, and the value of the items and services furnished. The bill establishes both a standardized documentation and review process of the relative values of physician services to determine appropriate fee payments and a physician consultation review board to review quality, cost effectiveness, and fair reimbursement of services and items delivered by physicians.

- **Option for Salaried Payments.** However, as determined by the Secretary, certain group practices and other health care providers with agreements to provide health care services at a specific institutional provider may choose to be paid a salary through such institutional provider's global budget instead of on a fee-for-service basis.
- **Capital Expenditures.** Providers seeking funding for capital expenditures—defined as expenses for the purchase, lease, construction, or renovation of capital facilities and for major equipment—are required to apply to the applicable regional director for funding and are subject to approval of the Secretary. The Secretary shall prioritize capital projects that improve service in a medically underserved area or that address health disparities among racial, income, or ethnic groups, or based on geographic regions. Regional directors seeking funding for special projects—which can be used for be used for the construction of new facilities, major equipment purchases, and staffing in rural or medically underserved areas—must present a budget to the Secretary for review. The bill prohibits comingling of funding for operating expenses with funding for capital projects.

How would the single-payer system purchase prescription drugs?

The Secretary would negotiate prices for prescription drugs. If a pharmaceutical company refuses to negotiate a reasonable price for a prescription drug, the bill authorizes the Program to issue competitive licenses for generic production of the drug.[30]

How would a single-payer system contain health care costs?

Studies have shown that Medicare for All would not only contain costs, but would save the country up to $5.1 trillion over 10 years.[31] Conservative estimates conducted by the Mercatus Center concluded that the U.S. would save more than $2 trillion over a ten-year period under Medicare for All.[32] Specifically, H.R. 1384 would contain costs and produce savings primarily by reducing administrative costs, negotiating prescription drug and medical device prices, and controlling provider payments.

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[30] H.R. 1384 § 616.

[31] Pollin, Robert et al. "Economic Analysis of Medicare for All." Political Economy Research Institute (PERI), (Nov. 2018), available at https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all .

[32] Blahous, Charles. "The Costs of a National Single-Payer Healthcare System." Mercatus Working Paper. Mercatus Center, George Mason University: Arlington, VA (Jul. 2018), available at https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.

- **Administrative Costs.** Under our current fragmented, multi-payer system, we spend about 31 percent of total health expenditures on administrative costs. This amounted to an estimated $1.1 trillion in 2017.[33] Implementing a single payer system with a single, comprehensive benefits plan would create uniformity in claims and billing processing. Insurer costs such as care denial and containment, marketing, profit, and executive compensation would be eliminated. Health care providers would no longer need large billing departments to manage the manifold insurance cost-sharing schemes, collect unpaid bills from the uninsured and the underinsured, or obtain preauthorization for tests and treatments.
- **Prescription Drug and Medical Device Prices.** The Secretary would wield tremendous bargaining power by negotiating on behalf of the entire U.S. population. This would enable the Secretary to drive down costs for prescription drugs and medical devices. As noted above, if the Secretary were unable to negotiate a reasonable price for a prescription drug, competitive licenses for generic production of the drug would be issued.[34]
- **Provider Payments.** As the single payer, the Medicare for All Program would have the power to regulate provider payments. Payment inequities would also be addressed; some providers would see their reimbursements rates reduced[35] while others would see their rates increased.
  - **Institutional providers**—Massive consolidation among private hospitals and other institutional providers, as well as the acquisition of physician practices, have enabled some hospital and health systems to charge exorbitant prices, while hospitals in rural and underserved areas close and funding for public hospitals dwindles. Whereas the former would see their bargaining power—based on market share—diminished and with it their ability to extract exorbitant reimbursement rates, the latter would see reimbursement rates increase and funding stabilize.
  - **Health care professionals**—Rates also may change based on the type of medicine a physician or other health care professional practices. The bill addresses a pay inequity that undervalues the cognitive-based services that primary care physicians provide and overvalues procedure-based services that specialists tend to provide[36] by establishing both a review process of the relative values of physician services[37] and a physician consultation review board to review

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[33] Woolhandler, Steffie and Himmelstein, David. "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs." *Ann. Intern. Med.* (2017) 166(8): 587-588. According to the Centers for Medicare and Medicaid Services, national health expenditures was $3,492.1 billion in 2017. Centers for Medicare and Medicaid Services. "National Health Expenditure Accounts (2017)." U.S. Department of Health and Human Services (accessed on April 26, 2019), available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html.

[34] H.R. 1384 § 616.

[35] As discussed above, reductions in reimbursement rates would be offset by significant administrative savings.

[36] Goodson, J. D. "Patient Protection and Affordable Care Act: Promise and Peril for Primary Care." Ann Intern Med. (2010), *152*(11):742-744.

[37] H.R. 1384 § 613.

quality, cost effectiveness, and fair reimbursement of services and items delivered by physicians.[38]

How would a single-payer system be financed?

Current U.S. expenditures provide sufficient funding for the Program, but they must be captured in a new way. Amounts equal to federal expenditures for programs that the bill sunsets—including Medicare, Medicaid, the State Children's Health Insurance Program, and the ACA exchanges—would be deposited annually into a newly established Universal Medicare Trust Fund. These deposits would be adjusted annually for cost savings resulting from implementation of the Program and for changes in the consumer price index. The bill does not specify how the balance of the national expenditures would be financed, but there are many options. These could include a corporate gross receipts tax, progressive personal income tax, financial transaction tax, and repealing the corporate tax cuts passed in 2017.[39]

[38] H.R. 1384 § 612(d).
[39] H.R. 1384 § 701.

ATTACHMENT 4: Medicare for All Act of 2019: Global Budgets & Other Provider Reimbursements

Medicare for All: Putting Patient Care Over Pocketbooks

The program outlined in the Medicare for All Act of 2019, H.R. 1384, takes several steps to ensure that providers can focus on patient care rather than on their pocketbooks.

- **Less Time on Billing, More Time for Patients.** Medicare for All would simplify the administrative process for doctors and other providers by having one payer. Precious time that doctors and other health care providers spend on billing and coding would be freed up, allowing providers to do what they do best—care for patients.
- **Negotiating Lower Prices.** Under the Medicare for All program, health care corporations would no longer be able to overcharge for their services. By leveraging its buying power as the single payer of health care, Medicare for All would be able to negotiate better, fairer health care prices for everyone. Reimbursement rates for hospitals and doctors will be based on negotiations with the regional directors. Negotiations over health care prices would include prescription drug price negotiations. The Act would also allow the HHS secretary to issue "compulsory licenses" to allow generic production if reasonable prices are not reached with pharmaceutical corporations.
- **Health Care Dollars No Longer Line Pockets.** The Medicare for All program would bar Medicare for All providers from siphoning off health care dollars to line their pockets. The Act does so through limits on executive pay and prohibitions on bonuses and other financial incentives for upcoding. Importantly, provider reimbursement must be used for the costs of providing care and could not be used for profit. The Act also prohibits Medicare for All providers from entering into financial relationships that could interfere with decisions on patient care. Health corporation board members would no longer be able to receive bonuses from pharmaceutical or medical device manufacturers for entering into exclusive contracts.

Global Budgeting for Hospitals & Other Institutional Providers

Under the Act, each hospital and each institutional provider—including skilled nursing facilities, federally qualified health centers, home health agencies, and independent dialysis facilities—will be paid through an institution-specific "global budget".

- **Negotiated Annually.** The global budgets would be negotiated annually between institutional providers and regional directors. Institutional providers would receive a fixed annual allowance, paid and reviewed quarterly, to fund operating expenses related to furnishing health care to Medicare for All members. Major factors

included in negotiations are historical volume and costs of care, projected changes in volume and type of care, and wages for all employees, including physicians that work directly for the hospitals. Capital expenditures for costs such as renovating facilities or building new ones will require separate approval from the regional director.

- **Aligning Hospital Reimbursements With Actual Costs.** Global budgeting simplifies the reimbursement system so that payments more closely reflect the actual costs of providing health care to the population served by each hospital and institutional provider.[1] The global budgeting process would allow the Medicare for All program to ensure that providers get the appropriate funding for the health care services that their patient population needs—providers would be accountable for their spending and would no longer be able to overcharge.
- **Simplification of Hospital Reimbursements.** By eliminating the billing process, global budgets bring hospitals and other providers administrative simplicity and associated savings. Information necessary to predict annual global budgets—including financial cost data, case mix, and volume of services—is readily available and already captured by hospitals and other institutions.[2] Additionally, this information is already reported to the Centers for Medicare and Medicaid Services in Medicare cost reports.
- **Transparent and Accountable Spending.** Global budgets allow for the public to know where our health care dollars are going and it helps us ensure that rural hospitals and hospitals in underserved areas are getting the funding that they need. Providers must report all relevant data associated with operational costs and justify their spending during annual negotiations. With periodic audits and review, providers would be held accountable for their projected spending and the program could monitor whether the provider is meeting program goals and standards. Budget shortfalls, unexpected or emergent public health conditions, or other marginal cost differences between planned and actual health care spending can be addressed through budget adjustments year-over-year or through quarterly reviews.
- **Funding Certainty for Hospitals Serving Vulnerable Communities.** Global budgets can be a blessing to hospitals that serve rural and underserved communities that currently have inconsistent or undependable funding streams. Global budgets would ensure that our safety net hospitals that provide care to low-income, rural, and minority communities are sufficiently funded and resourced. The American Hospital Association agrees that global budgets are good for stabilizing funding of vulnerable rural and urban hospitals.[3]
- **International Use of Hospital Global Budgeting.** Many countries with publicly-funded health care—Canada, Scotland, Wales, New Zealand, Australia,

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[1] Dredge, Robert. *Hospital Global Budgeting*. World Bank Health Nutrition and Population Discussion Paper. World Bank (2004), pp. 37-38.

[2] *Id.* at pp.18, 37-38.

[3] American Hospital Association. "Ensuring Access in Vulnerable Communities – Taskforce Report and Resources." (2016), available at https://www.aha.org/system/files/content/16/ensuring-access-taskforce-report.pdf.

Denmark, Sweden, Switzerland, Norway, Iceland, Ireland, and Singapore—use global budgets as key components of their hospital payment methodologies.[4]

- **Successes in Global Budgeting in the U.S.** Notably, Maryland has been successfully paying all hospitals in the state through global budgets since 2014, and the city of Rochester, NY successfully implemented hospital global budgets in the 1980s for almost a decade under a Medicare waiver. In Rochester, global budgets led to lower overall health care costs for families and a 17% reduction in the hospital component of total health care spending. Administrative costs were 7% compared to 14-24% nationally. In Maryland, global budgeting resulted in $429 million in hospital savings for Medicare within 3 years of implementation outperforming Medicare's initial goal of $330 million in savings over 5 years.[5] Following Maryland's successes, Pennsylvania recently adopted global budgets for its rural hospitals.

Payment Options for Doctors & Medical Group Practices

There are two payment options for doctors and doctor groups under the Medicare for All Act of 2019—reimbursements based on the Medicare fee schedule or salaries based on negotiated global budgets. The Secretary of the U.S. Department of Health and Human Services would establish a national fee schedule in consultation with doctors and regional directors. Instead of payments based on the national fee schedule, individual providers and group practices could opt to receive salaries through an institutional providers' global budget.

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[4] See Mossialos, Elias et al. "International Profiles of Health Care Systems." The Commonwealth Fund (May 2017); Wolfe, Patrice and Moran, Donald. "Global Budgeting in OECD Countries." Health Care Fin. Rev. (1993) Vol 14:3.

[5] Sabatini, Nelson et al. "Maryland's All-Payer Model—Achievements, Challenges, And Next Steps." *Health Affairs Blog* (Jan. 31, 2017), available at https://www.healthaffairs.org/do/10.1377/hblog20170131.058550/full/.

ATTACHMENT 5: Medicare for All Act of 2019: Cost & Savings Analyses

The tables below summarize the findings from two major cost and savings analyses of national implementation of Medicare for All. The first study was conducted by Robert Pollin and his colleagues with the Political Economy Research Institute (PERI) of the University of Massachusetts Amherst.[1] The second study was conducted Charles Blahous with the Mercatus Center of George Mason University.[2] Blahous testified at the House Rules Committee hearing on the Medicare for All Act of 2019, H.R. 1384, on April 30, 2019. These two studies contain the most rigorous methodologies for analyzing potential savings in addition to increases in cost that would result from implementation of Medicare for All.

Both the Pollin study and Blahous study support the conclusion that the savings produced by Medicare for All would exceed increases in cost. Blahous' analysis finds that Medicare for All would result in $2.1 trillion in savings over 10 years in National Health Expenditures (Table 1).[3] Pollin's analysis found that Medicare for All would result in $5.1 trillion in savings over ten years (Table 1).[4] Breaking those results down, Pollin's findings show that although there could be, on the high-end, a $390 Billion increase in costs as a result of increases in health care demand, Medicare for All would also capture $697 Billion (18.78%) in savings in administration, pharmaceutical payments, provider rates, and reduced waste, fraud, and abuse (Table 2).[5] Blahous' study similarly demonstrates that although Medicare for All would increase health care demand by $435 Billion, the program would also produce $528 Billion (10.56%) in savings on administration, pharmaceutical payments, and provider rates (Table 2).[6]

Some minor adjustments have been made to Pollin's percentages below in order to reflect percentages of National Health Expenditures rather than National Health Consumption, which Pollin uses in his study. Blahous' percentages of increases and savings are percentages of National Health Expenditures.

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[1] Pollin, Robert, et al. "Economic Analysis of Medicare for All." Political Economy Research Institute (PERI), University of Massachusetts Amherst (2018), available at https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all.

[2] Blahous, Charles. "The Costs of a National Single-Payer Healthcare System." Mercatus Center, George Mason University (2018), available at https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.

[3] *Id.* at 7 (Summing projected National Health Expenditures for 2022-2031 from Table 2).

[4] Pollin (2018) at p. 3.

[5] *See Id.* at pp. 40-44 (adjusting percentages to reflect percentage savings of national health expenditures).

[6] *See* Blahous (2018) at p. 4 (Table 1).

Table 1. Projected Savings in National Health Expenditures, Pollin & Blahous

	Pollin Study	Blahous Study
Projected Savings MFA (10 Years) in National Health Expenditures	**$5.1 Trillion**	**$2.1 Trillion**
Years	2017-2026	2022-2031
Projected Savings MFA (First Year) in National Health Expenditures	**$310 Billion**	**$93 Billion**
Year	2017	2022

Table 2. Projected Increases, Projected Savings (Breakdown) in National Health Expenditures, Pollin & Blahous

	Pollin Study	Blahous Study
Increases in National Health Expenditures due to Medicare for All		
Projected Increase in Utilization/Demand	**$390 Billion**	**$435 Billion**
Percentage Increase in Utilization/Demand	**11.73%***	**9.50%**
Savings in National Health Expenditures due to Medicare for All		
Administrative Savings	$327 Billion	$83 Billion
Percentage	8.80%*	1.66%
Drug Savings	$214 Billion	$61 Billion
Percentage	5.77%*	1.22%
Medicare Rates	$102 Billion	$384 Billion
Percentage	2.74%*	7.68%
Savings From Reduced Waste & Fraud	$54 Billion	N/A
Percentage	1.47%*	N/A
TOTAL SAVINGS	**$697 Billion****	**$528 Billion**
Percentage	**18.78%***	**10.56%**

* The Pollin Study used Health Consumption Expenditures and the Blahous Study used National Health Expenditures. To ensure compatibility in comparing the data, percentages from the Pollin Study were adjusted to reflect National Health Expenditures. *See* Pollin, pg. 22, for explanation on use of Health Consumption Expenditures.

** Projected National Health Expenditure savings in Table 1 are slightly different than total savings minus increases in Table 2 because of rounding in the Pollin Study.

ATTACHMENT 6: Medicare for All Act of 2019: Canada, Taiwan & U.S. Comparison

Two international examples of single-payer programs—Canada's Medicare program and Taiwan's National Health Insurance program—are detailed below in comparison to U.S. health spending and costs (Table 1) and in comparison to the system design of the Medicare for All Act of 2019, H.R. 1384.

The single-payer health systems of Canada and Taiwan are most similar in design to the single-payer program proposed under the Medicare for All Act of 2019. Similar to the United States, Canada and Taiwan both have a mix of publicly and privately delivered health care.

Table 1. Health Care Spending & Insurance Administrative Cost Comparison: Canada, Taiwan & U.S. (2017)

	Canada	Taiwan	U.S.
Total Spending on Health, % of total national GDP	10.4%*	6.1%**	17.2%*
Mean Spending on health per capita, PPPUSD	$4,721*	$3,047**	$10,209*
Insurance administrative costs,* by percentage**	2.7% of total national health spending*	0.77% of NHI budget**	8.3% of total national health spending* 13% of private insurer spending** 7% of traditional Medicare and Medicare Advantage spending combined** 1.1% of traditional Medicare spending alone**

* Organization for Economic Cooperation and Development. "OECD Health Statistics 2018." OECD Stat (Updated Nov. 2018), available at http://www.oecd.org/els/health-systems/health-data.htm.
** Cheng, Tsung-Mei. "Health Care Spending in the US and Taiwan: A Response to *It's Still The Prices, Stupid, And a Tribute to Uwe Reinhardt.*" *Health Affairs* (Feb. 2019), available at https://www.healthaffairs.org/do/10.1377/hblog20190206.305164/full/.
*** Health care providers also incur substantial billing and insurance administrative costs that are not included in these figures.

Table 2. Program Design Comparison: Canada, Taiwan & H.R. 1384[1]

Design Feature	Canada	Taiwan	H.R. 1384
Program Name	Medicare	National Health Insurance (NHI)	Medicare for All (MFA)
Level of Administration	Provincial or territorial government	National government	National government; regional subdivisions responsible for allocation of funds and negotiations with providers
Eligibility			
Universal coverage	Yes	Yes	Yes
Separate public programs for certain groups other than military	Yes	No	Yes. Although veterans and American Indians/Alaskan Natives may receive services through the Veterans Health Administration or Indian Health Services, respectively, they may also enroll in MFA.
Mandated Benefits Package			
Hospital and physicians' services	Yes	Yes	Yes
Outpatient prescription drugs	No	Yes	Yes
LTSS	No	Has a "Long-Term Care 2.0" plan to fully cover comprehensive home- and community-based care under NHI by 2026. Home-based care programs are currently being rolled out to expand coverage.	Yes, with a prioritization of home- and community-based services.
Dental, vision, and mental health services	No	Yes. Also, includes Chinese medicine, and home nursing care.	Yes
Private Health Insurance			
Supplemental	Yes	Yes, plays a non-substantive role; used primarily as a cash benefit to use for private rooms, co-pays, etc., and not used for coverage of services with the exception of long-term care.	Permitted for services not overlapping with Medicare for All, which would be extremely limited given the comprehensive benefits of the program.
Substitutive	No	No	No

[1] Information complied from: Congressional Budget Office. "Key Design Components and Considerations for Establishing a Single-Payer Health Care System." CBO Publications (May 1, 2019), available at https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf; and Mossialos, Elias et al. "International Profiles of Health Care Systems." The Commonwealth Fund (May 2017).

Design Feature	Canada	Taiwan	H.R. 1384
Other types of private insurance	No	No	No
Participating Provider Rules			
Balance billing allowed	No	No	No
Payments from private-pay patients for covered services	No	No	No
Hospitals			
Primary ownership	Mixed	Private	Private
Primary payment method	Global budget	FFS with overall hospital sector global budget	Global budget
Primary Care Physicians			
Primary employment	Private	Private	Private
Primary payment method	FFS	FFS with overall primary care global budget	FFS with option to elect salaried reimbursement through hospital global budgeting.
Outpatient Specialist Physicians			
Primary employment	Private	Private	Private
Primary payment method	FFS	Salary	FFS with option to elect salaried reimbursement through hospital global budgeting.

ATTACHMENT 7: Medicare for All Act of 2019: Frequently Asked Questions

What is Medicare for All?

- The Medicare for All Act of 2019 would establish a single-payer health care system, which would expand the existing Medicare program to cover everyone in the United States and improve it so that everyone would be guaranteed comprehensive benefits without regard to their ability to pay.
- A single government agency would replace private insurance plans and provide public financing of health care. Because of the generous benefits package available under Medicare for All—including dental, vision, long-term services and supports, comprehensive reproductive services, and mental health services—with no cost-sharing, there would be no need for catastrophic or supplemental coverage to meet most health needs.

Would there be out-of-pocket costs, premiums, deductibles, or other cost-sharing under Medicare for all?

- Under Medicare for All there would no premiums, co-pays, deductibles, or other out-of-pocket payments. There would be uniform benefits and one standard of comprehensive care—guaranteed healthcare for everyone no matter what the size of your wallet.
- Employers would no longer be burdened with annually negotiating health plans or paying private insurer premiums.
- Seniors would immediately benefit from coverage that would be more comprehensive than Medicare, and would no longer need to purchase supplemental insurance to cover aspects of their care.

Would choice of doctors be limited?

- Medicare for All expands choice because you can see any doctor, go to any clinic, and be admitted at any hospital. Medicare for All is completely portable and not tied to any job, any doctors group, or any network.
- Medicare for All reforms only how health care dollars are collected and paid to providers; it does not dictate which providers individuals can visit.

Would the government be making decisions on care?

- Under the Medicare for All Act of 2019, the program would put health care decisions into the hands of you and your doctor instead of insurance companies and corporate boardrooms. Currently, unaccountable insurance companies call the shots on our

health care and tell us which procedures are approved or what is necessary or unnecessary care.

- The Act also ensures that the professional judgment of doctors, nurses, and other health care professionals in consultation with their patients is the basis for health care decisions.

How is Medicare for All better than private insurance?

- With Medicare for All, Americans would no longer have to deal with persistent changes to their health insurance when their employers annually renegotiate plans, and we would no longer be at the mercy of commercial insurers that suddenly change which doctors or hospitals are inside or outside their network. Even if you are unemployed, or lose or change your job—your health coverage under Medicare for All stays with you.
- Even the best private insurance plans in this country do not cover the comprehensive list of services without any out-of-pocket costs or premiums paid by you or your employer. Under Medicare for All, everyone would have comprehensive benefits and full choice of provider without having to pay perpetually increasing premiums, copays, or deductibles.
- Under Medicare for All, everyone would have the same high standard of quality health care guaranteed, from birth to death. On the other hand, private insurers, as for-profit corporations, have an incentive to deny necessary care in order to maximize profits. When enrollees receive health care services, health insurers consider these losses. Insurers also view vulnerable populations, rural areas, women, and minority groups as risks to the corporate ledger.

Shouldn't we try a Medicare buy-in or public option first?

- Medicare buy-ins and public option plans perpetuate current inequities in our system of health care. These stop-gap measures placed on existing commercial insurance systems, shore up the profit-driven insurance system. Under a public option or Medicare buy-in, private plans would maximize revenue by cherry-picking coverage of only the healthiest people and leave the public plans to care for all the sickest and most expensive cases.
- Unlike Medicare for All, public options and buy-ins retain administrative complexity and will not produce the financial savings that we can capture with Medicare for All. These programs also cannot wield the massive negotiating power of single payer system to reduce health care prices and contain skyrocketing costs.
- Even worse, the public option and Medicare buy-in still place limits on coverage and eligibility, restrict the choice of providers, and impose costly premiums and out-of-pocket costs in the form of deductibles and copayments. "Access" to a health plan is not a guarantee of health care.

Would Medicare for All save taxpayer money?

- Taxpayers already finance nearly two-thirds of health care spending in the United States.[1] Medicare for All would produce savings because insurance industry profit, executive compensation, advertising, and marketing would no longer be necessary. We currently spend about 31 percent of total health expenditures on billing and insurance-related costs and other administrative costs.[2] And we spend at least $30 billion per year on health care marketing.[3]
- Medicare for All would eliminate administrative waste created by private insurance and the attendant administrative complexity that comes with a multi-payer system.
- The Act would also control health care spending by eliminating marketing costs and prohibiting health industry profiteering, and excessive executive pay from public health dollars.
- The Medicare for All program through its bulk purchasing power, would negotiate not only lower drug and medical equipment prices, but also lower prices for other health care costs through global budget negotiations with hospitals and other institutional providers.
- Studies have shown that Medicare for All would save the country up to $5.1 trillion over 10 years.[4] Conservative estimates conducted by the Mercatus Center concluded that the U.S. would save $2 trillion over a ten-year period under Medicare for All.[5] The savings produced from reduced health care prices under Medicare for All would be allocated to expand benefits and to eliminate deductibles, copays, and out-of-pocket costs for everyone.

How much will doctors get paid?

- Reimbursement rates may go up for some doctors and down for others Medicare rates have tended to fall in between Medicaid and private insurer rates. Changes, if any, in how much a provider makes will depend on each specific provider's payer mix (or the mixture of payment sources the doctor gets now).

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[1] Himmelstein, David and Woolhandler, Steffie. "The Current and Projected Taxpayer Shares of U.S. Health Costs." *Amer. J. of Pub. Health* (Mar. 2016), Vol 106:3, pp. 449-452.

[2] Total administrative costs are estimated to be over $1,097 billion in 2017. Steffie Woolhandler and David U. Himmelstein. "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs." Ann Intern Med. (2017) 166(8):587-588. According to the Centers for Medicare and Medicaid Services national health expenditures was $3,492.1 billion in 2017. Centers for Medicare and Medicaid Services. "Historical National Expenditures." National Health Expenditure Accounts (2017), accessed on April 26, 2019, available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html.

[3] Schwartz,Lisa and Woloshin, Steven. "Medical Marketing in the United States, 1997-2016." *JAMA* (2019) Vol 321:1, available at https://jamanetwork.com/journals/jama/fullarticle/2720029.

[4] Pollin, Robert et al. "Economic Analysis of Medicare for All." Political Economy Research Institute (PERI), (Nov. 2018), available at https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all.

[5] Blahous, Charles. Mercatus Working Paper. "The Costs of a National Single-Payer Healthcare System." Mercatus Center at George Mason University, Arlington, VA (Jul. 2018), available https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.

- Rates may change based on the type of medicine a doctor practices because the Medicare for All program would ensure that primary care doctors in rural and underserved areas are sufficiently paid. Primary care physicians may see rates increase while specialists may see them reduced. Providers in rural and underserved areas would see reimbursements and funding stabilize.
- By reducing time on billing and paperwork, changes to rates could be offset because doctors have more time to spend on caring for patients and for other reimbursable services.

Does the legislation provide comprehensive reproductive services to women?

- Medicare for All would dramatically improve access to important reproductive services, including contraception coverage, comprehensive maternity and newborn care, reproductive health screening, abortion care, and family planning services.
- Medicare for All ensures that women have access to comprehensive benefits that include early and periodic screening, diagnostic, and treatment services. These services are important to prevent reproductive diseases and other illnesses that women are more at risk of developing, including lung and breast cancer.[6]
- The Act would ensure that any restrictions on the use of federal funds for reproductive health services, including the Hyde Amendment, would not apply to Medicare for All funds. The Act also includes a non-discrimination clause, which bars discrimination on the basis of pregnancy, including termination of pregnancy.
- Despite an international decline in maternal mortality rates, the United States has seen an increase. More women die of pregnancy-related complications in the U.S. than any other developed country.[7] The Act includes comprehensive maternity and newborn care, which is critical to lowering mortality rates and improving health outcomes for women and babies.

What impact would Medicare for All have on workers and is there a plan for a just transition?

- The Act would direct at least 1% of the Medicare for All budget for the first 5 years towards assistance programs for any workers displaced from the implementation of the program, including workers in health insurance and billing-related jobs.
- Just transition funding would include wage replacement, retirement benefits, job training, and education benefits.

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[6] Jemal, Ahmedin et al. "Higher Lung Cancer Incidence in Young Women Than Young Men in the United States." *New Eng. J. of Med.* (2018).

[7] Martin, Nina and Montagne, Renee. "The Last Person You'd Expect to Die in Childbirth." *ProPublica* & *National Public Radio* (May 12, 2017).

How are community health care needs addressed under Medicare for All and how are preventive services covered?

- Medicare for All provides health planning by region through special projects and capital expenditure funds. Regional planning ensures that hospitals and clinics are built in communities where they are needed and ensures that providers who serve vulnerable communities, which insurers currently view as a risk to corporate bottom lines, are appropriately paid under Medicare for All. By increasing care capacity in local communities, many racial, economic, and geographic disparities in health and health care would be mitigated and life expectancy improved.
- By removing financial roadblocks to care, Medicare for All encourages preventive care. This not only reduces the occurrence of pain and illness but it also decrease the societal cost of untreated disease and overuse of emergency rooms.

ATTACHMENT 8: National Nurses United Report on Medicare for All

Full report included below.

MEDICARE FOR ALL VS. ALL THE HEALTHCARE THAT EACH CAN AFFORD

Michelle Grisat
National Nurses United
The Sanders Institute
June 2017

the
Sanders Institute

MEDICARE FOR ALL VS. ALL THE HEALTHCARE THAT EACH CAN AFFORD

We stand at the crossroads between guaranteeing healthcare to everyone through an improved and expanded Medicare program and leaving increasingly more people at the mercy of the market with legislation such as the American Health Care Act. Now is the time to take on our market-driven system and fight for an improved and expanded Medicare for all.[1]

In contrast to our current system, a Medicare-for-all health plan would provide comprehensive healthcare benefits for all medically appropriate care without regard to income, employment, or health status. Instead of many insurers, each with a variety of health plans and cost-sharing schemes, funding for healthcare would be administered from a single government fund based on a uniform set of benefits.[2] Payments would be negotiated by representatives of the Medicare-for-all plan and representatives of hospitals, physicians, and other providers. Finally, prescription drugs, medical devices, and other related supplies would be negotiated in bulk for the entire U.S. population at reduced prices. There would be a single standard of excellence in care for all – not bronze for some and platinum for others. People would be free to seek care from any participating healthcare provider. We would receive the care our doctors and nurses determine we need – not what a profit-seeking insurer deems it will cover or deny. Finally, care would be provided without deductibles or copayments thereby easing economic inequality and health disparities.

This paper begins by examining our market-driven healthcare system and the failings of our private insurance system. It includes discussions on why adding a government-run public insurance option to the ACA private insurance marketplaces could not remedy the problems the marketplaces face and on the limitations in care under a market-driven system. Finally, it will examine the major features of a Medicare-for-all system and how our country could provide healthcare as a right, not a privilege.

Corporate Healthcare and the Games that Insurers Play

For decades, corporate healthcare has played a major role in defeating attempts to guarantee healthcare for all. The influence of this sector decisively shaped the Affordable Care Act (ACA). In the years leading up to and following the passage of the ACA, 2006 through 2012, the health sector spent $3.4 billion on lobbying – more than any other sector for four out of seven years and second for the other three.[3] It also contributed a whopping $709 million in campaign contributions over that same time period.[4] Of this $709 million, $332 million went to Republicans, $304 million went to Democrats ($23 million to candidate Obama in 2008), and the balance went to outside spending groups. The "investment" in lobbying and campaign contributions paid off. By spending these vast sums, corporate healthcare was able to block measures that would have improved our healthcare system, but interfered with the health industry's ability to reap enormous profits, and win provisions that guaranteed increased healthcare industry profits.

Still, in many ways, the ACA was a step forward. Those with pre-existing conditions can no longer be denied coverage and insurers cannot base premiums on health status. The number of uninsured has dropped considerably, with 20.4 million gaining coverage from 2010 to 2016.[5] Unfortunately, the ACA didn't go far enough. With plans available in the ACA insurance marketplaces requiring cost sharing ranging from 10% to 40%, on top of premiums, cost continues to make it prohibitive for many to access healthcare. Catastrophic plans are even worse. Even though the federal government has been propping up the insurance marketplaces through premium support and cost-sharing subsidies, paid by taxpayers to private insurers, these insurance marketplaces have struggled from the beginning. These struggles have been exacerbated under the current administration.

Some contend that adding a public option to the ACA insurance marketplaces could serve as a corrective to the abuses of the profit-based insurance industry and, perhaps, even be a first step on the road to Medicare for all. The public option plans, as designed by a pair of current congressional bills,[6] would be administered by the federal government, funded by premiums, and have their own provider networks. The public option plans would be offered alongside the private insurance plans in the marketplaces and be subject to the same terms and conditions, including the premium tax credits and cost-sharing reductions as the other metal plans – bronze, silver, gold, and platinum. The idea is that a public option would be able to drive down insurance prices by competing against private health plans as a low-cost option that would not need to spend huge amounts on executive compensation packages, turn a profit, or pay dividends to shareholders.[7] However, the market for health insurance differs dramatically from markets for most goods and services in such a way that increased competition does not necessarily drive down prices. Though the differences are many, consider just two. First, those buying insurance are unable predict in advance what type of healthcare they may need; even those currently being treated for a health condition may have unanticipated health needs arise. The second and crucial point is that the private insurance business model, which seeks to limit claims paid on policies, conflicts with the very reason most people have for purchasing health insurance, the need for healthcare. Insurers' biggest costs are what they term *medical loss*, or the costs of paying for policyholders' covered healthcare services. Thus, insurers strive to limit how much they pay out in claims for care provided to their enrollees. Health insurers do not focus on maximizing policy sales, but on maximizing sales to individuals who they deem will pay more in premiums than they cost in care. Competition among health insurers amounts to competing to sell policies to healthier individuals (also known as "cherry picking").

This practice continues under the ACA even with thousands of pages in statutes and related regulations. Studies have documented discriminatory insurance policies on the marketplaces that place key HIV/AIDS, cancer, and multiple sclerosis drugs in the highest cost-sharing tier in a drug formulary.[8] Selective provider network design offers another means of excluding costly patients. For example, the network may include a limited number of oncologists and other specialists or exclude academic medical centers and cancer treatment centers.[9] Although increased competition generally may lower premiums in some of the ACA insurance marketplaces,[10] the question remains whether a public option would have a sufficient competitive edge over private plans to keep premium rates affordable, particularly when the private insurers game the system.[11] As the public option would not want to replicate the unscrupulous practices of private insurers, it is likely to end up with a great number of costly enrollees that private insurers want to offload, making it nearly impossible for the public option to maintain competitively priced premiums, discrediting the role of the government, and undermining support for public programs such as Medicare and Medicaid.

Moreover, in many areas where the ACA marketplaces are down to a lone insurer, competition is not the problem.[12] Rather, many are losing money as the enrollees are much sicker and costlier.[13] Insurers that remain in these areas have raised their premiums by double digits and, in one case, triple digits.[14] In the four states which dropped down to one insurer in 2017, the increases ranged from 29% to 69%, while cities and counties with a single insurer saw increases ranging from 26% in Anchorage, Alaska to 145% in Phoenix, AZ – which dropped from eight insurers in 2016 to just one in 2017.[15] Recent filings for 2018 indicate further dramatic rate increases.[16] The only solution to bringing down premiums is to broaden the risk pool by inducing those who are younger, healthier, and less costly to enroll. Given the cost and quality of many of the insurance plans in the ACA marketplaces, this would be very challenging even without the sabotage of the current administration. It may prove to be impossible to cover costs while maintaining premiums at a level that enrollees can manage. Without federal premium support, the premiums required to cover the cost of care in these markets would surely outstrip many enrollees' ability to pay and, thus, end in a death spiral. The larger issue here is that even if a public option were the answer to saving the insurance marketplaces, we would still be left with the tiered plan model and 10% to 40% cost sharing or worse, a catastrophic plan.

Finally, not only do private insurers avoid covering the most costly patients, they also attempt to limit care to those they do cover. In a more insidious approach than outright denial, insurers impose clinical practice guidelines and protocols that interfere with physician autonomy by limiting the types of tests and treatments that the insurer will reimburse. Physicians may not be able to order a test because a patient does not meet the criteria in the "guideline" the insurer designates, whether or not the criteria are relevant to a particular patient's circumstances.[17] In cases where an insurer, hospitals, and physicians work together as a health plan, such as a health maintenance organization (HMO) or an accountable care organization (ACO), care is often limited through the electronic health record (EHR). EHRs go beyond an electronic version of a paper chart that merely records information.[18] Protocols and guidelines, as well as programs to order tests and treatments, can be embedded in the EHR as clinical decision support. Although these software programs may be called clinical decision "support," and the embedded clinical practice requirements may be called "guidelines," they often function as hard-and-fast rules that override physicians' professional judgment as well as limit the full professional practice of nurses and other practitioners that care for patients. As protocols and clinical practice guidelines are based on studies and data regarding a certain percentage of a patient population as a whole, they may not apply to a particular patient. Practitioners must be free to provide care based on their professional judgment about the tests and treatments appropriate for their individual patients.

All the blame for high premium costs cannot be laid at the feet of insurers, however. Consolidation in hospital and physician practices has also contributed to the increased cost.[19] The rate of increase in hospital consolidation has accelerated in recent years. Since 2009, the number of hospital mergers and acquisitions has doubled and the number of independent community hospitals has dwindled.[20] In 2015, the most recent year for which data is available, only one in three hospitals remained independent.[21] Price gouging in the hospital industry becomes readily apparent by examining charge-to-cost ratios – that is, the relationship between how much a hospital charges compared to its costs. The latest data show that, on average, hospitals charge 379%, nearly four times, more than an item or service costs. Hospitals that belong to systems have, on average, charge-to-cost ratios that are 53% higher than independent hospitals.[22] Hospitals are quick to say that this is what they charge, but it is not necessarily what they receive in payment. Yet, as insurers typically negotiate rates based on a percentage of what hospitals charge, the more they charge, the higher their profit margin.[23] Unfortunately, the horrifying irony of our current system is that the uninsured pay the highest rates of all.[24]

If there is any doubt that our market-driven healthcare system is failing us, two measures, expenditures and health status, make it clear. Although the United States consistently spends more on healthcare than any other country, it typically has poorer results. The most recent data from the Organisation for Economic Co-operation and Development (OECD),[25] a widely utilized source for making international comparisons, show that the United States spent 16.9% of GDP, nearly twice the average rate of 9% for the 35 member countries.[26] The differences are even greater in the amount we spent per person. At $9,451, we spent nearly two and half times the $3,814 average of OECD countries.[27] Yet, despite the amount we spend, the patchwork U.S. "system" leaves 28 million uninsured and millions more underinsured.[28] The result is poorer health and shorter lives. A widely cited study by the Commonwealth Fund comparing the United States to ten other countries ranked the U.S. dead last overall as well as in the categories of healthy lives, cost-related problems to access, equity, and efficiency.[29] A second study, covering 195 countries regarding deaths that were preventable had the patient received "timely and effective medical care," ranked the U.S. at number 35 on its Health Access and Quality index – in between Estonia and Montenegro.[30] The worst U.S. scores were for lower respiratory infections, ischemic heart disease (coronary heart disease), and chronic kidney disease. Looking strictly at the United States, we find a recent dip in the average life expectancy,[31] a gap of 10 to 15 years in life expectancy between the richest and the poorest among us,[32] and numerous health disparities related to class, race, and sex.

Medicare for All: How it Works

Corporate control of healthcare and our misguided faith in the market has resulted in an inefficient, fragmented "system" that leaves millions with little or no access to healthcare. Our current approach treats healthcare as a commodity on a par with other commodities rather than a public good. We have accommodated the failure of the private insurance market by cobbling together the most expensive public-private system the world has ever seen. The shift to a Medicare-for-all plan reorients our system to providing healthcare as a right, not a privilege. It would be a tremendous step toward ending health disparities and would mitigate economic inequality. Finally, recent public opinion polls demonstrate that a strong majority of Americans favor Medicare for all. In December 2015, the Kaiser Health Tracking Poll found:

> When asked their opinion, nearly 6 in 10 Americans (58 percent) say they favor the idea of Medicare-for-all, including 34 percent who say they strongly favor it. This is compared to 34 percent who say they oppose it, including 25 percent who strongly oppose it. Opinions vary widely by political party identification, with 8 in 10 Democrats (81 percent) and 6 in 10 independents (60 percent) saying they favor the idea, while 63 percent of Republicans say they oppose it.[33]

A 2017 poll by the Pew Research Center demonstrates that support is growing.

> Currently, 60% of Americans say the government should be responsible for ensuring health care coverage for all Americans, compared with 38% who say this should not be the government's responsibility. The share saying it is the government's responsibility has increased from 51% last year and now stands at its highest point in nearly a decade.[34]

So what's stopping us? Supporters of our market-driven model typically sabotage efforts to provide Medicare for all by focusing on how we would pay for it. This is disingenuous. We are already paying for it; we're just not receiving it. Approximately two-thirds of U.S. healthcare expenditures already come from taxpayers in the form of federal, state, and local government spending.[35] Healthcare in the U.S. costs more both because of administrative complexity and higher prices, rather than increased utilization. The comparisons of U.S. spending and health outcomes to other countries strongly suggest that there is enough money in our current system to provide healthcare for all, if we spend that money fairly and wisely. The key point is to demonstrate that there is enough money currently being spent on healthcare in the U.S. to provide Medicare for all, rather than specifying particular funding mechanisms.[36]

As mentioned above, we would reap enormous savings by eliminating private insurance company costs such as profits, shareholder dividends, excessive executive compensation, and marketing costs. Additional savings would come from the uniformity in health benefits and in claims and billing processing. Instead of many insurers, each with a variety of health plans and cost-sharing schemes, funding for healthcare would be administered from a single government fund based on a uniform set of benefits.[37] Hospitals, physicians, and other providers would no longer need large billing departments to manage payments or to pursue collections from the uninsured and the underinsured. Each of these areas is discussed in more detail below.

Cost sharing — copayments, coinsurance, and deductibles. Eliminating patient cost sharing is a first step to achieving health equity and easing the economic inequality that is rife in our country. The very idea of requiring patient cost sharing, also called "out-of-pocket costs," derives from a market-based approach to healthcare. Those who take this economistic approach to providing healthcare argue that people need to "have skin in the game," meaning that they must have a financial stake in accessing healthcare, otherwise they will use their health insurance indiscriminately and not just when they truly need it.[38]

Research confirms that even minimal cost-sharing requirements reduce healthcare utilization.[39] Unfortunately, cost sharing keeps people from seeking both needed and unneeded care.[40] This should not come as a surprise; laypersons cannot be expected to know prior to seeing their healthcare provider whether or not they need medical treatment. As the cost of providing care has increased, costs have been shifted to individuals and families. Imposing higher deductibles, copayments, and coinsurance is a double win for insurers; healthcare utilization drops and they pay less when healthcare is used. Today, millions with health insurance delay seeking healthcare or filling a prescription because of high deductibles, but even copayments can be difficult for many to manage.[41] Those who are sick or low income fare the worst.[42] Thus, eliminating cost sharing reduces both health disparities and economic inequality.[43] Finally, while prompt treatment of injury and illness is reason enough to eliminate cost sharing, in some cases it also reduces the overall cost of treatment.[44]

Administrative savings. Administrative savings would come from two primary sources: insurers and providers such as doctors and hospitals.[45] On the insurer side, eliminating private insurance company waste such as profits, shareholder dividends, excessive executive compensation, and marketing costs would produce tremendous savings. Having a single, comprehensive benefits package and a single payer, the federal government, creates uniformity in claims and billing processing. Doctors and hospitals would no longer need large billing departments to manage payments or to pursue collections from the uninsured and the underinsured, nor for preauthorizing tests and treatments or checking drug formularies before prescribing medications. This would produce additional savings that could be redirected to care. Overall, replacing our complex, fragmented health system with its many insurers – each with multiple benefit packages and numerous cost-sharing schemes – would produce savings of 9.3% to 14.7%.[46] Based on projected national health expenditures of more than $3.5 trillion dollars in 2017, this would amount to $330 to $520 billion in administrative savings alone.[47]

Global budgets. Hospitals, nursing homes, and similar facilities, as well as home care agencies, would receive a fixed lump-sum annual budget, called a global budget, rather than getting paid separately for each patient's hospital stay. A global budget, typically paid out in monthly installments, would reimburse the facilities for all their operating expenses and, under a separate budget, for capital expenses such as new buildings and equipment. The savings would accrue primarily from reduced administrative costs related to billing and insurance. The administrative savings estimated above derive, in part, from global budgeting for hospitals and other healthcare facilities. Multiple studies have documented the savings achieved by using the global budget approach.[48] A recent study of hospital administrative costs in eight countries found that Canada and Scotland, which are paid using global budgets, had the lowest administrative costs at 12.4% and 14.3%, respectively.[49] In contrast, hospitals in the United States, which must manage a far more complex billing system, had the highest administrative costs at 25.3%.

Capital investment. A Medicare-for-all program would require approval for investment in expanding medical facilities and major equipment purchases to ensure they are allocated fairly and where needed. The approval process would prioritize capital investment in projects that address medically underserved populations and health disparities related to race, ethnicity, income, or geographic region. This approach contrasts sharply with a market-driven approach which seeks to maximize revenue. For years, hospital corporations have shuttered "under-performing" hospitals in communities with high numbers of uninsured, often reopening them a few miles down the road in areas with better insurance coverage and higher incomes. Most public hospitals, which typically care for the uninsured, on the other hand, have been severely underfunded and stand in need of critical infrastructure and equipment upgrades. Thus, relying on the market has resulted in a maldistribution of healthcare resources from what should be the guiding rationale, providing care to those who need it. Finally, our current system often leaves expensive equipment standing idle. For example, in a profit-seeking healthcare system with hospitals in relatively close proximity to one another, if one hospital purchases an MRI machine, the other

area hospitals may feel the need to do so in order to claim the same capabilities as they compete against each other. In contrast, a Medicare-for-all plan would direct investment in expensive equipment, new hospitals, and medical offices where it is needed, not where corporate healthcare deems most lucrative.

Bulk purchasing. The pharmaceutical/health products industry has spent more money lobbying than any other industry every year since 1999. The spending topped out at $274 million in 2009, with spending at a still sizeable amount of $246 million in 2016.[50] In addition, the industry has contributed millions to federal campaigns. According to the Center for Responsive Politics: "The pharmaceutical and health products industry ... is consistently near the top when it comes to federal campaign contributions. ... The industry's political generosity increased in the years leading up to Congress' passage in 2003 of a Medicare prescription drug benefit." [51] This appears to have been money well spent. As part of the Medicare Modernization Act of 2003, Congress not only created a Medicare prescription drug benefit, but also prohibited the Health and Human Services Secretary from negotiating prices or creating a formulary of approved prescription drugs.[52] The Center for Responsive Politics also found that "industry spending levels have fluctuated, though they have usually hovered around the $30 million range..."[53] That is until 2012, when campaign contributions increased to over $50 million and topped out in 2016 at nearly $60 million.[54]

A Medicare-for-all plan would negotiate prices on drugs and medical devices for the entire U.S. population.[55] Thus, it would garner far greater bargaining power than our fragmented system of insurers, each competing against each other and seeking to maximize profits. Negotiating with pharmaceutical companies would bring the costs of prescription drugs in this country in line with the rest of the world. A recent study found that this alone would have saved $113 billion in 2017.[56]

Primary care. Research shows that access to primary care, understood as having a usual place of care, continuity over time, care coordination, and a whole-person focus– rather than focusing on a particular disease or body part as specialty care often does – leads to better health.[57] Greater emphasis on primary care lowers overall costs by facilitating earlier intervention in disease processes, staying current with preventive measures, and reducing the use of emergency departments. Eliminating cost sharing is crucial to meeting these goals.[58]

The U.S. lags behind other countries in both access and health status, and spends far more, partially due to a shortage of primary care physicians.[59] Although estimates differ as to the magnitude of the growing shortfall of primary care physicians, all agree that it is significant. The mid-range projected shortfall in primary care physicians is 7,800 to 32,000 by 2025, increasing to 7,300 to 43,100 by 2030.[60] In addition to this general shortage, many geographic regions and populations are currently suffering due to a severe shortage of primary care physicians. According to the U.S. Health Resources & Services Administration, there are 6,790 health professional shortage areas[61] that need primary care physicians, predominantly in rural and low- income urban communities and among specific population groups within a geographic area such as the homeless, migrant farmworkers, and other groups.[62] Over 69 million people live in a shortage area – more than one in five Americans.[63] More than 10,000 primary care physicians are needed now to provide the care they need.[64]

The market has clearly failed to distribute primary care physicians where they are needed or to fulfill overall demand. A difference in compensation between specialists and primary care providers, coupled with the massive debt many students incur in becoming physicians, has resulted in too few primary care physicians. On average, primary care physicians earn far less than specialists. A recent survey found that average annual full-time physician compensation was $294,000 with specialist compensation 46% higher than primary care physicians at $316,000 and $217,000, respectively.[65] Orthopedic surgeons, at the top of recent compensation surveys, make more than twice as much as family medicine physicians, who are at or near the bottom.[66] A Medicare-for-all program could address these needs, for example, by increasing the number of primary care residencies, scholarships, and loan-repayment programs; targeting education of primary care physicians through dedicated Graduate Medical Education funding; and increasing the reimbursement of primary care physicians.[67] Although none of these ideas is new, a Medicare-for-all program

would reorient our healthcare system to put primary care at the center with a focus on preventive care and early intervention and treatment.

Physician compensation. First, to prevent inequity in access and care, physicians who accept payment from the Medicare-for-all plan would be prohibited from also receiving compensation for patient care from private payers, including patients themselves. Second, physicians would be required to accept payment by the Medicare-for-all plan as payment in full. There would still be some physicians who would cater to the wealthy, but there would not be inequity in access or care within the system based on higher reimbursement from private payers or additional fees charged on top of the Medicare-for-all payment rate. Finally, no part of physician compensation would derive from incentives to provide less care such as performance bonuses linked to utilization or profitability.[68]

Representatives of physicians, and other practitioners, would negotiate compensation with representatives of the Medicare-for-all plan. Physicians and their staff would spend far less time on insurance-related administrative matters such as billing and prior authorization for treatment. This decrease in overhead expenses would factor into overall compensation. Compensation would be on either a fee-for-service basis or by a fixed salary, for those working for an organization paid on a per capita basis or operating under a global budget.

The negotiations would also address the difference in compensation between primary care physicians and specialists. This pay inequity lies in undervaluing the cognitive-based services that primary care physicians provide compared to procedure-based services that specialists tend to provide.[69] Unlike surgeons and other specialty physicians who are paid based on the number of procedures they perform and often use complex, expensive equipment, "primary care physicians spend most of their time providing cognitive services, such as acquiring and assimilating information, developing management strategies, coordinating care, and counseling."[70] While some specialists would still be compensated at higher rates than the primary care generalists, the difference between rates would be reduced.

Conclusion

Numerous studies document the many inefficiencies of our "system" and its high financial costs. Likewise, study after study documents our failure to provide healthcare to all those who need it, as well as the vast disparities in health and healthcare in terms of class, race, and sex. Finally, our failure to guarantee healthcare to all exacerbates economic inequality through high out-of-pocket costs for care, medical debt, and bankruptcy.

The reason is clear. As discussed above, a market-driven approach to providing care is based on a business model that fundamentally conflicts with the very reason that people purchase health insurance. Whereas private insurers aim at limiting the amount they "lose" by paying for healthcare, people purchase insurance for the express purpose of accessing healthcare when they need it. A Medicare-for-all program would be accountable to the people, not to shareholders and the bottom line. Rather, it would facilitate the distribution of healthcare resources, such as new facilities and equipment, based on human need, not market share. Compensation for physicians and other healthcare providers would encourage better primary and preventive care. Rural and low-income urban areas would no longer be neglected. Additional resources would be directed to medically underserved areas and populations.

The threat by Congress and the Trump Administration to repeal the ACA makes this a crucial and timely issue. Although the ACA has improved healthcare insurance access, it did so by further entrenching the private insurance industry. Improving our current Medicare system and expanding it to cover everyone is the best solution. If we stand together, we can achieve it.

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[26] Organisation for Economic Co-operation and Development. OECD.Stat. (http://stats.oecd.org, accessed April 20, 2017) Data are based on estimates and projections; Centers for Medicare & Medicaid Services. (2017, March 21). NHE Fact Sheet. (https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and- reports/nationalhealthexpenddata/nhe-fact-sheet.html, accessed April 26, 2017). Although we don't have the actual data for the other OECD countries for 2015, we know that in the U.S. actual costs were even higher than the OECD estimate. The most recent figures on our national health expenditures (NHE) from 2015 show that the NHE grew 5.8% to $3.2 trillion, or $9,990 per person, and accounted for 17.8% of Gross Domestic Product (GDP).

[27] Ibid.

[28] Martinez, M E., Zammitti, E. P., & Cohen, R. A. Division of Health Interview Statistics, National Center for Health Statistics. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2016. (https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf, accessed May 15, 2017).

[29] Davis, K., Stremikis, K., Schoen, C., & Squires, D. (2014, June 16). Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally. The Commonwealth Fund. (http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror, accessed May 12, 2017). The other countries included in the study are Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom.

[30] Barber, R. M., et al. (2017, May 18). Healthcare Access and Quality Index Based on Mortality from Causes Amenable to Personal Health Care in 195 Countries and Territories, 1990–2015: a novel analysis from the Global Burden of Disease Study 2015. *The Lancet*. (http://www.thelancet.com/journals/lancet/article/PIIS0140- 6736(17)30818-8/fulltext, accessed May 21, 2017).

[31] Xu, J., Murphy, S.L., Kochanek, K.D., & Arias, E. (2016, December). Mortality in the United States, 2015. *NCHS, 267*. (https://www.cdc.gov/nchs/data/databriefs/db267.pdf, accessed April 21, 2017).

[32] Chetty R., Stepner M., Abraham S., Lin S., Scuderi B., Turner N., Bergeron A., & Cutler D. (2016, April 26). The Association between Income and Life Expectancy in the United States, 2001-2014. *Journal of the American Medical Association, 315*(16):1750-1766. doi:10.1001/jama.2016.4226 (http://jamanetwork.com/journals/jama/fullarticle/2513561, accessed May 11, 2017).

[33] Di Julio, B., Firth, J., & Brodie, M. Kaiser Health Tracking Poll: December 2015. (2015, December 17). Kaiser Family Foundation. (http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-december-2015/, accessed May 26, 2017.

[34] Bialik, K. More Americans Say Government Should Ensure Health Care Coverage. Pew Research Center. (http://www.pewresearch.org/fact-tank/2017/01/13/more-americans-say-government-should-ensure-health-care- coverage/, accessed May 26, 2017).

[35] Himmelstein, D. U. & Woolhandler, Steffie. (2016, March). The Current and Projected Taxpayer Shares of US Health Costs. *American Journal of Public Health, 106*(3):449-452. (http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302997, accessed May 11, 2017). This figure includes the money spent to purchase private health insurance for public sector employees and tax expenditures to subsidize employer-sponsored health insurance in the private sector.

[36] Some of the savings discussed below would enable federal dollars to go further in providing care. The balance would need to be allocated through the federal budget and, if needed to expand coverage, captured through progressive taxation.

[37] To prevent tiered care, insurers, including employers who self-insure, would be prohibited from providing coverage for benefits provided by the Medicare-for-all plan, but could offer supplemental insurance. Typically, temporary assistance for up to five years would be provided to workers displaced by the change.

[38] Brook, R. H., Keeler, E. B., Lohr, K. N., Newhouse, J. P., Ware, J. E., Rogers, W. H., Davies, A. R., Sherbourne, C. D., Goldberg, G. A., Camp, P., Kamberg, C., Leibowitz, A., Keesey, J., & Reboussin, D. (2006). The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate. RAND Corporation. (https://www.rand.org/pubs/research_briefs/RB9174.html, accessed May 16, 2017); Hoffman, B.A. (2006, Winter). Restraining the Health Care Consumer. *Social Science History, 30*:4 doi: 10.1215/01455532-2006- 007

[39] Hoffman, B.A. (2006, Winter). Restraining the Health Care Consumer. *Social Science History, 30*:4 doi: 10.1215/01455532-2006-007; Trivedi, A. N., Rakowski, W., & Ayanian, J. Z. (2008, January 24). Effect of Cost Sharing on Screening Mammography in Medicare Health Plans. *New England Journal of Medicine, 358*:375-383. (http://www.nejm.org/doi/pdf/10.1056/NEJMsa070929, accessed May 16, 2017); Howard, D. H., Guy, G. P. Jr., & Ekwueme, D. (2014, October 9). "Eliminating Cost-Sharing Requirements for Colon Cancer Screening in Medicare." *Cancer*. (http://onlinelibrary.wiley.com/doi/10.1002/cncr.29093/full, accessed May 1, 2017). Some have argued for a sliding scale for cost-sharing based on income and no cost-sharing for certain types of preventive care (the ACA has no cost-sharing for certain preventive care measures). But requiring any type of cost sharing would undermine the uniformity that enables much of the administrative savings discussed above.

[40] Brook, R. H., Keeler, E. B., Lohr, K. N., Newhouse, J. P., Ware, J. E., Rogers, W. H., Davies, A. R., Sherbourne, C. D., Goldberg, G. A., Camp, P., Kamberg, C., Leibowitz, A., Keesey, J., & Reboussin, D. (2006). The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate. RAND Corporation. (https://www.rand.org/pubs/research_briefs/RB9174.html, accessed May 16, 2017).

[41] Ibid.; Collins, S. R., Gunja, M., Doty, M. M., & Beutel, S. (2015, November). How High Is America's Health Care Cost Burden? Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, July– August 2015. The Commonwealth Fund. (http://www.commonwealthfund.org/publications/issue- briefs/2015/nov/how-high-health-care-burden, accessed May 16, 2017). Among privately insured adults ages 19-64: 43% of those across all income groups found paying deductibles either "very difficult or impossible" or "somewhat difficult" and 17% of those across all income groups found paying copayments either "very difficult or impossible" or "somewhat difficult."

[42] Osborn, R., Squires, D., Doty, M. M., Sarnak, D. O., & Schneider, E. C. (2010). In New Survey of Eleven Countries, US Adults Still Struggle with Access to and Affordability of Health Care. *Health Affairs, 29*(5):766-772. (http://content.healthaffairs.org/content/35/12/2327, accessed May 16, 2017); Brook, R. H., Keeler, E. B., Lohr, K. N., Newhouse, J. P., Ware, J. E., Rogers, W. H., Davies, A. R., Sherbourne, C. D., Goldberg, G. A., Camp, P., Kamberg, C., Leibowitz, A., Keesey, J., & Reboussin, D. (2006). The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate. RAND Corporation. (https://www.rand.org/pubs/research_briefs/RB9174.html, accessed May 16, 2017); Hoffman, B.A. (2006, Winter). Restraining the Health Care Consumer. *Social Science History, 30*:4 doi:10.1215/01455532-2006-007

[43] For deep discussion of these issues see the Lancet series, America: Equity and Equality in Health. (2017, April 8). (http://www.thelancet.com/series/america-equity-equality-in-health, accessed May 23, 2017.)

[44] Goldman, D. P., Joyce, G. F., & Karaca-Mandic, P. (2006). Cutting Drug Co-Payments for Sicker Patients on Cholesterol-Lowering Drugs Could Save a Billion Dollars Every Year. RAND Corporation. (https://www.rand.org/pubs/research_briefs/RB9169/index1.html, accessed May 16, 2017); Chandra, A., Gruber, J., & McKnight, R. (2010). Patient Cost-Sharing and Hospitalization Offsets in the Elderly. The American Economic Review, 100(1):193–213. http://doi.org/10.1257/aer.100.1.193 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2982192/, accessed May 16, 2017).

[45] There would also be insurance-related administrative savings for employers that are not captured here.

[46] Berwick, D.M. & Hackbarth, A.D. (2012). Eliminating Waste in US Health Care. *Journal of the American Medical Association*, 307(14):1513-1516. http://dx.doi.org/10.1001/jama.2012.362. (http://jamanetwork.com/journals/jama/fullarticle/1148376, accessed May 16); Jiwani, A., Himmelstein, D., Woolhandler, S., & Kahn, J. G. (2014). Billing and Insurance-Related Administrative Costs in United States' Health Care: Synthesis of Micro-Costing Evidence. *BMC Health Services Research* 14(556); Woolhandler, S. & Himmelstein, D. U. (2017, April 18). Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs. *Annals of Internal Medicine*, 166(8):587-588. DOI: 10.7326/M17-0302 (http://annals.org/aim/article/2605414/single-payer-reform-only-way-fulfill-president-s-pledge-more, accessed May 19, 2017). Percentages calculated based on data in the articles. These are mid-range savings; the smaller number comes from Berwick, et al. and the larger number comes from the Jiwani, et al. article. The 2017 Woolhandler and Himmelstein article puts the savings slightly lower at 14.2% and $503.6 billion.

[47] Centers for Medicare & Medicaid Services. (2017, March 21). NHE Fact Sheet. (https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html, accessed April 26, 2017).

[48] Himmelstein, D. U., Jun, M., Busse, R., Chevreul, K., Geissler, A., Jeurissen, P., Thomson, S., Vinet, M. & Woolhandler, S. D. (2014). A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far. *Health Affairs 33*(9):1586-1594. doi: 10.1377/hlthaff.2013.1327 (http://content.healthaffairs.org/content/33/9/1586.full.pdf+html, accessed May 4, 2017); Patel, A., Rajkumar, R., Colmers, J. M.., Kinzer, D., Conway, P. H., & Sharfstein, J. M. (2015, November 12) Maryland's Global Hospital Budgets — Preliminary Results from an All-Payer Model. *New England Journal of Medicine, 373*(20):1899-1901. (http://www.nejm.org/doi/pdf/10.1056/NEJMp1508037, accessed May 4, 2017), Hsiao, W. C., Knight, A. G., Kappel, S., & Done, N. (2011). What Other States Can Learn From Vermont's Bold Experiment: Embracing a Single-Payer Health Care Financing System. *Health Affairs, 30*(7):1232-1241. doi: 10.1377/hlthaff.2011.0515 (http://content.healthaffairs.org/content/30/7/1232.full.pdf+html, accessed May 4, 2017).

[49] Himmelstein, D. U., Jun, M., Busse, R., Chevreul, K., Geissler, A., Jeurissen, P., Thomson, S., Vinet, M. & Woolhandler, S. D. (2014). A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far. *Health Affairs 33*(9):1586-1594. doi: 10.1377/hlthaff.2013.1327 (http://content.healthaffairs.org/content/33/9/1586.full.pdf+html, accessed May 4, 2017).

[50] Center for Responsive Politics. Pharmaceuticals/Health Products Industry Profile. (https://www.opensecrets.org/lobby/indusclient.php?id=H04, accessed May 19, 2017).

[51] Center for Responsive Politics. Pharmaceuticals/Health Products Industry: Background. (2015, August). (https://www.opensecrets.org/industries/background.php?ind=H04++, accessed May 19, 2017).

[52] Cubanski, J. & Neuman, T. (2017, January 23). Searching for Savings in Medicare Drug Price Negotiations. Kaiser Family Foundation. (http://kff.org/medicare/issue-brief/searching-for-savings-in-medicare-drug-price- negotiations/, accessed May 19, 2017).

[53] Center for Responsive Politics. Pharmaceuticals/Health Products Industry: Background. (2015, August). (https://www.opensecrets.org/industries/background.php?ind=H04++, accessed May 19, 2017).

[54] Center for Responsive Politics. Pharmaceuticals/Health Products: Long-Term Contribution Trends. (https://www.opensecrets.org/industries/totals.php?cycle=2014&ind=H04, accessed May 23, 2017.

[55] Medicare for all legislation would include repealing the prohibition of negotiating drug prices.

[56] Woolhandler, S. & Himmelstein, D. U. (2017, April 18). Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs. *Annals of Internal Medicine, 166*(8):587-588. DOI: 10.7326/M17-0302 (http://annals.org/aim/article/2605414/single-payer-reform-only-way-fulfill- president-s-pledge-more, accessed May 19, 2017).

[57] Chang, C.-H., Stukel, T. A., Flood, A. B., & Goodman, D. C. (2011). Primary Care Physician Workforce and Medicare Beneficiaries' Health Outcomes. *The Journal of the American Medical Association, 305*(20):2096–2104. http://doi.org/10.1001/jama.2011.665 (http://jamanetwork.com/journals/jama/fullarticle/900155, accessed May 17, 2017); Osborn, R., Squires, D., Doty, M. M., Sarnak, D. O., & Schneider, E. C. In New Survey of Eleven Countries, US Adults Still Struggle with Access to and Affordability of Health Care. (2010). *Health Affairs, 29*(5):766-772. (http://content.healthaffairs.org/content/35/12/2327.full, accessed May 16, 2017); Starfield, B., Shi, L., & Macinko, J. (2005, September) Contribution of Primary Care to Health Systems and Health. *Milbank Quarterly, 83*(3):457-502. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/, accessed May 17, 2017).

[58] Osborn, R., Squires, D., Doty, M. M., Sarnak, D. O., & Schneider, E. C. (2010). In New Survey of Eleven Countries, US Adults Still Struggle with Access to and Affordability of Health Care. *Health Affairs, 29*(5):766-772. (http://content.healthaffairs.org/content/35/12/2327.full, accessed May 16, 2017).

[59] Ibid.; Institute of Medicine. (2013, January 9). U.S. Health in International Perspective Shorter Lives, Poorer Health. The National Academies Press. (https://www.nap.edu/catalog/13497/us-health-in-international-perspective- shorter-lives-poorer-health, accessed May 17, 2017).

[60] IHS Markit. (2017). The Complexities of Physician Supply and Demand: Projections from 2015 to 2030. Prepared for the Association of American Medical Colleges. (https://aamc-black.global.ssl.fastly.net/production/media/filer_public/a5/c3/a5c3d565-14ec-48fb-974b- 99fafaeecb00/aamc_projections_update_2017.pdf, accessed May 21, 2017); U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2013, November). Projecting the Supply and Demand for Primary Care Practitioners through 2020. U.S. Department of Health and Human Services. (https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projectingprimarycare.pdf, accessed May 17, 2017). This study projects a shortfall of 20, 400 in 2020; Petterson, S. M., Liaw, W. R., Phillips, R. L., Rabin, D. L., Meyers, D. S., & Bazemore, A. W. (2012). Projecting US Primary Care Physician Workforce Needs: 2010-2025. *Annals of Internal Medicine, 10*(6):503-509. doi:10.1370/afm.1431. (http://www.annfammed.org/content/10/6/503.full.pdf, accessed May 17, 2017). This study projects a shortfall of nearly 52,000 by 2025.

[61] Bureau of Health Workforce, Health Resources & Services Administration, U.S. Department of Health & Human Services. (2017, May 23). Table 1. Health Professional Shortage Areas: Number, Population, and Additional Practitioners Needed for Geographic Areas, Population Groups, and Facilities as of May 23, 2017. (https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry_HTML&rc:Toolbar=false, accessed May 23, 2017).

[62] Bureau of Health Workforce, Health Resources & Services Administration, U.S. Department of Health & Human

Services. Health Professional Shortage Areas. (2016, October). Health Professional Shortage Areas (HPSAs). (https://bhw.hrsa.gov/shortage-designation/hpsas, accessed May 18, 2017).

[63] Bureau of Health Workforce, Health Resources & Services Administration, U.S. Department of Health & Human Services. (2017, May 23). Table 1. Health Professional Shortage Areas: Number, Population, and Additional Practitioners Needed for Geographic Areas, Population Groups, and Facilities as of May 23, 2017.

[64] Ibid.

[65] Grisham, S. (2017, April 5). Medscape Physician Compensation Report 2017. *Medscape*. (http://www.medscape.com/slideshow/compensation-2017-overview-6008547, accessed May 22, 2017).

[66] Ibid.; Zimmerman, B. (2017, January 26). 207 Statistics on Physician Compensation. *Becker's Hospital Review*. (http://www.beckershospitalreview.com/compensation-issues/207-statistics-on-physician-compensation-2017.html, accessed May 22, 2017); Conn, J. (2016, July 16). Competition for New Docs Pushing Pay Higher. *Modern Healthcare*. (http://www.modernhealthcare.com/article/20160716/MAGAZINE/307169981, accessed May 22, 2017); Medical Group Management Association. (2015). Trends in Physician Compensation. (http://www.mgma.com/industry-data/research-and-studies-overview/survey-infographics/trends-in-physician- compensation, accessed May 22, 2017). Other primary care providers such as internists and pediatricians also rank low in compensation surveys.

[67] Sanders, Bernard. (2013, January 29). Primary Care Access: 30 Million Patients and 10 Months to Go: Who Provide Will Their Primary Care. (https://www.sanders.senate.gov/imo/media/doc/PrimaryCareAccessReport.pdf, accessed May 18, 2017).

[68] The Working Group on Single-Payer Program Design. "Beyond the Affordable Care Act: A Physicians' Proposal for Single-Payer Health Care Reform." (http://www.pnhp.org/beyond_aca/Physicians_Proposal.pdf, accessed May 22, 2017). This proposal also identifies ways to address concerns that fee-for-service payments inappropriately drives up utilization such as "monitoring for extreme practice patterns; adjusting fee schedules to attenuate discrepancies between cognitive and procedural care; enforcing regional caps on fee-for-service payments; and facilitating education on low-value medical interventions."

[69] Goodson, J. D. (2010, June 1). Patient Protection and Affordable Care Act: Promise and Peril for Primary Care. Annals of Internal Medicine, *152*(11):742-744. doi: 10.7326/0003-4819-152-11-201006010-00249 (http://annals.org/aim/article/745811/patient-protection-affordable-care-act-promise-peril-primary-care, accessed May 18, 2017).

[70] Ibid.

STATEMENT FOR
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON THE BUDGET
HEARING ON
KEY DESIGN COMPONENTS & CONSIDERATIONS FOR ESTABLISHING
A SINGLE-PAYER HEALTH CARE SYSTEM
MAY 22, 2019

The Partnership for Employer-Sponsored Coverage is an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and the over 181 million American workers and their families who rely on employer-sponsored coverage every day. We are committed to working to ensure that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come.

Employer-sponsored coverage has been the backbone of our nation's health system for nearly eight decades. Employers of all sizes contribute vast resources to employees and their families through the employer-sponsored system. Employers have a vested interest in health care quality, value, and system viability. Employers have been on the leading edge of health delivery innovation and modeling for decades.

Benefits offerings and coverage plans in the employer-sponsored system are as diverse as employers and employees themselves. With self-insured coverage under the Employee Retirement Income Security Act (ERISA), an employer can tailor coverage to meet their workforce's specific needs across state lines, pays all health claims and bears the financial risk, and utilizes a third-party administrator (insurance carrier) for daily plan management. Through the fully-insured state regulated insurance market, employers purchase a prescribed benefit insurance product sold in a state from an insurance carrier and does not bear the full financial risk of claims.

Employers have led the way in benefits design and innovation for decades and will continue to do so for decades to come. There is no one-size-fits-all employer health plan nor should the federal government enact or implement laws that stifle an employer's ability to develop benefits offerings that meet the needs of their specific workforce. All levels of government should work constructively with private sector employers to ensure that employers have the tools and flexibility to foster benefits design and innovations that provide employees with benefits that are crucial to the wellbeing of themselves and their families.

The foundation of the employer-sponsored coverage system is rooted in workforce policy and business operations. Employers of all sizes offer coverage for employee recruitment and retention, and the functionality of a business is centered around a productive, thriving, and healthy workforce.

The ability to offer coverage to employees and the capacity to operate a business for its core purpose are not mutually exclusive functions. An employer offer of coverage is not merely a transaction in which an employee fills out paperwork, enrolls in coverage, and receives an insurance card – it is a multifaceted fiscal and operational commitment at the core of any business. As employers are making the decision to offer coverage and determine which type of coverage to offer their employees, a critical aspect of this deliberation is the administrative compliance costs and complexities associated with coverage.

When considering legislative and regulatory policy development and implementation, federal lawmakers and regulators must understand and appreciate the societal and economic commitments employers make to our nation's workforce through the employer-sponsored coverage system. The following policy and implementation questions should be carefully considered in the context of today's hearing and future deliberations.

- What would a single-payer health care system mean for employment? Recruitment and retention of employees?
- How would a Medicare or Medicaid buy-in program be an advantage or disadvantage to employees and employers?
- How would expansion of Medicare/Medicaid through a buy-in program effect current program beneficiaries and resources?
- How would a Medicare/Medicaid buy-in program effect timely access to providers and services for the influx of new beneficiaries?
- How would the employee-employer relationship change by a Medicare buy-in plan? Specifically with regard to working Americans between 50-64?
- What is a Medicare buy-in program striving to accomplish? Cohort of uninsured?
- How would a Medicare/Medicaid buy-in program effect take-up rates for fully-insured employer-sponsored plans? How would it effect other populations of employees?

The Partnership for Employer-Sponsored Coverage opposes the establishment of a single-payer health care system. Dismantling our nation's private sector employment-based health system which provides coverage for the largest percentage of the population would create utter chaos and massive disruptions to the care system for all Americans. We urge Congress to devote its attention and resources toward issues to improve our current health care system such as increasing market competition, providing more coverage choices and access to providers for all Americans, and addressing systematic cost drivers and wasteful spending. Our public principles include:

- Preserving the current tax treatment of employer-sponsored coverage
- Promoting innovations and diversity of plan designs and offerings for employees
- Providing employers with compliance relief from burdensome regulations

- Repealing the Affordable Care Act taxes on employer-sponsored coverage
- Protecting ERISA

As a coalition representing businesses of all sizes, the Partnership for Employer-Sponsored Coverage has the unique ability to provide operational input across the full spectrum of the employer system – from the smallest family-owned business to the largest corporation. Employers have a great stake in the development and implementation of health care policies. We stand ready to work with the 116th Congress in a bipartisan manner strengthen and preserve our nation's private sector employment-based health system.

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

American Hotel & Lodging Association
American Rental Association
American Staffing Association
Associated Builders and Contractors, Inc.
Associated General Contractors of America
Auto Care Association
The Council of Insurance Agents & Brokers
Food Marketing Institute
HR Policy Association
International Franchise Association
National Association of Health Underwriters
National Association of Wholesaler-Distributors
National Restaurant Association
National Retail Federation
Retail Industry Leaders Association
Society of American Florists
Society for Human Resource Management

Statement for the record of

Eagan Kemp

Health Care Policy Advocate, Public Citizen

for the

U.S. House of Representatives

Committee on the Budget

Hearing on Single-Payer Health Care

May 22nd, 2019

Thank you for the opportunity to submit a statement for the record on this crucial issue. And thank you for holding this important hearing on single-payer health care. Public Citizen is a national non-profit organization with more than 500,000 members and supporters. We represent the public interest through legislative and administrative advocacy, litigation, research, and public education on a broad range of issues including ensuring access to health care. Pertinent to this hearing, Public Citizen has supported the creation of a single-payer health care system since our founding in 1971. Our health care system currently fails to meet the needs of the American people, while a single-payer Medicare for All system would guarantee coverage to everyone in the United States.

The recent Congressional Budget Office (CBO) report, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System*, identified a number of key policy considerations when designing and implementing a single-payer health care system.[1] In this statement, I describe relevant findings and how Medicare for All would address the components described in the CBO report.

I. ELIGIBILITY, ENROLLMENT, AND ADMINISTRATION

Despite the successes of the Affordable Care Act (ACA) in expanding access to coverage, more than 30 million Americans remain uninsured and tens of millions more are underinsured, meaning they are unable to afford the care they need despite having health insurance.[2] Being uninsured or underinsured hinders access to health care. For example, nearly half of uninsured working-age adults lacked a regular source of care, compared with approximately 10 percent of those who were insured, whether through public or private coverage.[3] Further, nearly one in four reported postponing care due to cost and one in five reported going without needed care or prescription medication due to cost.

By improving Medicare and expanding it to everyone in the United States, Medicare for All would finally guarantee access to health care. Access to medically necessary care, including preventive services, would reduce the incidence of many preventable diseases and allow earlier treatment for a variety of maladies. This, in turn, would reduce both personal and system-wide spending by preventing illnesses or treating diseases at earlier stages when they are cheaper and easier to treat, including reducing more expensive medical interventions and related complications.

Enrollment for Medicare for All would be similar to traditional Medicare but would happen at birth, establishment of residency, or other similar circumstances. Such a system would be administered through the Department of Health and Human Services, with appropriate regional administration to ensure adequate oversight and accountability.

Our country's transition to the traditional Medicare system serves as an example of a successful transition to a single-payer system for America's seniors. After being signed into law in 1965, Medicare enrolled

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[1] CONGRESSIONAL BUDGET OFFICE, KEY DESIGN COMPONENTS AND CONSIDERATIONS FOR ESTABLISHING A SINGLE-PAYER HEALTH CARE SYSTEM, at 1 (May 2019), https://bit.ly/2UPxKk8 .

[2] SARAH R. COLLINS, MUNIRA Z. GUNJA, AND MICHELLE M. DOTY, THE COMMONWEALTH FUND, HOW WELL DOES INSURANCE COVERAGE PROTECT CONSUMERS FROM HEALTH CARE COSTS? — FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY, 2016, at 1 (October 2017), https://bit.ly/2D3WbG5.

[3] KAISER FAMILY FOUNDATION, KEY FACTS ABOUT THE UNINSURED POPULATION, at 5 (September 2017), https://bit.ly/2q8AEU7.

more than 19 million people in its first year.[4] Prior to the implementation of Medicare, only around half of America's seniors had health coverage, and the coverage available to them was not very good.[5] For example, a survey in 1963 found that 80 percent of seniors paid for their own health costs out of pocket, without help from either government programs or private insurance.[6]

Medicare has grown steadily since its implementation and covered more than 58 million seniors and people with disabilities in 2017.[7] Supporting the transition to Medicare for All would be the more than 50 years of experience that the country already has with implementing and running Medicare. While the scope of the population served will expand significantly, the necessary functions and infrastructure are already in place. The Centers for Medicare and Medicaid Services already has the capacity to enroll beneficiaries and physicians, process claims, and engage stakeholders. This expertise will serve the program well both during the transition to Medicare for All and upon full implementation.

The Medicare for All Act of 2019 (H.R. 1384) includes details for a two-year transition to a single-payer Medicare for All system. In the first year after enactment anyone under 19 and anyone 55 or older would be transitioned to Medicare for All coverage. All other populations should be transitioned to Medicare for All within 2 years of enactment. A Medicare transition buy-in would be established that would allow anyone to purchase into the Medicare for All system prior to full implementation. For-profit private insurance would still be available to cover things not covered by Medicare for All, such as non-therapeutic cosmetic surgery or lifestyle treatments or medications.

Certain populations, including patients with complex long-term care needs, would need particular attention in the transition to Medicare for All, as any disruption in their care could lead to serious health consequences. Beneficiaries with complex medical needs would need to have consistent access to necessary services throughout the transition, which H.R. 1384 provides for.

Once everyone is enrolled in Medicare for All, there would be no further need for additional coverage transitions. Everyone in the U.S. would finally be covered when they were born, became residents, or under other similar circumstances and would remain covered throughout their lives. Compared with the constant disruptions and transitions in insurance plans that Americans currently face every time they change jobs or their employer changes their insurance plan, the one-time transition to Medicare for All would be much less disruptive to Americans

II. COST CONTAINMENT, FINANCING, AND PAYMENT RATES

In the United States, we spend $3.5 trillion, or more than $10,000 per person, on health care annually—a staggering sum—a great deal of which is wasted or unnecessary.[8] As a country, we spend far more on health care than other comparably wealthy nations. Our public spending on health care, per capita, alone is higher than what nearly all other wealthy countries pay, per capita, for their *entire* health care systems. This is all the more remarkable because all of these countries, unlike the United States, provide universal

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[4]Steve Anderson, *A Brief History of Medicare in America*, MEDICARE RESOURCES (February 27, 2018), https://bit.ly/298fU4W.
[5]Louis Jacobson, *Were the Early 1960s a Golden Age for Health Care?*, POLITIFACT (April 12, 2012), https://bit.ly/2UpFvxs.
[6]*Id.*
[7]Steve Anderson, *A Brief History of Medicare in America*, MEDICARE RESOURCES (February 27, 2018), https://bit.ly/298fU4W.
[8]CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURES 2016 HIGHLIGHTS, at 1 (January 2018), https://go.cms.gov/1V5YDcI.

coverage to their residents. Despite this excessive spending, the United States has the worst health outcomes compared to similar countries. [9]

Numerous studies have analyzed the prospective effectiveness of single-payer plans nationally and at the state level, as well as other universal coverage approaches.[10] Most of these studies found savings, to varying degrees. These findings are supported by the experiences of countries that already have universal health care and provide care more efficiently than the United States.[11] A recent study found that Medicare for All could save nearly 20 percent versus our current system, with the largest sources of savings being increased administrative efficiency and significantly lower pharmaceutical prices.[12] Another recent estimate found that simplified administration under Medicare for All would save the U.S. more than $500 billion a year.[13]

Medicare for All would create enough savings that even a significant increase in the amount of care rendered would be more than offset.[14] This would be achieved by reducing administrative waste, harnessing the federal government's negotiating power to bring down the price of care, and setting global budgets for institutions that would reduce the incentive for providers to administer unnecessary, expensive treatments.

1. Reducing Administrative Waste

In the 1980s our spending was much more in line with similar countries, before rapidly rising over the last few decades.[15] Increased administrative costs are one of the key reasons that overall health care costs have risen sharply over the past 40 years. The United States has the highest rate of administrative health care costs among wealthy countries.[16] Excessive administrative spending is wasteful because it contributes nothing to treating patients or improving health outcomes. Under our fragmented system, around one-third of U.S. health care dollars are spent on administrative functions, including insurance company overhead; administrative costs of hospitals, practitioners, nursing homes and other providers; and costs incurred by employers in managing their workers' benefits.[17]

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[9]Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1024 (2018).
[10]See *e.g.*, *Listing of Single Payer Studies*, HEALTHCARE-NOW, https://bit.ly/2yplxwr (viewed May 20, 2019).
[11]Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1024 (2018).
[12]ROBERT POLLIN, ET AL, POLITICAL ECONOMY RESEARCH INSTITUTE, ECONOMIC ANALYSIS OF MEDICARE FOR ALL, at 66 (November 2018), https://bit.ly/2E6AhCw.
[13]Steffie Woolhandler and David U. Himmelstein, *Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs*, 166 ANNALS OF INTERNAL MEDICINE 587-588, 588 (2017).
[14]ROBERT POLLIN, ET AL, POLITICAL ECONOMY RESEARCH INSTITUTE, ECONOMIC ANALYSIS OF MEDICARE FOR ALL, at 2 (November 2018), https://bit.ly/2E6AhCw.
[15]*OECD.Stat – Health Expenditure and Financing*, ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, https://bit.ly/2sNaLux (viewed on January 27, 2019).
[16]ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (OECD), TACKLING WASTEFUL SPENDING ON HEALTH, at 232 (January 2017), https://bit.ly/2yVVrhT.
[17]Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENGLAND JOURNAL OF MEDICINE 768-775, 772 (2003).
Alexis Pozen and David M. Cutler, *Medical Spending Differences in the United States and Canada: The Role of Prices, Procedures, and Administrative Expenses*, 47 INQUIRY 124-134, (2010).

Costs relating to managing health insurance are a major component of these rising administrative costs. Private insurers spend around 12 percent of their annual budgets on administration.[18] Traditional Medicare is much more efficient, spending only around two percent on administrative costs.[19] Higher costs for hospitals also contribute to our excessive spending. If our hospital administrative spending were brought in line with more efficient countries, the U.S. could save more than $150 billion each year on hospital spending alone.[20]

2. Lowering Health Care Costs Through Negotiation

One reason our health care is so expensive is that prices for common procedures, such as appendectomies, hip replacements, and angioplasties, are often significantly higher in the United States than in other comparably wealthy countries.[21] In addition, basic health care prices for the same procedure vary wildly between health care providers, which reveals inefficiencies and overpriced services.[22] Providers and insurers generally negotiate prices behind closed doors and refuse to disclose their negotiated prices, citing trade secrets.

Allowing the federal government to use its full negotiating power would make health care pricing more rational and wring out the massive amount of abusive overcharging. Under Medicare for All, the U.S. government would be able to negotiate reasonable prices for services and would prevent providers from charging vastly different prices for the same services.

The prices Americans pay for prescription drugs are also unreasonably high. One recent study compared our health care spending with 10 other wealthy nations and found that the United States spent around $1,450 per capita on prescription drugs, the most of any wealthy country and more than double the roughly $750 per capita average of all 11 countries.[23] Further, an analysis by *The Wall Street Journal* compared U.S. prices across a number of drugs to prices in England, Norway, and Ontario, Canada. It found that U.S. drug prices were almost always higher, often significantly higher.[24]

Spending on prescription drugs in the United States totaled more than $480 billion in 2016, almost 15 percent of the $3.3 trillion total spent on health care that year.[25] Instituting a Medicare for All system would finally allow the government to negotiate the price of prescription drugs on behalf of all Americans.

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[18]CONGRESSIONAL BUDGET OFFICE, PRIVATE HEALTH INSURANCE PREMIUMS AND FEDERAL POLICY, at 27 (February 2016) https://bit.ly/1Qw9D0s.

[19]Nick Buffie, *Overhead Costs for Private Health Insurance Keep Rising, Even as Costs Fall for Other Types of Insurance*, CENTER FOR ECONOMIC AND POLICY RESEARCH (CEPR) BLOG (February 6, 2017), https://bit.ly/2l6XVB0.

[20]David U. Himmelstein, et al., *A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far*, 33 HEALTH AFFAIRS 1586-1594, 1589 (2014).

[21]INTERNATIONAL FEDERATION OF HEALTH PLANS, 2015 COMPARATIVE PRICE REPORT: VARIATION IN MEDICAL AND HOSPITAL PRICES BY COUNTRY, at 17, 22, & 24 (September 2016), https://bit.ly/2RS7R6K.

[22]Elisabeth Rosenthal, *The $2.7 Trillion Medical Bill*, THE NEW YORK TIMES (June 1, 2013), https://nyti.ms/2yW7Gef.

[23]Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1035 (2018).

[24]Jeanne Whalen, *Why the U.S. Pays More Than Other Countries for Drugs*, THE WALL STREET JOURNAL (December 1, 2015), https://on.wsj.com/2pe6SiS.

[25]Nancy L. Yu, Preston Atteberry, and Peter B. Bach, *Spending on Prescription Drugs in The US: Where Does All the Money Go?*, HEALTH AFFAIRS BLOG, (July 31, 2018) https://bit.ly/2LIPRbm.

Under its prescription drug benefit, known as Medicare Part D, Medicare is currently prohibited from negotiating drug prices.[26] In contrast, the Veterans Health Administration (VHA) negotiates the price of drugs for the veterans it serves. As a result, the VHA pays much lower drug prices than the general public. A 2015 study that Medicare Part D would save around $16 billion a year if the agency were able to negotiate similar prices to those negotiated by the VHA on the same brand-name drugs.[27]

Given that Medicare for All would mean the government would have negotiating power on behalf of a much larger population—all Americans—drug prices would be even lower under Medicare for All than they are for the VHA. A recent estimate found that Medicare for All could save over $100 billion a year on drug costs.[28]

3. Using Global Budgets to Improve Efficient Spending

Finally, by using global budgets—comprehensive budgets negotiated between the government and health care institutions (such as hospitals and nursing homes)—Medicare for All would control spending while ensuring access to medically necessary services.[29] Under global budgets, institutions have the incentive to control costs as they provide care. In contrast, our current system creates incentives for institutions to maximize revenue, for example by building expensive new hospital wings and then pressuring providers to refer patients for care, instead of furnishing the most sensible and medically necessary care.[30] Global budgets would have the potential to align providers' incentives with their missions to provide medically necessary care to those who need it.

A key part of reducing the incentive for institutions to maximize revenue is to ensure rational spending on expensive renovations and on purchasing brand-new health care technology that can cost millions of dollars for a single machine. This would be done by creating a separate budget for capital expenditures, such as on medical equipment and expansions of facilities, from operating expenditures under global budgets. Capital purchases impose upfront costs on providers. Once purchased, they create incentives to provide unnecessary care to recoup their investments.[31] By requiring separate budgets for the purchases of expensive medical equipment and building expansions, Medicare for All could ensure that such purchases are warranted by a community's needs and would thus reduce unnecessary spending, both on the capital expenses themselves as well as on spending for related services. Instead of having every hospital compete by purchasing complex

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[26]JULIETTE CUBANSKI AND TRICIA NEUMAN, KAISER FAMILY FOUNDATION, SEARCHING FOR SAVINGS IN MEDICARE DRUG PRICE NEGOTIATIONS, at 1 (April 2018), https://bit.ly/2i1ffYJ.

[27]MARC-ANDRÉ GAGNON AND SIDNEY WOLFE, MIRROR, MIRROR ON THE WALL: MEDICARE PART D PAYS NEEDLESSLY HIGH BRAND-NAME DRUG PRICES COMPARED WITH OTHER OECD COUNTRIES AND WITH U.S. GOVERNMENT PROGRAMS, at 11 (July 2015), https://bit.ly/2p8FRJi.

[28]Steffie Woolhandler and David U. Himmelstein, *Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs*, 166 ANNALS OF INTERNAL MEDICINE 587-588, 588 (2017).

[29]STEPHEN H. LONG AND M. SUSAN MARQUIS, RAND CORPORATION, TOWARD A GLOBAL BUDGET FOR THE U.S. HEALTH SYSTEM: IMPLEMENTATION ISSUES AND INFORMATION NEEDS, at 1 (July 1994), https://bit.ly/2O3v3YS.

[30]ROBERT A. BERENSON, ET AL., URBAN INSTITUTE, GLOBAL BUDGETS FOR HOSPITALS, at 2 (April 2016), https://urbn.is/2O2ExmU. JOSHUA M. SHARFSTEIN, ET AL., THE COMMONWEALTH FUND, AN EMERGING APPROACH TO PAYMENT REFORM: ALL-PAYER GLOBAL BUDGETS FOR LARGE SAFETY-NET HOSPITAL SYSTEMS, at 3 (August 2016), https://bit.ly/2Ra6awE.

[31]U.S. GOVERNMENT ACCOUNTABILITY OFFICE, MEDICARE: HIGHER USE OF ADVANCED IMAGING SERVICES BY PROVIDERS WHO SELF-REFER COSTING MEDICARE MILLIONS, at 16 (September 2012), https://bit.ly/2CDgusT.
Dan Munro, *Why Physician Self-Referrals Have to Stop Now*, FORBES (January 26, 2015), https://bit.ly/2ArvYPd.

new technology or building fancy new hospital wings, city and regional capacity would be considered to ensure access to needed care across the country.

Health care providers in private practice or in other care settings without global budgets would be paid through fee-for-service, the rates for which would be negotiated through mechanisms similar to traditional Medicare. However, because Medicare rates would now serve as the primary rates for the health care system, there is likely to be variation from current Medicare payment rates. Similar to current rates, provider payments will likely vary by a number of factors, including region, specialty, and care setting. However, given that Medicare for All will have a more holistic view toward ensuring adequate access to necessary care, underpaid providers in primary care, mental health, and other settings may actually see their rates go up. In addition, providers will have more time to see patients as they will no longer need to spend as much time dealing with billing multiple different insurance companies and related administrative issues.

III. COVERED SERVICES AND COST SHARING

Poor quality coverage and the presence of excessive cost sharing are key reasons that Americans have the worst health outcomes of peer nations and report the highest rates of unmet health care needs of comparable countries.[32] Nearly one in four Americans reported skipping a health care appointment due to the cost, a number more than double the average across comparable countries.[33] For lower-income Americans, than number was even higher, with more than 40 percent reporting having unmet health care needs due to cost—meaning not going to the doctor; skipping a test, treatment or follow up; or not filling a prescription or skipping doses.[34] Another study found that the U.S. ranked worst out of 16 industrialized countries for deaths that could be prevented with proper medical care.[35]

And when Americans seek care, many face medical debt or bankruptcy. A survey by the Consumer Financial Protection Bureau found that medical debt was the most common reason for debt collection calls in the United States.[36] Nearly 60 percent of consumers who were contacted about debt collection were contacted due to outstanding medical debt.

Even Americans with insurance may have difficulty paying their medical bills. The percentage of working-age adults with insurance through their job who were underinsured—meaning they face such excessive out-of-pocket costs that they cannot afford to use their coverage—rose from 10 percent in 2003 to 25 percent in 2016.[37]

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[32]Eric C. Schneider, et al., The Commonwealth Fund, Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care, at 5 (July 2017), https://bit.ly/2PTfYe2.

[33]Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1037 (2018).

[34]*Id.*

[35]Ellen Nolte and Martin McKee, *Variations in amenable mortality—Trends in 16 high-income nations*, 103 HEALTH POLICY 47-52, 49 (2011).

[36]CONSUMER FINANCIAL PROTECTION BUREAU (CFPB), CONSUMER EXPERIENCES WITH DEBT COLLECTION: FINDINGS FROM THE CFPB'S SURVEY OF CONSUMER VIEWS ON DEBT, at 21 (January 2017), https://bit.ly/2ODIkk5.

[37]A person in the study was considered underinsured if they had out-of-pocket cost, excluding premiums, over the prior 12 months were 10 percent or more of household income (or 5 percent of household income for households making less than 200 percent of the federal poverty level) or if their deductibles was 5 percent or more of their household income.

Rising out-of-pocket costs, such as co-pays and deductibles, are a key reason many Americans face challenges affording the care they need. Studies have found that out-of-pocket costs cause consumers to decrease their use of needed health care.[38] Further, a recent survey found that middle-income Americans with private insurance were the most likely to report increases in their out-of-pocket costs.[39] By eliminating out-of-pocket costs, Medicare for All would ensure access to needed care for everyone in the United States and would reduce the administrative burden of collecting and processing those payments.

Medicare for All would also guarantee access to vision and dental services, which many Americans, including seniors, struggle to afford. Lack of access to dental services can put Americans at risk for infection, decreased quality of life, and difficulty eating. Low-income seniors were particularly likely to not have had a dental visit, with only around one in four having done so in the past year, compared to nearly 75 percent of beneficiaries with higher incomes.[40] By including vision and dental services in Medicare for All, everyone in the U.S. would finally be able be guaranteed access to the services they need to live a full life.

Medicare for All would also ensure access to long-term care, improving patients' quality of life while also bringing down the cost of care, as more people would be able to receive care in their homes instead of in expensive institutions, like nursing homes. The long-term care benefits available under Medicare for All would provide more comprehensive and sensible benefits than Medicaid, including ensuring that beneficiaries could be served in the setting of their choice with the services they need. And by providing more care through long-term home and community-based services (HCBS), Medicare for All could save money compared to institutional care, given that a year of care in a nursing home costs more than twice as much as having a home health aide for a year and five times as much as a year of care through adult health day care.[41]

Improving the efficiency of our long-term care is crucial because around 70 percent of people over 65 will require at least some long-term care in their lifetimes.[42] Given our changing demographics—by 2030 all baby boomers will be 65 or older and by 2035 Americans age 65 and older will outnumber the number of children under 18 for the first time in U.S. history—we must ensure that we are providing access to

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SARAH R. COLLINS, MUNIRA Z. GUNJA, AND MICHELLE M. DOTY, THE COMMONWEALTH FUND, HOW WELL DOES INSURANCE COVERAGE PROTECT CONSUMERS FROM HEALTH CARE COSTS? — FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY, 2016, at 1 (October 2017), https://bit.ly/2D3WbG5.
Rich Daly, *Narrow Networks Spread From ACA Plans to Employers*, HMFA (December 5, 2017), https://bit.ly/2O6GLSo.
Stephen Miller, *Employers May Adopt 'Narrow Networks' of Health Care Providers*, SHRM (January 10, 2017), https://bit.ly/2ikrVLj.
[38]Zarek C. Brot-Goldberg, et al,, *What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 THE QUARTERLY JOURNAL OF ECONOMICS 1261-1318, 1261 (2017).
[39]Nearly sixty percent of respondents with private insurance responded that their out-of-pocket health care spending had increased, compared with 51 percent of the uninsured, 46 percent for Medicare, 43 percent for Medicaid and 39 percent for VA & TRICARE.
IPSOS, HEALTH CARE EXPERIENCE STUDY, at 3 (April 2018), https://bit.ly/2TjlRpr.
[40]*Id.*
[41]ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), https://bit.ly/2CAzEPY.
[42]Emily Gurnon, *The Staggering Prices of Long-Term Care 2017*, FORBES (September 26, 2017), https://bit.ly/2W5hFZp.

needed long-term care in the most humane and efficient way possible.[43] Medicare for All would meet both of these goals and begin the crucial transition from the institutional bias of our current long-term care system to a system that serves patients in the setting and community of their choice.

IV. ROLE OF CURRENT PROGRAMS

Medicare for All would build on Medicare's current success at providing timely access to care. Medicare patients reported having consistent access to care, with more than 95 percent reporting having a usual source of care, such as a doctor's office or primary care clinic.[44] Around 90 percent of Medicare beneficiaries reported that they were able to schedule timely appointments for primary and specialty care.[45] Seniors with Medicare were more likely than adults age 50-64 with private insurance to report that they had never had to wait longer than they wanted for a routine care appointment.[46]

In addition, Medicare for All would build on the success of the expansion of access to HCBS, something many states have been improving in recent years. Under our current system, the availability of HCBS varies widely by state, because states must request waivers of certain federal Medicaid requirements in order to do so.[47] However, even states with waiver programs often have waiting lists for their programs and face challenges ensuring access to services for all who need them.[48] And regardless of waivers, before someone can receive Medicaid long-term care, they must prove they are already in poverty or spend down their assets.[49] These requirements can create significant hardship for many families, especially those who may face significant or unexpected expenses not covered by Medicaid after having spent down their assets.

Advocates have successfully pushed to improve access to home and community-based services in recent decades. As a result, HCBS recently overtook institutional coverage, in terms of overall Medicaid long-term care spending.[50] The states with the highest percentage of HCBS spending—Minnesota, New Mexico, and Oregon—devote more than 75 percent of their Medicaid long-term care spending to HCBS, while the states with the lowest spending—Mississippi, Florida and Indiana—all devoted only around a third of their spending toward home and community-based services.[51] Medicare for All would build on the successful expansion that many states have undertaken by ensuring that more Americans would be able to access HCBS, regardless of what state they live in.

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[43]Press Release, U.S. Census Bureau, *Older People Projected to Outnumber Children for First Time in U.S. History* (Sep. 6, 2018), https://bit.ly/2p8zoQY.
[44]CRISTINA BOCCUTI, CHRISTINA SWOOPE, ANTHONY DAMICO AND PATRICIA NEUMAN, KAISER FAMILY FOUNDATION, MEDICARE PATIENTS' ACCESS TO PHYSICIANS: A SYNTHESIS OF THE EVIDENCE, at 2 (December 2013), https://bit.ly/2D6KFtl.
[45]*Id.* at 3.
[46]*Id.*
[47]ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), https://bit.ly/2CAzEPY.
[48]MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, DATA DO NOT SUPPORT RELATIONSHIP BETWEEN MEDICAID EXPANSION AND HOME AND COMMUNITY-BASED SERVICES WAIVER WAITING LISTS, at 1 (March 2018), https://bit.ly/2O25tTZ.
[49]ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), https://bit.ly/2CAzEPY.
Harold Pollack, *Health-Care Reform's Disability Blind Spot*, THE AMERICAN PROSPECT (January 9, 2018), https://bit.ly/2yxmj4l.
[50]STEVE EIKEN, ET AL, TRUVEN HEALTH ANALYTICS, MEDICAID EXPENDITURES FOR LONG-TERM SERVICES AND SUPPORTS (LTSS) IN FY 2015, at 10 (April 2017), https://bit.ly/2PUZmm3.
[51]*Id.* at 11.

While enrollees in most health care programs would be enrolled in Medicare for All, some health programs would remain independent, including the Veterans Health Administration and the Indian Health Service, because they provide specialized care to populations with unique medical needs. However, beneficiaries of such programs could be able to supplement their coverage with services through Medicare for All, when appropriate.

V. PROVIDER ROLES AND RULES

Under Medicare for All, most doctors' offices and institutions would remain in private hands, as they do now. However, Medicare for All would limit the ability of providers to use public funds for profit, marketing, and other expenses that drive up the cost of health care without improving health outcomes. In addition, Medicare for All would also end the scourge of unexpected bills that can devastate families' finances and even send them into medical debt or bankruptcy. This happens because some providers located in facilities that are otherwise in-network for someone's insurance may not actually be included in their insurer's network. For example, during an emergency, a patient doesn't have time or the ability to check whether each provider that is treating them is considered in-network by their plan. And during surgery, there could be multiple doctors and nurses, some of whom may not be in-network.[52] Referred to as "surprise billing" or "balance billing," this practice leaves patients on the hook for the difference between the amount the insurance company is willing to pay and a provider's total fee.[53]

Even a patient who is vigilant and tries to ensure they are being treated by in-network providers may have trouble avoiding surprise bills. Nearly 70 percent of respondents who experienced surprise bills that they were unable to pay did not know that the health care provider was considered out-of-network when they received care.[54] In addition, more than half of Americans received a medical bill for something they thought their health insurance covered.[55] Medicare for All providers would be prohibited from submitting any such bills to patients as their compensation would be handled through the Medicare for All system.

VI. CONCLUSION

It is inhumane to have 30 million Americans lack any form of health care coverage, placing them at risk of personal and financial ruin if they get sick. Further, having so many Americans uninsured leads to tens of thousands of needless deaths each year.[56] The United States has for too long debated creating a single-payer universal health care system without delivering. Despite this failure, Medicare has successfully achieved universal coverage for Americans 65 and older since its passage more than 50 years ago. The

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[52]GARY CLAXTON, ET AL., KAISER FAMILY FOUNDATION, AN ANALYSIS OF OUT-OF-NETWORK CLAIMS IN LARGE EMPLOYER HEALTH PLANS, at 3 (August 2018), https://bit.ly/2OOHNaN.

[53]ADAM CROWTHER, PUBLIC CITIZEN, OUT OF CONTROL: PATIENTS ARE UNWITTINGLY SUBJECTED TO ENORMOUS, UNFAIR, OUT-OF-NETWORK 'BALANCE BILLS', at 4 (April 2014), https://bit.ly/2yyzrdA.

[54]KAREN POLLITZ, KAISER FAMILY FOUNDATION, SURPRISE MEDICAL BILLS, at 1 (March 2016), https://bit.ly/2ObKpe0.

[55]NORC AT THE UNIVERSITY OF CHICAGO, AMERICANS' VIEWS ON HEALTHCARE COSTS, COVERAGE AND POLICY, at 7 (March 2018), https://bit.ly/CuBUXo.

[56]Steffie Woolhandler and David U. Himmelstein, The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?, 167 Annals of Internal Medicine 424-431, 429 (2017).

success of Medicare highlights the importance of building on that program's accomplishments and finally extending guaranteed access to health care to everyone in America.

Everyone depends on the health care system at some time in their lives. From the moment you are born (likely at a hospital) to the day you die, you are part of the health care system whether you are healthy or sick. Even when we feel perfectly fine and haven't had a checkup, the health care system serves and protects us through the development of vaccines, control of infectious disease, and research on ailments likely to befall us, our family, or our community.

And because we rarely know when we might experience our next brush with illness or injury, we need the health care system ready and waiting, just in case.

Thankfully, momentum for a better system is growing. The public outcry for a fairer system that allows everyone access to the care they need will only get stronger as costs of the status quo continue to rise. For example, a recent poll found that 70 percent of Americans, including a majority of Republicans, support providing Medicare to every American.[57]

A single-payer Medicare for All system would improve the current Medicare program and expand it to everyone in the United States. Such a system would provide better access to care and would be far more efficient than our current fragmented health care system. The successful experience of other nations implementing similar programs for their citizens shows what great potential such a system has for improving the lives of everyone in the United States.

For questions, please contact me at ekemp@citizen.org.

[57]Julia Manchester, *70 percent of Americans support 'Medicare for all' proposal*, THE HILL (October 22, 2018), https://bit.ly/2FZoy9N.

Chairman YARMUTH. I thank our witnesses once again for helping us with this important discussion, and I look forward to your testimony.

I now yield five minutes to the Ranking Member, Mr. Womack, for his opening statement.

[The prepared statement of Chairman Yarmuth follows:]

Chairman Yarmuth
House Committee on the Budget
Key Design Components and Considerations for Establishing a Single-Payer Health Care System
Opening Statement
May 22, 2019

This hearing will come to order. I'd like to welcome our witnesses from the Congressional Budget Office – thank you for joining us. I appreciate the opportunity to dive in to your recent report on single-payer health care systems.
Ensuring access to quality, affordable health care remains one of the greatest policy challenges of our time.

The Affordable Care Act has given us a great foundation on which to build. Since it was enacted, 20 million more Americans have been able to gain meaningful health coverage. Now, 89 percent of Americans under 65 are insured—a historic high.
But even with these dramatic gains, 30 million Americans still live without health insurance. And even for those Americans with health insurance, many are underinsured and still struggle with high deductibles and copays. Too many American families still must make the impossible choice between going to the doctor or putting food on their table; filling their gas tank or refilling a prescription.

We cannot accept this tragic reality as the status quo. Progress must produce more progress, and we must begin to pursue the next wave of health care reforms.
That's why last summer I promised that if I became Chairman of the House Budget Committee, we would hold a hearing on single-payer health care. In January, I requested a CBO report on key policy considerations to lay the groundwork for advancing legislation to expand quality and affordable health coverage. Earlier this month, CBO released this report, and today we will examine its findings.

My goal for this hearing is to work through some of the policy issues laid out in this report, including: what eligibility would look like, and what benefits could be covered? How the system could be financed? How a single-payer system might affect the price of prescription drugs? What kind of transition period would be needed to allow health care providers and other stakeholders time to prepare?

Major reforms like the ones outlined in this report would mean major consequences for the health of our citizens, as well as the health of our economy. They must be done carefully and methodically – but not without urgency. Access to affordable health care isn't just a policy proposal or a political slogan—it's life or death for millions of Americans.

I also hope to review what we, as a country, spend on health care now and what we get in return – as well as our long-term fiscal outlook with or without major reforms. Last year, health

spending accounted for 18 percent of our economy. We spend upwards of $3.5 trillion annually as a nation on health care – more, per person, than any other country -- and yet our outcomes are some of the worst among developed nations. Our wasteful and inefficient system has led to skyrocketing prescription drug prices and out-of-pocket costs for consumers, all while insurance companies and CEOs continue to post massive profits.

A single-payer system could expand access to care, decrease our nation's total health care spending and help grow our economy. The trick is closing the *information gap* on what single-payer health care truly is, so that we can close the *health coverage gap* for millions of American families.

I know that the advocates here today and across the country have been at the front lines of this fight for years, and I want to thank you for that hard work and dedication. I have also talked to small business owners and numerous CEO's of Fortune 500 companies; they privately tell me they are all for a single-payer system. They know we are the only country that provides healthcare the way we do. Last year, the average U.S. employer spent more than $5,700 for a single employee plan and more than $14,000 for a family health insurance plan. These CEO's know that a system of employer-based coverage puts them at a disadvantage with their global competitors. There is a consensus among economists that our system of employer-based coverage displaces wages. Relieving employers from the burden of providing coverage will empower American companies to raise employee wages, expand their businesses, and help to grow our nation's economy.

Given all these reasons, it is incumbent upon us to begin to work through the opportunities and tradeoffs involved in a single-payer system, as well as other ways to achieve universal coverage, many of which have been proposed by members of this committee. I strongly believe it's not a matter of *if* we will have universal coverage, but *when*. The CBO report and this subsequent hearing are designed to advance that timeline.

Before I close, I would like to request unanimous consent to submit materials from the American Academy of Actuaries, American Hospital Association, Health Over Profit for Everyone, Healthcare Leadership Council, National Association of Health Underwriters, National Nurses United, Partnership for Employer-Sponsored Coverage, and Public Citizen in the hearing record.

Without objection, the letters will be included in the formal hearing record.
I thank our witnesses for helping us with this important discussion and look forward to your testimony.

Mr. WOMACK. I thank the Chairman.

And good morning, everyone.

Chairman Yarmuth, thank you for scheduling this hearing today. If I read Politico correctly, I understand that there is a chance we can have another hearing on the Jayapal proposal, which I certainly would look forward to, and, hopefully, we can make that happen.

Deputy Director Mark Hadley, welcome.

And to the other two witnesses, thank you for your team being here today.

We are here to discuss a sobering report developed by CBO, at the request of our Chairman, that details some of the risks of imposing a one-size-fits-all, government-run health care system as proposals like Medicare for All would do.

What is noticeably missing from the report is a cost estimate for specific proposals. My friends across the aisle didn't ask for one. I think I know why.

While the score would be useful, we already know how much a one-size-fits-all health care system would cost the American people. Independent analyses from economists across the ideological spectrum, including George Mason University, the Urban Institute, the American Action Forum, have projected single-payer type proposals, such as Medicare for All, to cost at least $32 trillion.

That number bears repeating, $32 trillion, on top of what we are already spending on health care. That is at least $10 trillion more than our nation's astronomically high $22 trillion debt. That is roughly $10,000 per every American per year and is equivalent to 11 percent of GDP each year.

CBO states very clearly in its report that government spending on health care would increase substantially under a single-payer system.

How could the federal government pay for these substantial spending increases? Well, the report outlines four methods. The government could impose tax hikes. It could increase premiums. It could rely more heavily on cost sharing, which is another way of saying out-of-pocket costs such as copays. Or it could just add this enormous price tag to our existing debt without any pay-fors at all. My guess is all of the above.

Now, if you are someone who subscribes to the modern monetary theory, maybe the debt doesn't matter to you. That's, of course, not the way I see it.

Putting aside discussions about how to finance such a costly proposal, this report has been especially helpful in showing that these ideas will never work in America. Imposing a single-payer health care system would eliminate private insurance. That includes the health care 158 million Americans receive through their employer or their union.

The CBO report even warns that under this type of system, patients would not have a choice of insurer or health benefits, and the public plan might not address the needs of some people.

Further, the CBO report also explicitly points out the broader impact the proposal could have on health care. For example, by reducing payment rates for providers, that is, payments for doctors, hospitals, and so on, the report explains, there will not only be a

reduction in the quality of care, there would be a reduction in the supply of care, hampering access to the treatments and services people need.

It is clear proposals like Medicare for All will chase a lot of doctors out of health care. That is not only my strong opinion; it is backed up by hard facts.

These are just a few of the findings from the CBO report, and I expect to discuss many more with our witnesses today.

I hope my colleagues and the public will listen carefully. The consequences of what health care could become under a Democrat-controlled government will be articulated very clearly here today.

With that in mind, I urge all my colleagues not to look at this report in isolation, but rather to look at this report in the context of existing proposals, including the Medicare for All Act of 2019.

Toward that end, when considering other proposals, the other side admits that more limited expansions of existing federal programs, a Medicare buy-in or a Medicaid buy-in, for example, are, in fact, a step towards single-payer, government-run health care. They admit this openly.

This is the direction some lawmakers want to take your healthcare, and it will have consequences that ripple through the most personal aspects of American life, from fewer doctors and longer wait times to less access and no choices. That is why this conversation today is so important.

Before I conclude, I would like to ask for unanimous consent to enter into the record the three studies I mentioned earlier from George Mason University, the Urban Institute and the American Action Forum. Additionally, I would like to seek unanimous consent to enter into the record a study of the impact of single-payer proposals on our nation's hospitals.

Chairman YARMUTH. Without objection.

[The information follows:]

The Costs of a National Single-Payer Healthcare System

Charles Blahous

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Abstract

The leading current bill to establish single-payer health insurance, the Medicare for All Act (M4A), would, under conservative estimates, increase federal budget commitments by approximately $32.6 trillion during its first 10 years of full implementation (2022–2031), assuming enactment in 2018. This projected increase in federal healthcare commitments would equal approximately 10.7 percent of GDP in 2022, rising to nearly 12.7 percent of GDP in 2031 and further thereafter. Doubling all currently projected federal individual and corporate income tax collections would be insufficient to finance the added federal costs of the plan. It is likely that the actual cost of M4A would be substantially greater than these estimates, which assume significant administrative and drug cost savings under the plan, and also assume that healthcare providers operating under M4A will be reimbursed at rates more than 40 percent lower than those currently paid by private health insurance.

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The Costs of a National Single-Payer Healthcare System

Charles Blahous

The cost of adopting a national single-payer healthcare system is a critical factor in assessing whether such a system is desirable or practicable. The leading current bill to establish single-payer health insurance, Senator Bernie Sanders's (I-VT) Medicare for All Act (M4A), would under conservative estimates increase federal budget commitments by approximately $32.6 trillion during its first 10 years of full implementation (2022–2031), assuming enactment in 2018.[1] This projected increase in federal healthcare commitments would equal approximately 10.7 percent of GDP in 2022, rising to nearly 12.7 percent of GDP in 2031 and further thereafter. For perspective on these figures, consider that doubling all currently projected federal individual and corporate income tax collections would be insufficient to finance the added federal costs of the plan.[2] The federal cost increase would by itself be more than two times all currently projected federal discretionary appropriations, including all defense as well as domestic discretionary spending.[3]

It is likely that the actual cost of M4A would be substantially greater than has been estimated from its legislative text. That text specifies that healthcare providers including hospitals, physicians, and others will be reimbursed for all patients at Medicare payment rates, which are projected to be roughly 40 percent lower than those paid by private insurers during the first 10 years of M4A's proposed implementation.[4] By assuming these payment reductions

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[1] For a summary of the provisions of the Medicare for All Act, see Katie Keith and Timothy Jost, "Unpacking the Sanders Medicare-for-All Bill," *Health Affairs*, September 14, 2017.
[2] This statement refers to income tax collections only, not to Social Security or Medicare payroll taxes.
[3] Congressional Budget Office (CBO), *The Budget and Economic Outlook: 2018 to 2028*, April 2018, table 4-1. In other words, it would be less expensive to the federal government to triple all projected appropriations than to enact M4A.
[4] Medicare for All Act of 2017, S. 1804, 115th Cong. (2017); and Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers,* June 5, 2018.

will be implemented and sustained, these cost estimates essentially represent a lower bound. To ease the interpretation of these estimates, the following simplification of the calculations is provided in table 1, using the year 2022 as an example. Table 2 (page 7) provides further details of the 10-year estimates.

Table 1. Effects of M4A in 2022

Individual effect of M4A	Cost of individual effect
2022 currently projected personal healthcare spending	$3.859 trillion
+ healthcare utilization increase	+ $435 billion
– provider payment cuts	– $384 billion
– lower prescription drug costs	– $61 billion
= 2022 personal healthcare spending under M4A	= $3.849 trillion
2022 currently projected national health expenditures (NHE)	$4.562 trillion
– decreased personal health spending ($3.859T – $3.849T, per above)	– 10 billion
– administrative cost savings	– $83 billion
= 2022 NHE under M4A	$4.469 trillion
2022 federal share of NHE under M4A	$4.244 trillion
– currently projected federal health subsidies	– $1.709 trillion
= net addition to 2022 federal costs under M4A	= $2.535 trillion

As shown in table 1, US personal healthcare spending is currently projected to be $3.859 trillion in 2022. Enacting M4A would increase healthcare utilization by covering the previously uninsured, by eliminating cost-sharing for those already insured, and by increasing the range of health services covered. These effects are estimated to add $435 billion to national healthcare spending. The plan would sharply cut payments to providers, subtracting $384 billion, and has also been credited with $61 billion in lowered prescription drug costs. Combining these effects results in projected personal health spending in 2022 of $3.849 trillion, a slight net decrease of $10 billion.

National health expenditures (NHE) are currently projected to be $4.562 trillion in 2022.[5] Subtracting the $10 billion decrease in personal health spending, as calculated in the previous paragraph, and crediting the plan with $83 billion in administrative cost savings results in an NHE projection under M4A of $4.469 trillion. Of this, $4.244 trillion in costs would be borne by the federal government. Compared with the current projection of $1.709 trillion of federal healthcare subsidy costs, this would be a net increase of $2.535 trillion in annual costs, or roughly 10.7 percent of GDP.

Performing similar calculations for each year results in an estimate that M4A would add approximately $32.6 trillion to federal budget commitments during the period from 2022 through 2031, with the annual cost increase reaching nearly 12.7 percent of GDP by 2031 and continuing to rise afterward.

Large though these dollar figures are, they are broadly consistent with those estimated by other experts in advance of the M4A bill's introduction in September 2017.[6] In 2016, an Urban Institute (UI) team projected that Senator Sanders's proposal as described during his presidential campaign would add $32 trillion to federal spending in the years spanning 2017 through 2026, a projection that included a $2.94 trillion federal cost estimate of the plan's provisions for covering long-term supports and services (LTSS).[7] Also in 2016, the Center for Health and Economy (CHE) projected that from 2017 through 2026, the Sanders proposal would increase federal budget deficits by $27.3 trillion.[8] The CHE score did not include an estimate of increased LTSS

[5] NHE differs from personal health spending in that NHE also includes expenditures for research, structures and equipment, and administrative costs.
[6] Medicare for All Act of 2017, S. 1804, 115th Cong. (2017).
[7] John Holahan et al., *The Sanders Single-Payer Healthcare Plan: The Effect on National Health Expenditures and Federal and Private Spending* (Washington, DC: Urban Institute, 2016), tables 1 and 9.
[8] Center for Health and Economy, "Medicare for All: Leaving No One Behind," *HealthAndEconomy.org*, May 1, 2016, table 6. The $27.3 trillion estimate arises from the difference between the two subtotals provided on table 6 for costs and savings, respectively, under the Sanders plan, excluding the deficit effects embedded in the current-law baseline. CHE authors confirmed this interpretation when reviewing a draft of this paper and in a separate email exchange.

costs. Emory University professor Kenneth Thorpe estimated the federal financing required for the proposal at $24.7 trillion from 2017 through 2026, also not including LTSS.[9] When considering the same years and the same benefit provisions, these other independent estimates are quite close to those presented in this paper.

The estimates in this study focus primarily on the 10-year window of 2022 through 2031 because the M4A bill provides for a four-year phase-in period during which increasing numbers of individuals (phased in by age) would be permitted to buy into a transitional public health plan. Estimating a voluntary take-up rate during this transition period is inherently speculative, and even if that rate could be projected with precise accuracy, the projections would not fully reflect the eventual costs of a national single-payer system. Alternatively, if the single-payer system in the M4A bill were fully effective beginning in 2019, the net additional federal cost would be approximately $27.7 trillion (conservatively estimated) during the 10-year window (2019–2028) shown in table 3 (page 22). The details of these and other key assumptions are discussed in the following sections of this paper.[10]

[9] Kenneth E. Thorpe, "An Analysis of Senator Sanders Single Payer Plan," *Healthcare-Now.org*, January 27, 2016.
[10] Shifting from private to public financing of medical care would have potentially significant but unforeseeable effects on the allocation of medical goods and services, which this study does not attempt to model.

Table 2. Financial Effects of Medicare for All Act, in Billions of Dollars

	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2022–2031
Currently projected personal healthcare spending[a]	3,859	4,077	4,309	4,546	4,824	5,120	5,433	5,766	6,120	6,494	
+ Added induced demand from increased coverage[b]	+435	+459	+485	+511	+542	+574	+609	+645	+684	+725	+5,671
– Applying Medicare payment rates	–384	–411	–441	–473	–505	–540	–577	–616	–658	–702	–5,307
– Drug cost savings	–61	–66	–70	–75	–80	–86	–92	–98	–105	–113	–846
= Healthcare spending under M4A	3,849	4,060	4,283	4,509	4,780	5,068	5,373	5,697	6,041	6,406	
Currently projected national health expenditures (NHE)[c]	4,562	4,819	5,091	5,370	5,696	6,042	6,410	6,799	7,213	7,651	
– Change in healthcare spending	–10	–18	–26	–36	–44	–52	–60	–69	–79	–89	–482
– Admin. cost savings	–83	–88	–142	–149	–158	–168	–179	–190	–201	–214	–1,572
= NHE under M4A	4,469	4,713	4,923	5,184	5,494	5,823	6,171	6,541	6,933	7,348	
Federal gov't share of NHE under M4A[d]	4,244	4,475	4,670	4,915	5,207	5,516	5,844	6,191	6,559	6,950	
– Currently projected net federal health subsidies[e]	–1,709	–1,770	–1,833	–1,984	–2,130	–2,262	–2,465	–2,476	–2,590	–2,708	
= Added federal budget cost under M4A	2,535	2,705	2,837	2,931	3,077	3,254	3,379	3,715	3,970	4,241	32,644
Added federal cost as a percentage of GDP[f]	10.7%	11.0%	11.1%	11.0%	11.1%	11.3%	11.3%	12.0%	12.3%	12.7%	

[a] CMS, *NHE Projections 2017–2026*, February 2018, table 2, extrapolated. The totals calculated here differ slightly from those in the NHE tables (e.g., 3,859 vs. 3,869) because of reconciliation with MEPS data as explained in footnote 19. In the MEPS data, some small category totals are rounded to 0, causing national aggregates to add inexactly.

[b] This includes effects of covering the uninsured, increasing the actuarial value of insurance by eliminating deductibles and copayments and by expanding coverage categories to include dental, vision, and hearing.

[c] CMS, *NHE Projections 2017–2026*, table 1, extrapolated.

[d] This subtracts state "maintenance of effort" payments and continued out-of-pocket payments for LTSS, continued private or state funding of research, and capital expenditures from NHE. Holahan et al., *Sanders Single-Payer Healthcare Plan*; and Medicare for All Act of 2017, S. 1804, 115th Cong. (2017).

[e] This includes federal Medicaid payments, Medicare outlays net of receipts, tax subsidies for employer-provided and ACA marketplace coverage, CHIP, other ACA subsidies and research funding, net of revenues from employer-mandate penalties and taxes on health insurance plans and providers. See CBO, *Federal Subsidies for Health Insurance Coverage for People under Age 65: 2018–2028*, May 23, 2018; CBO, *Medicaid Spending and Enrollment—CBO's April 2018 Baseline*, April 2018; and CBO, *Medicare—CBO's April 2018 Baseline*, April 9, 2018. CBO estimates were extrapolated beyond 2028, with adjustments for the additional Medicare payments projected to occur within 2028 because October 1 (the start of the next fiscal year) occurs on a weekend.

[f] CBO, *The Budget and Economic Outlook: 2018–2028*, April 9, 2018.

Increased Demand and Utilization

M4A would increase healthcare demand and utilization in at least three important ways. First, the plan would provide health insurance coverage to all Americans who are currently uninsured, greatly increasing their utilization of healthcare services.[11] Coverage of the currently uninsured is estimated to increase their health service costs by roughly 89 percent.[12]

Second, the plan would expand the range of services covered by existing insurance, explicitly covering dental, vision, and hearing care for all participants.[13] This, too, would increase utilization of such services in addition to shifting their financing from private to public spending, especially for those now reliant on traditional Medicare. Currently, only 12 percent of all personal healthcare expenses in the United States are paid out of pocket, while 22 percent are paid by Medicare. By contrast, 40 percent of national dental care expenses are paid out of pocket, while the national share financed by traditional Medicare rounds to 0 percent.[14] This indicates that the addition of dental, vision, and hearing benefits will substantially increase total projected health service utilization and costs.[15]

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[11] There remain approximately 30 million uninsured Americans in 2018. See Centers for Medicare and Medicaid Services (CMS), *NHE Projections 2017–2026*, February 2018, table 17.

[12] Kenneth Thorpe estimates that covering the uninsured would increase total spending per person by 70 percent, citing research by Jack Hadley and coauthors. Kenneth Thorpe, "Why Sanders's Single-Payer Plan Would Cost More Than His Campaign Says," *American Prospect,* February 29, 2016; and Jack Hadley et al., *Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage* (Washington, DC: Henry J. Kaiser Family Foundation, August 2008). Hadley and his coauthors "assume that the coverage offered to uninsured people would be broadly similar to the range of coverage currently held by low- and lower-middle-income people," rather than the first dollar coverage the M4A bill would provide. Adjusting for increased utilization patterns associated with higher-value insurance in recent research literature produces an estimated utilization increase of 89 percent. Thorpe agrees that 70 percent is "likely low" using the same reasoning. The 89 percent assumption occupies a middle ground between Thorpe's assumption and the UI team's projections. The UI team estimated that spending "for the otherwise uninsured would increase 169.5 percent" after all relevant cost-affecting factors, including utilization increases, were incorporated. See Holahan et al., *Sanders Plan*.

[13] Medicare for All Act of 2017, § 1013. Dental, vision, and hearing services encompassed roughly 5 percent of all US personal health expenses in 2017. See CMS, *NHE Projections 2017–2026*, table 2.

[14] CMS, *NHE Projections 2017–2026*, tables 5 and 8.

[15] The demand increase for these services is estimated at 15 percent, employing the methodology described in the footnotes for the subsequent paragraph. Estimates for vision and hearing services were made with assistance of supplemental data from Berhanu Alemayehu and Kenneth Warner, "The Lifetime Distribution of Healthcare Costs," *Health Services Research* 39, no. 3 (2004): 627–42.

Finally, the plan's requirement that "no cost-sharing, including deductibles, coinsurance, copayments, or similar charges, be imposed on an individual" would also significantly increase healthcare utilization.[16] As a general rule, the greater the percentage of an individual's healthcare that is paid by insurance (i.e., the insurance's actuarial value, or AV), the more healthcare services an individual tends to buy. There is an extensive literature devoted to estimating how much individuals increase their use of healthcare as the AV of their insurance increases—which, in the case of M4A, would be to an AV of essentially 100 percent.[17] Providing this first-dollar coverage is estimated to induce 11 percent additional demand for those currently covered by private insurance and 16 percent for those now in traditional Medicare without supplemental coverage.[18]

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[16] Medicare for All Act of 2017, § 202. Minor exceptions are included in the text, including cost-sharing designed to incent the use of generic drugs as well as cost-sharing for LTSS benefits.

[17] In addition to other references provided with this study, see Robert H. Brook et al., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Healthcare Reform Debate* (Santa Monica, CA: RAND Corporation, 2006). As the reference notes, the Rand study was "one of the largest and most comprehensive social science experiments ever performed in the United States," and "led to over 300 publications, including journal articles, reports, and books."

[18] Estimates of average AV provided by employer-sponsored insurance (ESI) include Frank McArdle et al., "How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?: A 2012 Update" (Issue Brief, Kaiser Family Foundation, Menlo Park, CA, April 4, 2012) (86 percent); Thomas G. Moehrle, "Measure of Generosity of Employer Sponsored Health Plans: An Actuarial Value Approach" (Office of Survey Methods Research, Bureau of Labor Statistics, 2015) (88.9 percent); Jon R. Gabel et al., "Consumer Cost-Sharing in Marketplace vs. Employer Health Insurance Plans, 2015," *Commonwealth Fund*, December 21, 2015 (83 percent); Actuarial Research Corporation for the US Department of Labor, *Analysis of Actuarial Values and Plan Funding Using Plans from the National Compensation Survey*, May 12, 2017 (84.8 percent); and Linda J. Blumberg, John Holahan, and Erik Wengle, "Are Nongroup Marketplace Premiums Really High? Not in Comparison with Employer Insurance," *Urban Institute*, September 2016 (83 percent). Combining and proportionately weighting these estimates for ESI with those for ACA marketplace insurance (see Kaiser Family Foundation, "Marketplace Enrollment by Metal Level," *KFF State Health Facts*, June 30, 2016), cross-referenced with data on the numbers of those enrolled in silver plans receiving cost-sharing assistance, as well as other private insurance (see CMS, *NHE Projections 2017–2026*, table 17), produces an aggregate estimate for the AV of private insurance plans of between 82 and 83 percent. The estimate of the induced demand increase associated with replacing these insurance policies with single-payer insurance of AV 100 percent was derived on the basis of the HHS Notice of Benefit and Payment Parameters for 2014. See HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410 (March 11, 2013). Thorpe, in "Analysis of Senator Sanders Single Payer Plan," and McArdle et al. estimate the AV for traditional Medicare in the absence of supplemental coverage at 80 percent while Daniel W. Bailey, "Actuarial Value and the Actuarial Value of Original A/B Medicare," *In the Public Interest* 9, no. 1 (2014): 27–34, estimates it at 84 percent. The estimate of the additional demand from those previously enrolled only in traditional Medicare, induced by raising Medicare's AV to 100 percent, is a rough midpoint between the estimates that derive from applying the HHS Notice factors to these AVs, and Marika Cabral and Neale Mahoney's estimates of increased utilization observed in Medicare beneficiaries when they acquire Medigap insurance that covers most expenses. See Marika Cabral and Neale Mahoney, "Externalities and Taxation of Supplemental Insurance: A Study of Medicare and Medigap" (NBER Working Paper No. 19787, National Bureau of Economic Research, Cambridge, MA, October 2017).

Provider Payment Reductions

To offset the substantial cost increases created by stimulating additional consumer demand for and utilization of healthcare, the M4A bill would constrain expenditures by subjecting healthcare providers—including hospitals, physicians, and others—to Medicare payment rates.[19] Under current law, Medicare reimburses healthcare providers at much lower rates than private health insurance does. In 2014, Medicare hospital payment rates were 62 percent of private insurance payment rates and are currently projected to decline to below 60 percent by the time M4A would be implemented, and to decline further afterward. Medicare physician payment rates were 75 percent of private insurance rates in 2016 and, per the terms of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), are projected to decline sharply in relative terms in future years, also falling below 60 percent within the first full decade of M4A.[20]

The M4A Act as introduced specifies that provider payment amounts are to be consistent with those paid under current Medicare law.[21] The adoption of Medicare payment rates would represent a substantial reduction in provider reimbursements for care provided to everyone now covered by private insurance (though it would also be a temporary increase in physician payments for those now covered by Medicaid, which currently pays physicians at lower rates

[19] The methodology for estimating cost increases arising from greater utilization is as follows. Estimates of national personal healthcare spending, total healthcare consumption, and NHE were taken from CMS, *NHE Projections 2017–2026*. Estimates for years beyond 2026 were made by extrapolating the projected rates of growth for these aggregates at the end of the 2017–2026 period. The share of expenditures financed by different sources was determined by data from the US Department of Health and Human Services, "Medical Expenditure Panel Survey," *AHRQ: Agency for Healthcare Research and Quality*, accessed April 8, 2018. Discrepancies between NHE and MEPS aggregates were resolved with assistance of insights in Didem Bernard et al., "Reconciling Medical Expenditure Estimates from the MEPS and NHEA, 2007," *Medicare and Medicaid Research Review* 2, no. 4 (2012). Fortuitously, the ratios of the discrepancies analyzed in that article almost exactly matched those between the 2014 NHE and MEPS data, making it straightforward to scale the reported results in the MEPS to the NHE aggregates. This in turn enabled estimates of the shares of national health spending financed by different insurance sources as well as out of pocket. Utilization changes were calculated for different populations according to their current sources of health coverage, and the resulting spending projections for each population were assembled to create aggregate personal healthcare spending projections under M4A.
[20] CMS, Office of the Actuary, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*, June 5, 2018.
[21] Medicare for All Act of 2017, § 611.

than does Medicare).[22] For example, in 2014, hospitals were reimbursed just 89 percent of their costs of treating Medicare patients and 90 percent of their costs of treating Medicaid patients—losses that were offset by hospitals collecting private insurance reimbursement rates equaling 144 percent of their costs.[23]

It is unclear whether current-law Medicare provider and physician payment schedules would be upheld even in the absence of M4A's enactment. For example, the schedule for Medicare physician payment growth constraints recently enacted in MACRA replaced other constraints under the previous Sustainable Growth Rate (SGR) formula, which were repeatedly overridden in periodic legislation before more recently being eliminated.[24] It remains to be seen whether MACRA will effectively restrain Medicare physician payment levels where SGR did not, as well as whether Affordable Care Act (ACA) provisions will effectively restrain Medicare provider costs over the long term.

Furthermore, it is not precisely predictable how hospitals, physicians, and other healthcare providers would respond to a dramatic reduction in their reimbursements under M4A, well below their costs of care for all categories of patients combined. The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary has projected that even upholding current-law reimbursement rates for treating Medicare beneficiaries alone would cause nearly half of all hospitals to have negative total facility margins by 2040.[25] The same study found that by 2019, over 80 percent of hospitals will lose money treating Medicare patients—a situation M4A would extend, to a first approximation, to all US patients. Perhaps some facilities and physicians would be

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[22] CMS, *Projected Medicare Expenditures*.
[23] American Hospital Association, *TrendWatch Chartbook 2016: Trends Affecting Hospitals and Health Systems*, 2016, appendix 4, table 4.4.
[24] Stan Veuger and Jeffrey Clemens, "Repeal of the Medicare Sustainable Growth Rate: Direct and Indirect Consequences," *AMA Journal of Ethics* 17, no. 11 (2015): 1053–58.
[25] CMS, *Projected Medicare Expenditures*. Also see CMS, Office of the Actuary, *Simulations of Affordable Care Act Medicare Payment Update Provisions on Part A Provider Financial Margins*, June 5, 2018.

able to generate heretofore unachieved cost savings that would enable their continued functioning without significant disruptions. However, at least some undoubtedly would not, thereby reducing the supply of healthcare services at the same time M4A sharply increases healthcare demand. It is impossible to say precisely how much the confluence of these factors would reduce individuals' timely access to healthcare services, but some such access problems almost certainly must arise.

Anticipating these difficulties, some other studies have assumed that M4A payment rates must exceed current-law Medicare payment rates to avoid sending facilities into deficit on average or to avoid triggering unacceptable reductions in the provision and quality of healthcare services.[26] These alternative payment rate assumptions substantially increase the total projected costs of M4A. Specifically, they would mean payment rates being set higher than they are under current Medicare law and lower than those now paid by private insurance. Even with a higher payment rate assumption, the UI team determined that "not all increased demand could be met because provider capacity would be insufficient." This constraint is reflected in their final cost estimates.[27]

In contrast with Thorpe's and the UI team's earlier estimates, the estimates in this study are based instead on the language of the M4A bill as subsequently introduced, imposing Medicare payment rates on all providers and thereby substantially reducing national average provider payment rates relative to current law.[28] Had this study assumed instead that total provider payment rates under M4A would be set to remain equal on average to the current-law blend of higher

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[26] Holahan et al., *Sanders Plan*. 8, 13, and 16; and Thorpe, "Analysis of Senator Sanders Single Payer Plan," 2 and 6.
[27] Holahan et al., *Sanders Plan*, 8.
[28] Medicare for All Act of 2017, § 611. Again, this also includes an offsetting increase for physicians currently treating Medicaid patients. First, NHE data were used to divide projected personal healthcare expenditures into shares for hospital care, professional or physician services, home healthcare, nursing care, and other healthcare. Then, NHE tables 6, 7, 10, 13, and 14 were used to determine the share of each of these expenditures paid by private insurance under current law. Provider payments for costs now incurred by private insurance in each of these areas were reduced according to the projected ratios of Medicare payment levels to private payment levels specified by John D. Shatto and M. Kent Clemens in CMS, Office of the Actuary, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers,* June 5, 2018. Projected physician payments under Medicaid were increased to Medicare levels according to the percentages specified in CMS, *Projected Medicare Expenditures*. The resulting aggregate payment reductions were then reconciled with MEPS data.

private and lower public reimbursement rates, the resulting cost estimates would be substantially larger: $38.0 trillion from 2022 through 2031, or $32.1 trillion if M4A were fully implemented from 2019 through 2028.[29] The federal cost increase would approach 14.8 percent of GDP in 2031, the last of the initial 10 years of proposed full implementation. This altered assumption would result in these estimates, on an annual basis, being within the range of estimates spanned by Thorpe, CHE, and the UI team, all working in advance of specific legislative text.[30]

Drug Costs

This analysis credits the M4A proposal with approximately $846 billion in additional savings over the 2022–2031 period from negotiating lower prices for prescription drugs. This is an aggressive assumption reflecting the intent of the bill to empower the secretary of Health and Human Services (HHS) to negotiate lower drug prices on behalf of beneficiaries and specifically to "promote the use of generic medications to the greatest extent possible."[31] There are limits to the potential effectiveness of this approach to lowering healthcare costs. Generics have prices 75 to 90 percent lower than those of brand-name drugs, but they already make up roughly 85 percent of all prescription drugs sold.[32]

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[29] The average of current-law reimbursement rates is a function of a blend of private insurance rates (which are higher) and public sector rates (which are lower). In other words, the alternative assumption described in this paragraph specifies that M4A's universal payment rates would be set between current public and private rates so that national average reimbursement rates do not change relative to current law.

[30] A $32.1 trillion federal cost estimate over 2019–2028 would be approximately equivalent to a $28.9 trillion cost over 2017–2026 if fully effective during that time, a number within the range of estimates produced separately by the Center for Heath and Economy, Kenneth Thorpe, and the Urban Institute. Those estimates, like those in this study, project the effects of adopting public financing along the lines stipulated by the text of the M4A Act. It should be noted that fiscal outcomes could vary significantly if the private sector retains a substantial role in healthcare financing, as has remained the case in several European nations. See Sarah Thomson, Thomas Foubister, and Elias Mossialos, *Financing Healthcare in the European Union: Challenges and Policy Responses* (Copenhagen: World Health Organization, 2009).

[31] Medicare for All Act of 2017, § 614.

[32] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2017, 409–10. Also see Statista, "Proportion of Branded Versus Generic Drug Prescriptions Dispensed in the United States from 2005 to 2016," *Statista*, May 2017. Other estimates of current generic drug penetration are higher. For example, see Association for Accessible Medicines, *2017 Generic Drug Access and Savings in the U.S.*, 2017.

Additionally, prescription drugs account for only 10 percent of total national health expenditures.[33] This analysis assumes virtually perfect success for M4A in replacing brand-name drugs with generics, both for those now on Medicare as well as for the population as a whole; therefore, actual savings are likely to be less than assumed under these projections.[34] It is a matter of wide speculation whether granting negotiating power to the HHS secretary could produce savings beyond these aggressive assumptions with respect to generic drug penetration.[35] Even if such a grant of power achieved greater savings, however, such additional savings are likely to be offset by imperfect success in eliminating brand-name drug purchases in favor of generics.[36] These cost estimates do not reflect other potential effects of the proposed policy, such as lessened pharmaceutical innovation.

Administrative Savings

This analysis assumes substantial administrative cost savings generated by replacing private insurance with national single-payer insurance, specifically a reduction of seven percentage points (from an estimated 13 percent to 6 percent) in the administrative cost of covering those now holding private insurance.[37] Again, this is an aggressive estimate of administrative savings that is more likely to lead to M4A costs being underestimated than overestimated.

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[33] CMS, *NHE Projections 2017–2026*, table 2. This figure does not include drugs dispensed in an inpatient setting.
[34] Specifically, the assumption is that the approximately 15 percent of prescription drugs that are now brand-name drugs will all be replaced by generics with an average cost savings of 80 percent per prescription, reducing total prescription drug costs by 12 percent.
[35] See Committee for a Responsible Federal Budget, "Fact Sheet: How Much Money Could Medicare Save by Negotiating Prescription Drug Prices?," *CRFB.org*, April 11, 2016.
[36] For example, the fact that prices are not now negotiated by the federal government may be a factor currently contributing to the already high levels of generic penetration of the drug market.
[37] See page 5 of the PDF version of Center for Health and Economy, "Medicare for All: Leaving No One Behind," *HealthAndEconomy.org*, May 1, 2016.

Current administrative cost rates for Medicare as a whole are cited as being roughly 4 percent, though closer to 6 percent for Medicare Advantage.[38] It is unlikely that the population now privately insured could be covered by M4A with administrative costs as low as 4 percent. Administrative cost rates are calculated as a percentage of total insurance costs, and these total costs per capita under private insurance are currently less than half of what they are in Medicare.[39] In other words, one reason Medicare's administrative cost rates appear to be so much lower than private insurance rates is that they are expressed as percentages of Medicare's overall per capita costs, which are much higher. These higher Medicare costs exist primarily because Medicare serves an older population that consumes more healthcare services than the generally younger population now served by private insurance.

Moreover, even if administrative cost rates could be lowered by more than seven percentage points, there would be offsetting cost increases. A further reason private insurance administrative costs are relatively higher is the necessity of policing fraudulent or other improper payments to ensure an insurer's continued solvency and to provide competitive value to its customers. Although government also polices fraud within its health insurance programs, financial survival and business competitiveness are concerns from which government-provided insurance is generally exempt. The Government Accountability Office found approximately

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[38] For the 4 percent citation, see page 5 of the PDF version of Center for Health and Economy, "Medicare for All: Leaving No One Behind," *HealthAndEconomy.org*, May 1, 2016. For the 6 percent figure, see Kip Sullivan, "How to Think Clearly about Medicare Administrative Costs: Data Sources and Measurement," *Journal of Health Politics, Policy and Law* 38, no. 3 (2013): 479–504. Holahan and his coauthors conclude that 6 percent is "the appropriate figure for estimating proposals that build upon the entire Medicare program." Holahan et al., *Sanders Plan*, 9.

[39] US Department of Health and Human Services, "Medical Expenditure Panel Survey," *AHRQ: Agency for Healthcare Research and Quality*, accessed April 8, 2018. Also see Robert A. Book, "Medicare Administrative Costs Are Higher, Not Lower, Than for Private Insurance" *Heritage Foundation*, June 25, 2009. Book notes that Medicare's "administrative costs are spread over a larger base of actual healthcare costs." MEPS data substantiate Book's assertion. For example, the MEPS data show that in 2014, individuals younger than 65 making claims on private insurance had an average of $4,421 in expenses per person, whereas those over 65 making claims on Medicare alone had average expenses of $9,221 per person, with still higher expenses per person for those carrying Medicare in addition to other private or public insurance.

$96 billion in improper Medicare and Medicaid payments in 2016, by itself more than twice the total government expenditures on health insurance administration.[40]

One apparent consequence of government's lesser investment in insurance administration is a substantial additional cost associated with improper payments.[41] Considering the various factors acting in combination, it is unlikely that total savings arising from less expensive administration could exceed the seven percentage point reduction assumed here.

Beyond this, other policy and political dynamics of federally administered insurance should tend to increase total costs. This is evident in the text of the M4A bill, which, among its other provisions, includes a line item authorizing expenditures of up to 1 percent of the total national health budget during its first five years for "programs providing assistance to workers who perform functions in the administration of the health insurance system and who may experience economic dislocation as a result of the implementation of this Act."[42] The policy and political dynamics that gave rise to this proposed spending program would likely give rise to others in the course of enacting and implementing M4A, reducing net savings from lowered administrative costs.

The M4A bill provides for a national health budget through which the federal government would finance additional health-related spending in a number of areas, including health professional education, innovation, and capital expenditures.[43] It is impossible to predict precisely the extent to which private-sector investments would be crowded out by increased

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[40] Government Accountability Office, "Medicare—High Risk Issue," *GAO.gov*, accessed April 11, 2018; and Government Accountability Office, "Medicaid—High Risk Issue," accessed April 11, 2018. Government administration costs are from CMS, *NHE Projections 2017–2026*, table 2.

[41] As another example, see Office of Inspector General, Department of Health and Human Services, *California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements*, February 2018. The OIG found that in a sample of 150 beneficiaries, Medicaid payments were made on behalf of 38 individuals who were either ineligible or potentially ineligible for coverage under the program.

[42] Medicare for All Act of 2017, § 601.

[43] Medicare for All Act of 2017, § 601.

federal activity in these areas. These projections incorporate rough estimates of these movements, but because this subcategory of health spending constitutes less than 5 percent of all NHE, inevitable errors of estimation will not qualitatively affect the aggregate projections.[44]

Long-Term Services and Supports

The M4A bill contains a "maintenance of effort" provision requiring states to continue their LTSS expenditures under Medicaid at current-law levels, automatically indexing the growth of these commitments going forward.[45] Lacking a model that permits an independent estimate of this provision's effects, this study incorporates projections of state Medicaid spending on LTSS under current law published by the UI team, interpolating and extrapolating from the UI team's published figures to arrive at estimates of continuing state expenditures conforming to the effective dates in the M4A bill.

Consistent with the assumptions employed throughout this paper, the resulting implicit estimates of national and federal spending on LTSS should be regarded as conservative. Although the M4A bill does not explicitly provide for new LTSS coverage, its broader expansion of health insurance coverage would likely increase the numbers of individuals utilizing LTSS benefits authorized under current law. This study's assumption of no net increase in LTSS benefit utilization, in addition to the assumption that M4A's "maintenance of effort" provision successfully binds state governments, is an additional factor contributing to these projections' being more likely to underestimate costs than to overestimate them.

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[44] CMS, *NHE Projections 2017–2026*, table 2. It is assumed that the federal share of healthcare research would remain essentially unchanged but that the federal government would finance a preponderance of new capital expenditures, based on a rough interpretation of the Medicare for All Act text. Alternative assumptions would cause only very minor changes to the aggregate cost projections.

[45] Medicare for All Act of 2017, § 204 and § 901. This "maintenance of effort" requirement does not apply to the rest of current-law state Medicaid spending.

Effects on National Health Expenditures and the Federal Budget

Table 2 summarizes the financial effects of the M4A bill over its first 10 years of full implementation, which would be 2022 through 2031 if enacted in 2018. One striking finding evident in the table is that, even under the assumption that provider payments for treating patients now covered by private insurance are reduced by over 40 percent, aggregate health expenditures remain virtually unchanged: national personal healthcare costs decrease by less than 2 percent, while total health expenditures decrease by only 4 percent, even after assuming substantial administrative cost savings. The additional healthcare demand that arises from eliminating copayments, providing additional categories of benefits, and covering the currently uninsured nearly offsets potential savings associated with cutting provider payments and achieving lower drug costs. Thus, the essential expenditure change wrought by movement to a single-payer system would be to replace private spending on healthcare with government spending financed by taxpayers.[46] At the same time, more generous healthcare insurance would be provided to everyone at the expense of healthcare providers, who would face reimbursements substantially below their service costs. As noted previously, whether providers could sustain such losses and remain in operation, and how those who continue operations would adapt to such dramatic payment reductions, are critically important questions.

While these estimates show little net change in NHE, the same cannot be said of the projected effects on the federal budget. Table 2 includes an estimate for the net increase in federal health budget commitments of $32.6 trillion from 2022 through 2031, which, by itself, is more than all federal individual and corporate income taxes projected to be collected during that

[46] Again, the assumption of public financing is retained throughout this study pursuant to the language of the M4A bill text. International experience has been that private financing often retains a substantial role. See Thomson, Foubister, and Mossialos, *Financing Healthcare in the European Union*.

time period.[47] This net increase in federal budget commitments was calculated by comparing projected federal obligations under M4A with Congressional Budget Office (CBO) estimates of current-law federal subsidies, including not only direct spending on Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and ACA marketplaces, but also subsidies provided through the tax code, such as the tax exclusion for employer-provided coverage as well as ACA-related tax credits. Some of these current subsidies are scored under budgeting conventions as federal revenue losses rather than spending outlays, but they all contribute to federal commitments for healthcare under current law. Netted against the current federal subsidy totals are certain revenue collections that would presumably be obviated in the course of enacting single-payer healthcare, including penalties on employers for failing to provide health insurance, taxes on health insurance providers, and the so-called Cadillac plan tax on high-premium health insurance plans.[48]

It should be noted that M4A's elimination of employer-sponsored insurance, including the federal tax preferences now accorded to it, should increase worker wages net of employer-provided health benefits. These estimates incorporate the increased federal revenues CBO projects to arise from subjecting these higher expected wages to federal taxation. Thus, at the same time

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[47] CBO, *Budget and Economic Outlook*, table 3-1. For purposes of this and other calculations, this study assumes full benefits will be paid without regard to the balance of funds in the M4A's Universal Medicare Trust Fund. M4A's legislative text provides that such a trust fund will be established and will receive funds that would otherwise be appropriated to finance payments for Medicare, Medicaid, and other federal health programs, as well as revenues arising from changing the tax treatment of private insurance. The trust fund revenue resources enumerated in the M4A text could fall well short of the amounts necessary to finance full promised benefits. For example, under current law the revenues allocated to the Medicare Hospital Insurance (HI) Trust Fund are insufficient to finance Medicare HI benefit payments, with the result that after HI Trust Fund depletion (now projected for 2026), "revenues would be inadequate to fully cover costs" and therefore "payments would be reduced." See Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2018 Annual Report*, June 5, 2018, 2 and 26. Although M4A would establish a trust fund that is analogous to Medicare's HI trust fund in some respects, the legislative language has been interpreted herein as a federal commitment to pay full benefits irrespective of trust fund asset levels.

[48] CBO, *Federal Subsidies for Health Insurance Coverage for People under Age 65: 2018–2028*, May 23, 2018; CBO, *Medicaid Spending and Enrollment—CBO's April 2018 Baseline*, April 2018; and CBO, *Medicare—CBO's April 2018 Baseline*, April 9, 2018.

that M4A would dramatically increase federal spending, it would increase taxable worker wages net of employer-provided benefits, while also relieving individuals, families, and employers of the substantial health expenditures they would experience under current law. It would also relieve states of such Medicaid expenditure obligations as are transferred to the federal government. These offsetting effects should be considered when weighing the implications of requiring federal taxpayers to finance the enormous federal expenditure increases under M4A.

These estimates should be understood as projecting the added federal cost commitments under M4A, as distinct from its net effect on the federal deficit. To the extent that the cost of M4A is financed by new payroll taxes, premium collections, or other revenue increases, the net effect on the federal budget deficit would be substantially less.[49]

Because the dollar figures presented in table 2 are enlarged by encompassing the 2022 through 2031 window for full implementation, table 3 presents a hypothetical alternative scenario in which all of the plan's benefit provisions are fully effective by 2019. In this hypothetical scenario, the 10-year (2019–2028) net federal budget cost would be $27.7 trillion, rising from roughly 10.4 percent of GDP annually in 2019 to 11.3 percent in 2028.

Tables 4 and 5 (pages 23 and 24, respectively) present alternative scenarios in which provider payment levels are not reduced to Medicare rates; instead, provider and physician reimbursement rates remain unchanged from current projections on national average. Under this scenario, the net added federal costs of M4A would be $38.0 trillion from 2022 through 2031, rising from approximately 12.3 percent of GDP in 2022 to nearly 14.8 percent of GDP in 2031 and continuing to rise afterward. If the benefit provisions of M4A under this higher payment scenario were fully effective by 2019 instead, then added federal costs would be $32.1 trillion by

[49] Beyond the transition period, the text of the Medicare for All Act does not specify what premiums might ultimately be assessed.

2028, rising from roughly 11.9 percent of GDP to 13.3 percent of GDP over that 10-year period. For perspective on these estimates, consider that all of the various current-law federal health subsidies tabulated earlier in this paper currently total approximately 6.6 percent of GDP, to which the costs above would be added.

As noted earlier, the federal cost of enacting the M4A Act would be such that doubling all federal individual and corporate income taxes going forward would be insufficient to fully finance the plan, even under the assumption that provider payment rates are reduced by over 40 percent for treatment of patients now covered by private insurance. Such an increase in the scope of federal government operations would precipitate a correspondingly large increase in federal taxation or debt and would be unprecedented if undertaken as an enduring federal commitment.[50] There should be a robust public discussion of whether these outcomes are desirable and practicable before M4A's enactment is seriously considered.

[50] Federal expenditures as a percentage of GDP rose dramatically but temporarily upon US entry into World War II, as distinct from the ongoing spending commitments associated with M4A.

Appendix: Additional Data Tables

Table 3. Financial Effects of Medicare for All Act if Benefits Were Fully Effective in 2019, in Billions of Dollars

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019–2028
Currently projected personal healthcare spending[a]	3,276	3,458	3,655	3,859	4,077	4,309	4,546	4,824	5,120	5,433	
+ Added induced demand from increased coverage[b]	+370	+390	+412	+435	+459	+485	+511	+542	+574	+609	+4,787
– Applying Medicare payment rates	**–314**	**–337**	**–360**	**–384**	**–411**	**–441**	**–473**	**–505**	**–540**	**–577**	**–4,342**
– Drug cost savings	–50	–54	–57	–61	–66	–70	–75	–80	–86	–92	–692
= Healthcare spending under M4A	**3,281**	**3,457**	**3,650**	**3,849**	**4,060**	**4,283**	**4,509**	**4,780**	**5,068**	**5,373**	
Currently projected national health expenditures (NHE)[c]	3,868	4,091	4,322	4,562	4,819	5,091	5,370	5,696	6,042	6,410	
+/– Change in healthcare spending	+5	–0	–5	–10	–18	–26	–36	–44	–52	–60	–246
– Admin. cost savings	**–70**	**–74**	**–78**	**–83**	**–88**	**–142**	**–149**	**–158**	**–168**	**–179**	**–1,190**
= NHE under M4A	3,802	4,016	4,239	4,469	4,713	4,923	5,184	5,494	5,823	6,171	
Federal gov't share of NHE under M4A[d]	3,611	3,815	4,026	4,244	4,475	4,670	4,915	5,207	5,516	5,844	
– Currently projected net federal health subsidies[e]	–1,406	–1,475	–1,573	–1,709	–1,770	–1,833	–1,984	–2,130	–2,262	–2,465	
= Added federal budget cost under M4A	**2,205**	**2,340**	**2,454**	**2,535**	**2,705**	**2,837**	**2,931**	**3,077**	**3,254**	**3,379**	**27,716**
Added federal cost as a percentage of GDP[f]	10.4%	10.6%	10.7%	10.7%	11.0%	11.1%	11.0%	11.1%	11.3%	11.3%	

[a] CMS, *NHE Projections 2017–2026*, February 2018, table 2, extrapolated. The totals calculated here differ slightly from those in the NHE tables (e.g., 3,859 vs. 3,869) because of reconciliation with MEPS data as explained in footnote 19. In the MEPS data, some small category totals are rounded to 0, causing national aggregates to add inexactly.

[b] This includes effects of covering the uninsured, increasing the actuarial value of insurance by eliminating deductibles and copayments and by expanding coverage categories to include dental, vision, and hearing.

[c] CMS, *NHE Projections 2017–2026*, table 1, extrapolated.

[d] This subtracts state "maintenance of effort" payments and continued out-of-pocket payments for LTSS, continued private or state funding of research, and capital expenditures from NHE. Holahan et al., *Sanders Single-Payer Healthcare Plan*; and Medicare for All Act of 2017, S. 1804, 115th Cong. (2017).

[e] This includes federal Medicaid payments, Medicare outlays net of receipts, tax subsidies for employer-provided and ACA marketplace coverage, CHIP, other ACA subsidies and research funding, net of revenues from employer-mandate penalties and taxes on health insurance plans and providers. See CBO, *Federal Subsidies for Health Insurance Coverage for People under Age 65: 2018–2028*, May 23, 2018; CBO, *Medicaid Spending and Enrollment—CBO's April 2018 Baseline*, April 2018; and CBO, *Medicare—CBO's April 2018 Baseline*, April 9, 2018. CBO estimates were extrapolated beyond 2028, with adjustments for the additional Medicare payments projected to occur within 2028 because October 1 (the start of the next fiscal year) occurs on a weekend.

[f] CBO, *The Budget and Economic Outlook: 2018–2028*, April 9, 2018.

Table 4. Financial Effects of Medicare for All Act without Provider Payment Cuts, in Billions of Dollars

	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2022–2031
Currently projected personal healthcare spending[a]	3,859	4,077	4,309	4,546	4,824	5,120	5,433	5,766	6,120	6,494	
+ Added induced demand from increased coverage[b]	+435	+459	+485	+511	+542	+574	+609	+645	+684	+725	+5,671
Provider payment changes	0	0	0	0	0	0	0	0	0	0	0
– Drug cost savings	–61	–66	–70	–75	–80	–86	–92	–98	–105	–113	–846
= Healthcare spending under M4A	4,233	4,471	4,724	4,982	5,286	5,608	5,950	6,313	6,699	7,107	
Currently projected national health expenditures (NHE)[c]	4,562	4,819	5,091	5,370	5,696	6,042	6,410	6,799	7,213	7,651	
+ Change in healthcare spending	+374	+394	+415	+436	+462	+489	+517	+547	+579	+613	+4,824
– Admin. cost savings	–83	–88	–142	–149	–158	–168	–179	–190	–201	–214	–1,572
= NHE under M4A	4,852	5,125	5,364	5,657	5,999	6,363	6,748	7,157	7,590	8,050	
Federal gov't share of NHE under M4A[d]	4,628	4,886	5,111	5,388	5,712	6,056	6,421	6,807	7,217	7,651	
– Currently projected net federal health subsidies[e]	–1,709	–1,770	–1,833	–1,984	–2,130	–2,262	–2,465	–2,476	–2,590	–2,708	
= Added federal budget cost under M4A	2,919	3,117	3,278	3,404	3,582	3,794	3,956	4,331	4,627	4,943	37,950
Added federal cost as a percentage of GDP[f]	12.3%	12.7%	12.8%	12.8%	13.0%	13.2%	13.3%	14.0%	14.4%	14.8%	

[a] CMS, *NHE Projections 2017–2026*, February 2018, table 2, extrapolated. The totals calculated here differ slightly from those in the NHE tables (e.g., 3,859 vs. 3,869) because of reconciliation with MEPS data as explained in footnote 19. In the MEPS data, some small category totals are rounded to 0, causing national aggregates to add inexactly.

[b] This includes effects of covering the uninsured, increasing the actuarial value of insurance by eliminating deductibles and copayments and by expanding coverage categories to include dental, vision, and hearing.

[c] CMS, *NHE Projections 2017–2026*, table 1, extrapolated.

[d] This subtracts state "maintenance of effort" payments and continued out-of-pocket payments for LTSS, continued private or state funding of research, and capital expenditures from NHE. Holahan et al., *Sanders Single-Payer Healthcare Plan*; and Medicare for All Act of 2017, S. 1804, 115th Cong. (2017).

[e] This includes federal Medicaid payments, Medicare outlays net of receipts, tax subsidies for employer-provided and ACA marketplace coverage, CHIP, other ACA subsidies and research funding, net of revenues from employer-mandate penalties and taxes on health insurance plans and providers. See CBO, *Federal Subsidies for Health Insurance Coverage for People under Age 65: 2018–2028*, May 23, 2018; CBO, *Medicaid Spending and Enrollment—CBO's April 2018 Baseline*, April 2018; and CBO, *Medicare—CBO's April 2018 Baseline*, April 9, 2018. CBO estimates were extrapolated beyond 2028, with adjustments for the additional Medicare payments projected to occur within 2028 because October 1 (the start of the next fiscal year) occurs on a weekend.

[f] CBO, *The Budget and Economic Outlook: 2018–2028*, April 9, 2018.

Table 5. Financial Effects of Medicare for All Act without Provider Payment Cuts if Benefits Were Fully Effective in 2019, in Billions of Dollars

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019–2028
Currently projected personal healthcare spending[a]	3,276	3,458	3,655	3,859	4,077	4,309	4,546	4,824	5,120	5,433	
+ Added induced demand from increased coverage[b]	+370	+390	+412	+435	+459	+485	+511	+542	+574	+609	+4,787
Provider payment changes	0	0	0	0	0	0	0	0	0	0	0
– Drug cost savings	–50	–54	–57	–61	–66	–70	–75	–80	–86	–92	–692
= Healthcare spending under M4A	3,595	3,794	4,010	4,233	4,471	4,724	4,982	5,286	5,608	5,950	
Currently projected national health expenditures (NHE)[c]	3,868	4,091	4,322	4,562	4,819	5,091	5,370	5,696	6,042	6,410	
+ Change in healthcare spending	+319	+336	+355	+374	+394	+415	+436	+462	+489	+517	+4,096
– Admin. cost savings	–70	–74	–78	–83	–88	–142	–149	–158	–168	–179	–1,190
= NHE under M4A	4,117	4,353	4,598	4,852	5,125	5,364	5,657	5,999	6,363	6,748	
Federal gov't share of NHE under M4A[d]	3,925	4,152	4,386	4,628	4,886	5,111	5,388	5,712	6,056	6,421	
– Currently projected net federal health subsidies[e]	–1,406	–1,475	–1,573	–1,709	–1,770	–1,833	–1,984	–2,130	–2,262	–2,465	
= Added federal budget cost under M4A	2,519	2,677	2,813	2,919	3,117	3,278	3,404	3,582	3,794	3,956	32,059
Added federal cost as a percentage of GDP[f]	11.9%	12.1%	12.3%	12.3%	12.7%	12.8%	12.8%	13.0%	13.2%	13.3%	

[a] CMS, *NHE Projections 2017–2026*, February 2018, table 2, extrapolated. The totals calculated here differ slightly from those in the NHE tables (e.g., 3,859 vs. 3,869) because of reconciliation with MEPS data as explained in footnote 19. In the MEPS data, some small category totals are rounded to 0, causing national aggregates to add inexactly.

[b] This includes effects of covering the uninsured, increasing the actuarial value of insurance by eliminating deductibles and copayments and by expanding coverage categories to include dental, vision, and hearing.

[c] CMS, *NHE Projections 2017–2026*, table 1, extrapolated.

[d] This subtracts state "maintenance of effort" payments and continued out-of-pocket payments for LTSS, continued private or state funding of research, and capital expenditures from NHE. Holahan et al., *Sanders Single-Payer Healthcare Plan*; and Medicare for All Act of 2017, S. 1804, 115th Cong. (2017).

[e] This includes federal Medicaid payments, Medicare outlays net of receipts, tax subsidies for employer-provided and ACA marketplace coverage, CHIP, other ACA subsidies and research funding, net of revenues from employer-mandate penalties and taxes on health insurance plans and providers. See CBO, *Federal Subsidies for Health Insurance Coverage for People under Age 65: 2018–2028*, May 23, 2018; CBO, *Medicaid Spending and Enrollment—CBO's April 2018 Baseline*, April 2018; and CBO, *Medicare—CBO's April 2018 Baseline*, April 9, 2018. CBO estimates were extrapolated beyond 2028, with adjustments for the additional Medicare payments projected to occur within 2028 because October 1 (the start of the next fiscal year) occurs on a weekend.

[f] CBO, *The Budget and Economic Outlook: 2018–2028*, April 9, 2018.

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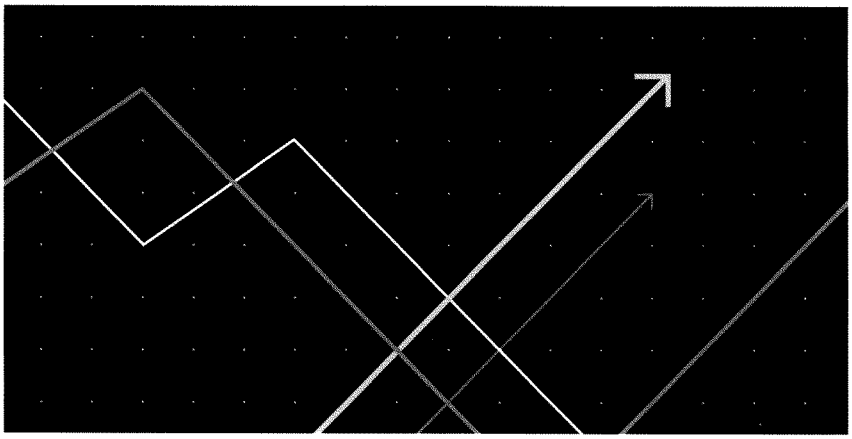

RESEARCH REPORT

The Sanders Single-Payer Health Care Plan

The Effect on National Health Expenditures and Federal and Private Spending

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The Sanders Single-Payer Health Care Plan

Presidential candidate Senator Bernie Sanders has called for adopting a single-payer health care system in the United States.[1] He proposes replacing the programs established under the Affordable Care Act (ACA), as well as preexisting public programs such as Medicaid and Medicare, with the new system. Under his approach, all individuals in the United States would be covered by a single insurance program. Sanders's plan would eliminate all private spending and replace all private and public coverage programs, except Veterans Health Insurance and the Indian Health Service. Benefits provided under the insurance plan would cover all medically necessary services, and cost sharing would be eliminated entirely. Coverage would include both acute and long-term care.

We analyze the effects of Sanders's approach on spending by governments, households, and employers, using information publicly provided by the campaign and making our assumptions explicit where detailed information is not available. In companion work, the Urban-Brookings Tax Policy Center estimated the revenue effects of the same proposal (Sammartino et al. 2016). Highlights from the revenue analysis, available in its entirety separately, are referenced here.

We estimate the impact of the Sanders plan on federal health expenditures and national personal health expenditures. We use three approaches, separately estimating the following changes:

- Changes in acute care spending for the nonelderly who would not have Medicare under current law (for simplicity, referred to as "the nonelderly"). This is by far the largest component of the analysis and is estimated using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).
- Changes in acute care spending on those otherwise enrolled in Medicare. Enhancements to Medicare are estimated using a spreadsheet model and assumptions about the different effects of the proposal.
- Changes in spending on long-term services and supports. We use the Urban Institute's Dynamic Simulation of Income Model (DYNASIM) to estimate the cost of a fully federally financed comprehensive long-term care plan.

The overall results are shown in table 1. The underlying assumptions and more detailed results are presented in the following sections.

Our central findings of the effects of the Sanders approach are shown in table 1 and include the following:

- All American residents would be automatically enrolled in acute care coverage, increasing insurance coverage by an estimated 28.3 million people in 2017, from an uninsurance rate for nonelderly adults of 10.4 percent under current law in 2017. In 2026, the Sanders plan would decrease the number of nonelderly uninsured by 30.9 million, or 11.0 percent of the population, relative to current law. (The uninsurance rate under current law in 2026 is projected to be larger than the rate in 2017 as a result of demographic changes and a slight decrease in the rate of employer-sponsored insurance.) Although the intent is unspecified in the campaign's materials, this finding assumes that the plan would cover the undocumented population as well as citizens and other legal residents.

- National health expenditures for acute care for the nonelderly would increase by $412.0 billion (22.9 percent) in 2017. Aggregate spending on acute care services for those otherwise enrolled in Medicare would increase by $38.5 billion (3.8 percent) in 2017. Long-term service and support expenditures would increase by $68.4 billion (28.6 percent) in 2017.

- Together, national health expenditures would increase by a total of $518.9 billion (16.9 percent) in 2017, and by 6.6 trillion (16.6 percent) between 2017 and 2026.

- The increase in federal expenditures would be considerably larger than the increase in national health expenditures because substantial spending borne by states, employers, and households under current law would shift to the federal government under the Sanders plan. Federal expenditures in 2017 would increase by $1.9 trillion for acute care for the nonelderly, by $465.9 billion for those otherwise enrolled in Medicare, and by $212.1 billion for long-term services and supports.

- In total, federal spending would increase by about $2.5 trillion (257.6 percent) in 2017. Federal expenditures would increase by about $32.0 trillion (232.7 percent) between 2017 and 2026. The increase in federal spending is so large because the federal government would absorb a substantial amount of current spending by state and local governments, employers, and households. In addition, federal spending would be needed for newly covered individuals, expanded benefits and the elimination of cost sharing for those insured under current law, and the new long-term support and services program.

- State and local governments could save $319.8 billion in 2017 and $4.1 trillion between 2017 and 2026 as the federal government absorbs these costs under the Sanders plan (not shown in table 1). A maintenance-of-effort requirement could make state and local funds available to help pay for the plan, but the legality of such a requirement is in question.
- Private health care spending by households and employers would drop as the federal government would absorb their spending under current law. Private sector expenditures for these groups would decrease by $1.7 trillion in 2017 and by $21.9 trillion between 2017 and 2026. These considerable savings would partially offset the impact on the private sector of new taxes required to pay for the Sanders plan.
- Analysis by the Tax Policy Center indicates that Sanders's revenue proposals, intended to finance all new health and nonhealth spending, would raise $15.3 trillion in revenue over 2017 to 2026. This amount is approximately $16.6 trillion less than the increased federal cost of his health care plan estimated here. The discrepancy suggests that to fully finance the Sanders approach, additional sources of revenue would have to be identified; that is, the proposed taxes are much too low to fully finance the plan.

TABLE 1

The Sanders Plan: The Impact on National Health Expenditures and Federal Spending, 2017 and 2017–2026

	2017	2017–2026
ACUTE CARE SPENDING FOR THE NONELDERLY UNDER SANDERS PLAN COMPARED TO CURRENT LAW[a]		
Increase in acute care spending ($ billions)	**$412.0**	**$4,996.1**
Percent increase	22.9%	22.1%
Increase in federal acute care spending ($ billions)	**$1,858.0**	**$23,227.8**
Percent increase	523.4%	531.4%
ACUTE CARE SPENDING UNDER SANDERS PLAN FOR THOSE OTHERWISE COVERED BY MEDICARE COMPARED TO CURRENT LAW[a]		
Increase in acute care spending ($ billions)	**$38.5**	**$507.5**
Percent increase	3.8%	3.6%
Increase in federal acute care spending ($ billions)	**$465.9**	**$5,838.6**
Percent increase	77.9%	71.4%
SPENDING ON LTSS UNDER SANDERS PLAN COMPARED TO CURRENT LAW		
Increase in LTSS spending ($ billions)	**$68.4**	**$1,093.8**
Percent increase	28.6%	35.9%
Increase in federal LTSS spending ($ billions)	**$212.1**	**$2,937.2**
Percent increase	221.4%	244.3%
TOTAL INCREASE IN SPENDING UNDER SANDERS PLAN COMPARED TO CURRENT LAW		
Increase in national health spending ($ billions)	**$518.9**	**$6,597.4**
Percent increase	16.9%	16.6%
Increase in federal spending ($ billions)	**$2,536.0**	**$32,003.5**
Percent increase	257.6%	232.7%
DECREASE IN PRIVATE HEALTH SPENDING (HOUSEHOLDS, EMPLOYERS) UNDER SANDERS PLAN COMPARED TO CURRENT LAW		
Decrease in private health spending[b] ($ billions)	**$1,679.7**	**$21,850.8**
Decrease in acute care spending for the nonelderly[a]	$1,240.0	$15,617.5
Decrease in acute care spending for those otherwise covered by Medicare[a]	$369.0	$5,050.4
Decrease in spending for LTSS	$70.7	$1,183.0
DECREASE IN UNINSURED UNDER SANDERS PLAN COMPARED TO CURRENT LAW		
	2017	**2026**
Decrease in uninsured	28.3 million	30.9 million
Uninsurance rate under current law	10.4%	11.0%

Source: Urban Institute analysis.

Notes: LTSS = long-term services and supports.

[a] Here, "acute care" includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

[b] Private health spending in this table includes spending by households and employers; it does not include spending by other sources, such as providers.

Background: The Sanders Proposal and Prior Estimates

The core of the Sanders proposal is comprehensive first-dollar government-financed health insurance for all Americans, with no benefit limits. Available materials do not specify whether the plan would provide coverage to undocumented immigrants, whether other provisions would be made for financing their care, or whether no such provisions would be made. According to campaign materials, benefits would range from "inpatient to outpatient care, preventive to emergency care, primary care to specialty care, including long-term care and palliative care, vision, hearing, and oral health care, mental and substance abuse services as well prescription medications, medical equipment and supplies, diagnostics and treatment."[2] The impact of the coverage and benefit expansions on expenditures would be partially offset by the government's use of its bargaining power to lower provider payment rates and, in turn, overall health care spending. Administrative costs would also be lower because of the efficiencies resulting from a number of sources, including no private insurance companies, uniform payment rates, and automatic enrollment (i.e., savings on marketing costs). Statements made by the Sanders campaign seem to suggest that he assumes a dramatic reduction in provider payment rates would be largely immediate; the growth rate of health spending would also be lower.

Federal government costs would increase substantially, but direct spending by employers who currently provide coverage and individuals who pay premiums and incur out-of-pocket costs would decrease considerably. The additional government costs would be financed by various taxes, described below. It is not clear whether the Sanders plan would allow individuals to purchase private insurance. Although the plan does not envision a need for coverage for supplemental benefits because no benefits would be excluded from the government coverage, some countries with single-payer systems do allow individuals to purchase private coverage to obtain care from providers with shorter wait times for services, usually in separate facilities. It also is not clear whether the Sanders plan would allow the continued operation of integrated health systems, such as Kaiser or Geisinger, entities that combine the direct provision of medical care with the insurers' role of managing the efficient provision and use of care. Also unclear is what would happen to Medicare Advantage.

The Sanders campaign estimates that their health program would lead to new public expenditures of $13.8 trillion from 2017 to 2026. This figure incorporates the campaign's estimate of the costs of coverage for the remaining uninsured, the universal expansion of benefits, the elimination of deductibles and copayments, the introduction of long-term care coverage, savings from lower administrative costs and provider payment rates, and the impact of provider supply constraints. After subtracting $3.1 trillion in reduced tax expenditures resulting largely from the elimination of the

current tax exclusion for employer-sponsored insurance, the campaign estimates that $10.7 trillion of new revenues would be needed. They propose a 2.2 percent income-based premium on households, a 6.2 percent payroll tax imposed on employers, additional revenues from revisions to the estate tax, increases in taxes on capital gains and dividends, new limits on deductions for high-income taxpayers, and increases in income taxes that largely affect high-income people. They anticipate that low-income individuals would save because the amounts they would be required to pay in new taxes would be less than what they are required to pay today in premiums, cost sharing, and other tax payments.

Similarly, employers that now provide coverage would pay less because their obligations under the proposed approach would be limited to the 6.2 percent payroll tax paid by employers. In contrast, across all employers (i.e., including those who offer health insurance and those who do not), employer-paid premiums for health insurance benefits currently average 8.3 percent of total compensation.[3] Higher-income individuals would be expected to pay considerably more toward health expenses than they do today.

Emory University professor and health economist Kenneth Thorpe (2016) independently estimates the cost of the Sanders plan at $1.8 trillion in 2017 and $24.7 trillion over the 10-year period beginning in 2017. These costs are based on current expenditures, making separate adjustments for current law Medicare enrollees, Medicaid enrollees, the privately insured, and the uninsured. For all populations, he assumes provider payment rates under Sanders would be set to 105 percent of health care costs (in other words, increasing such rates for Medicare and Medicaid enrollees and decreasing them for the privately insured) and that administrative costs of the program would be 4.7 percent of spending on health care services.

He assumes higher health care utilization under the Sanders proposal for current law Medicare enrollees without Medicaid and Medigap coverage, because the proposal would eliminate their deductibles and copayments. He also includes estimates for additional benefits such as dental care, vision, and hearing that are not provided under Medicare but would be covered by Sanders. Thorpe also assumes that states would be required to make ongoing maintenance-of-effort payments for their prior spending on the Medicaid and the Children's Health Insurance Program, with these payments offsetting federal costs of the reform.

Thorpe estimates that the Sanders approach would increase spending on the uninsured 70 percent over current spending levels, an estimate he considers low. Further, Thorpe estimates that spending on the currently insured would increase 10 percent, taking into account the greater generosity of coverage provided under the Sanders proposal. Finally, he assumes that the rate of growth in health care

spending would be 0.5 percentage points below current projections. He does not estimate long-term care benefits other than incorporating current Medicaid long-term care expenditures (which are currently financed by federal, state, and local governments) as fully federal spending under the Sanders plan.

Our approach differs from Thorpe's in several ways, and our methods are described in detail in the sections below. However, there are some central differences:

- We start with different data and modeling assumptions, leading to differences in population, coverage, and spending projections. Our nonelderly population and coverage estimates use simulation modeling based on the American Community Survey, which supports greater detail such as estimates related to undocumented immigrants. Our population and spending estimates for the Medicare population are based on the most recent Congressional Budget Office Medicare baseline.[4]
- We make different assumptions about key factors, including payment rates (for hospitals, physicians, and prescription drugs), administrative costs, induced demand, supply constraints, spending growth rates, and state maintenance-of-effort requirements.
- We include estimated spending for universal long-term services and supports.

Detailed Methods and Results

Acute Health Care for the Nonelderly

METHODS

Our estimates of the cost of the Sanders plan for acute care[5] for the nonelderly (excluding the nonelderly who would otherwise be enrolled in Medicare) are based on HIPSM, a microsimulation model of the cost and coverage effects of health care reforms (Buettgens 2011). We assume that all US residents, including the undocumented population, would be automatically enrolled in coverage, leading to universal insurance coverage. Although the Sanders campaign does not specify their intended treatment of the undocumented population, we assume they would be included because all government programs that currently help finance uncompensated care (e.g., Medicare and Medicaid disproportionate-share hospital payments) would be eliminated. (Spending related to those otherwise

enrolled in Medicare, both elderly and nonelderly, are estimated in the "Acute Health Care for Those Otherwise with Medicare Coverage" section.)

In the HIPSM model, current law health care coverage and costs are based upon reported insurance status, but the model also computes hypothetical costs for each individual under each possible health insurance status (i.e., enrollment in employer coverage, private nongroup coverage, Medicaid, or uninsurance). These hypothetical health care costs are used if a simulation indicates the individual would change his or her health insurance status. In estimating the Sanders proposal for first-dollar coverage for broadly comprehensive benefits without benefit caps or limits, we build off HIPSM's estimates of health care costs as if all individuals age 64 and younger were enrolled in Medicaid (as Medicaid benefits most closely resemble those promised under Sanders's plan). We increase the universal Medicaid spending estimates to account for our assumption that the federal government would pay considerably higher provider payment rates under the Sanders plan than states do under the average Medicaid plan.

By building off estimated Medicaid expenditures, we have the advantage of starting with a spending base that reflects a 100 percent actuarial value plan, that is, full benefits with no cost sharing. Using Medicaid also incorporates supply constraints into our estimates. That is, the Sanders plan would increase demand for health services by eliminating individuals' direct contributions to care (i.e., by eliminating deductibles, copayments, and coinsurance), but not all increased demand could be met because provider capacity would be insufficient.[6] By basing our estimates on spending within a universal Medicaid program, we implicitly incorporate the provider supply constraints faced by current Medicaid enrollees, applying to all US residents the health care utilization decreasing effect of the program's low rates of provider participation. This approach produces lower health care cost estimates than if we had assumed that all increased demand would be met. We do not adjust these estimated Medicaid costs upward to account for the fact that some state Medicaid programs impose benefit or service limits under current law. If we had done so, our cost estimates would have been somewhat higher than shown here. If supply constraints under the Sanders approach end up being lower than in the current-law Medicaid program, that is another source of underestimation of new costs in our analysis.

We inflate our estimated Medicaid costs to account for higher provider reimbursement rates. We assume that the Sanders plan would pay physicians and other providers at Medicare rates for all enrollees. The main exception is hospital payment rates, which we increase to 100 percent of costs because Medicare hospital payment rates are estimated to be 89 percent of costs, on average (American Hospital Association 2015). We also increase estimated Medicaid spending for prescription

drugs by a factor of 1.5 to account for our assumptions that the Sanders formularies would be less restrictive than Medicaid's and that the payment rates would be higher than Medicaid's.[7] This assumed increase over current-law Medicaid prescription drug payment rates is still equivalent to payment rates 25 percent below Medicare's prescription drug payment rates. It simply does not seem plausible to assume that the current Medicaid prescription drug rebates of about 50 percent could be applied to all individuals. This would be far too great a financial blow to the existing pharmaceutical and medical device industries, even assuming it would be possible to enact such proposals into law. We also assume a lower rate of growth in all health expenditures, 0.5 percentage points below current estimates each year, reflecting the potential impact of a large government monopsony payer.

We assume administrative costs of 6 percent of claims, based on the Centers for Medicare & Medicaid Services measure of Medicare's administrative expenditures in the National Health Expenditure Accounts. This is the appropriate figure for estimating proposals that build upon the entire Medicare program, not just traditional Medicare (Sullivan 2013). Although managed care providers, such as Kaiser, Geisinger, and others, are not specified in the Sanders materials, we assume they would be permitted because they provide valuable utilization management and quality control functions. In addition, 6 percent is plausible in this scenario because that is slightly below average for large firms' administrative costs. We do not believe that administrative costs can fall far below this level; far too many administrative functions must be conducted. One such function is rate setting for a wide array of providers, including both fee-for-service and any capitated providers that would remain—the latter would require separate payment negotiations. In the fee-for-service world, a considerable amount of care management and utilization control would be required, as would oversight and enforcement activities that prevent financial abuses by providers and ensure sufficient quality of care.

Because the HIPSM model includes detailed characteristics of each nonelderly individual, we can calculate their health expenditures under current law from 2017 to 2026 and how much of the expenditures are paid by the individuals themselves, public programs, employers, or health care providers.[8] Then, we use the model to estimate expenditures for all nonelderly people under the Sanders plan for those 10 years and compare that with current-law projections. We are then able to estimate the changes in health care spending for individuals with various characteristics. However, our estimates do not include the increased tax burden that has been estimated independently by the Urban-Brookings Tax Policy Center (Sammartino et al. 2016).

RESULTS

We estimate that under current law, 28.3 million people under age 65 will be uninsured in 2017. The Sanders plan would provide automatic coverage to all these individuals, eliminating the uninsured. Providing comprehensive health coverage for acute care without cost sharing, as specified in Sanders's proposal, to the nonelderly population—an estimated 272 million people—would cost $2.2 trillion in 2017. This is a 22.9 percent increase in personal national health expenditures over current levels for this population, reflecting the expansion of coverage to all Americans, the elimination of cost sharing, and the more comprehensive benefits relative to private coverage under current law (table 2). Acute care for the nonelderly would cost $27.6 trillion from 2017 to 2026, an increase of $5.0 trillion, or 22.1 percent relative to current law. Under current law, the federal government would spend $355.0 billion on acute care for the nonelderly in 2017 and $4.4 trillion from 2017 to 2026. Thus, there would be $1.9 trillion in additional federal spending in 2017 and $23.2 trillion in additional federal spending from 2017 to 2026.

TABLE 2

Acute Health Care Spending for the Nonelderly: Sanders Plan versus Current Law, 2017 and 2017–2026

	2017				2017–2026			
	Sanders plan ($ billions)	Current law ($ billions)	Difference ($ billions)	Difference %	Sanders plan ($ billions)	Current law ($ billions)	Difference ($ billions)	Difference %
Total acute health care spending for the nonelderly	$2,213.0	$1,801.0	$412.0	22.9%	$27,599.0	$22,602.9	$4,996.1	22.1%
Federal acute health care spending for the nonelderly	$2,213.0	$355.0	$1,858.0	523.4%	$27,599.0	$4,371.3	$23,227.8	531.4%

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2016.
Note: Here, the term "acute care" includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

Current spending for nonelderly acute care is shared among federal, state, and local governments; employers; households; and in-kind payments by providers. If existing costs were federalized, spending by state and local governments would be eliminated (a decrease in spending of $188.5 billion), as would

spending by employers ($749.8 billion), households ($490.3 billion), and providers ($17.6 billion in in-kind contributions; table 3). Thus, although federal spending on nonelderly acute care would increase by $1.9 trillion in 2017 under the Sanders plan, the savings for other payers would be considerable and would partially offset the financial burden of new taxes required to pay for the reform.

TABLE 3

Acute Health Care Spending for the Nonelderly under Current Law, 2017, by Source of Spending
($ billions)

	Total	Federal government	State/local government	Employers	Households	Providers
Acute health care spending for the nonelderly (public and private)	$1,801.0	$354.9	$188.5	$749.8	$490.3	$17.6

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2016.
Note: Here, the term "acute care" includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

The greatest increases in health care spending under the Sanders plan compared with current law occur on behalf of those with the lowest incomes, because the currently uninsured and underinsured are now concentrated in those income groups (table 4). Spending on behalf of those with incomes below the federal poverty level (FPL) would increase 47.9 percent, and spending on behalf of those with incomes between 100 and 200 percent of FPL would increase 32.9 percent. Even those with higher incomes would consume more health care services, however, because their current out-of-pocket spending would be eliminated, increasing their use of care. Spending on behalf of those with incomes above 400 percent of FPL would increase 6.1 percent in aggregate.

Of the $2.2 trillion in total acute care spending for the nonelderly that we estimate would occur in 2017 under the Sanders proposal, we estimate that $77.0 billion would be spent on health care for undocumented immigrants (table 5). Another $166.0 billion would be spent on those who would be uninsured under current law. Health care spending for the otherwise uninsured would increase 169.5 percent. The remaining $2.0 trillion would be spent on those who currently have health insurance. Their spending would increase 15.5 percent; they would receive more comprehensive benefits on average, and the elimination of cost sharing would lead to greater use of care.

TABLE 4

Acute Health Care Spending for the Nonelderly: Sanders Plan versus Current Law, 2017

	Sanders plan ($ billions)	Current law ($ billions)	Difference ($ billions)	Difference %
Total acute health care spending for the nonelderly	$2,213.0	$1,801.0	$412.0	22.9%
Income by federal poverty level				
< 100%	$562.0	$380.0	$182.0	47.9%
100–200%	$392.0	$295.0	$97.0	32.9%
201–300%	$322.0	$263.0	$59.0	22.4%
301–400%	$261.0	$226.0	$35.0	15.5%
> 400%	$676.0	$637.0	$39.0	6.1%

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2016.
Note: Here, the term "acute care" includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

TABLE 5

Acute Health Care Spending for the Nonelderly: Sanders Plan versus Current Law, 2017, by Current Coverage

	Sanders plan ($billions)	Current law ($ billions)	Difference ($ billions)	Difference %
Total acute health care spending for the nonelderly (public and private)	$2,213.0	$1,801.0	$412.0	22.9%
Coverage under the current law				
Insured	$1,970.0	$1,705.0	$265.0	15.5%
Uninsured	$166.0	$61.6	$104.4	169.5%
Undocumented immigrants	$77.0	$34.4	$42.6	124.0%

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2016.
Note: Here, the term "acute care" includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

Acute Health Care for Those with Medicare Coverage under Current Law

METHODS

This section describes our estimates of the cost of the Sanders plan for those who would be enrolled in Medicare under current law. The HIPSM model estimates above do not include spending for those enrolled in Medicare or spending on long-term services and supports, regardless of age; we address the latter in the "Long-Term Services and Supports" section. The estimates in this section include acute care costs for elderly and nonelderly individuals who would be enrolled in Medicare under current law (including nonelderly people with disabilities).[9] These estimates include spending on postacute stays in nursing facilities or postacute home care that Medicare would cover under current law.

For those otherwise enrolled in Medicare, we estimate the cost of the Sanders plan to be equal to the sum of current-law Medicare spending (Congressional Budget Office 2016), Medigap expenditures,[10] out-of-pocket spending for Medicare-covered services,[11] out-of-pocket spending for services not covered under Medicare (Nonnemaker and Sinclair 2009), Medicaid spending on Medicare coinsurance and premiums (Centers for Medicare & Medicaid Services 2013), estimated Medicaid acute care spending for those enrolled in Medicare,[12] and spending by employers and employees on retiree and employee coverage for those also enrolled in Medicare (McArdle, Neuman, and Huang 2014; Mercer 2013). We then assume additional spending that would be induced by the elimination of deductibles, copayments, and coinsurance for current-law Medicare beneficiaries who do not have supplemental coverage such as Medigap or Medicaid to wrap around their Medicare benefits. We estimate a smaller increase in spending for those who would otherwise face cost sharing under supplemental Medicare coverage, including Medigap, Medicare Advantage, or employer coverage, and we assume an increase in spending for current-law Medicare enrollees who do not have prescription drug coverage.

We also assume additional costs because the Medicare benefit package is not as comprehensive as what would be provided under Sanders, namely coverage of dental, vision, and hearing services.[13] We increase hospital payment rates to 100 percent of costs for Medicare hospital payments.[14] Physicians and other providers are assumed to be paid at Medicare rates. We reduce current-law Medicare drug spending 25 percent, assuming the federal government would begin direct price negotiations with pharmaceutical companies under the Sanders approach, and this adjustment is partly based on price comparisons in a recent report of the Office of the Inspector General (Levinson 2015). We subtract the administrative cost related to current benefit spending in Medicare and replace it with the common 6 percent administrative cost assumption that we make for the Sanders program as a whole.

Increased spending on the Medicare population attributable to the elimination of cost sharing is estimated based on published induction factors (US Department of Health and Human Services 2013). For spending increases related to those who currently have Medicare and no supplemental insurance, such as Medigap or employer-sponsored insurance, we apply a 4 percent induction factor; for those with supplemental insurance, we apply a 3.5 percent induction factor.[15]

RESULTS

Under the current system, an estimated $1.0 trillion in health care spending for those enrolled in Medicare in 2017 is spread across several payers (table 6). These payers are the federal government ($597.8 billion), state and local governments ($58.4 billion), employers ($43.1 billion) and households ($325.9 billion). Overall, acute care spending on those otherwise enrolled in Medicare would amount to $1,063.7 billion under the Sanders plan in 2017 compared with $1,025.2 billion under current law, a difference of $38.5 billion and a relative increase of 3.8 percent (table 7). The increase in federal spending on acute care for those otherwise enrolled in Medicare under the Sanders plan is projected to be $465.9 billion, a 77.9 percent increase in federal spending relative to current law for this population. Additional detail on spending for those otherwise enrolled in Medicare under current law and under the Sanders plan is provided in tables 6 and 7, respectively.

Under current law, spending by the federal government on Medicare enrollees (net of spending offsets from state and local government and household spending on premiums, cost sharing, and direct provision of acute care) is attributable to spending that falls under the Medicare program ($533.6 billion) and spending that falls under the Medicaid program ($64.2 billion; table 6).[16] Under current law, spending by state and local governments on Medicare enrollees includes Medicare Part D payments by states ($10.0 billion), state and local Medicaid funding of acute care spending for those with Medicare ($41.1 billion), and state and local Medicaid funding of Medicaid-covered Medicare premiums and cost sharing ($7.3 billion).

Individuals with Medicare coverage supplement Medicare benefits through spending in several categories: Medicare premiums collected for Parts A, B, and D ($92.0 billion); Medigap premiums for Medicare-covered services ($33.2 billion); out-of-pocket spending for Medicare-covered benefits ($117.9 billion); out-of-pocket spending for benefits not covered by Medicare ($24.5 billion); and employees' and retirees' premium contributions for employer-sponsored health insurance ($58.3 billion).[17] Employers spend on health care for those enrolled in Medicare through employer-based insurance and retiree premium contributions ($43.1 billion).

TABLE 6

Acute Health Care Spending under Current Law for Those with Medicare, 2017

	Spending under current law ($ billions)
Total acute care spending under current law for those with Medicare	**$1,025.2**
Federal spending	**$597.8**
Federal Medicare[a]	$533.6
Federal Medicaid (for those with Medicare)	$64.2
State and local spending	**$58.4**
Medicare Part D payments by states	$10.0
State/local Medicaid funding of acute care spending for those with Medicare	$41.1
State/local Medicaid funding of Medicaid-covered Medicare premiums and cost sharing	$7.3
Employer spending	**$43.1**
Employer share of employee and retiree premium contributions for health insurance sponsored by employer	$43.1
Household spending for those with Medicare	**$325.9**
Medicare premiums collected for Parts A, B, and D	$92.0
Estimated Medigap premiums for covered services	$33.2
Estimated out-of-pocket costs for Medicare-covered benefits	$117.9
Estimated out-of-pocket costs for benefits not covered by Medicare	$24.5
Employee and retiree share of premium contributions for health insurance sponsored by employer	$58.3

Sources: Urban Institute analysis of data and estimates from American Hospital Association (2015); Centers for Medicare & Medicaid Services (2013); Congressional Budget Office (2016); Cubanski et al. (2014); Garfield et al. (2015); Jacobson, Huang, and Neuman (2014); Levinson (2015); McArdle, Neuman, and Huang (2014); Mercer (2013); Nonnemaker and Sinclair (2009); Sullivan (2013); and US Department of Health and Human Services (2013).

Note: Here, the term "acute care" includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

[a] The federal Medicare amount is net of spending offsets from state and local government and household spending on premiums, cost sharing, and acute care. The Medicare benefit spending amount includes an estimated 6 percent administrative cost.

Spending for acute care under the Sanders plan for those otherwise enrolled in Medicare ($1,063.7 billion) would entail fully federalizing existing Medicare spending and spending related to the additional benefits being provided, plus the elimination of beneficiary cost sharing. This includes federalizing current-law state and local spending ($58.4 billion), current-law employer spending ($43.1 billion), and current-law household spending ($325.9 billion).

TABLE 7

Federal Acute Health Care Spending under Sanders Plan for Those Otherwise Covered by Medicare, 2017

	Spending under Sanders plan for those otherwise covered by Medicare, 2017
Total acute care spending under Sanders plan for those otherwise covered by Medicare ($ billions)	**$1,063.7**
Current law spending ($ billions)	**$1,025.2**
Current law federal spending	$597.8
Federalization of current law state/local spending	$58.4
Federalization of current law employer spending	$43.1
Federalization of current law household spending	$325.9
Additional federal spending and savings ($ billions)	**$38.5**
Decrease in Medicare prescription drug spending from payment rate adjustment	-$24.9
Additional prescription drug costs for Medicare enrollees who do not currently have prescription drug coverage	$17.0
Additional Medicare hospital spending from payment rate adjustment	$25.3
Additional Medicare spending of Medicare enrollees who have cost sharing under current law due to lack of supplemental coverage or cost sharing under various supplemental coverage arrangements	$21.1
Increase in total acute care spending under Sanders plan compared to current law for those otherwise covered by Medicare ($ billions)	**$38.5**
Percent increase	3.8%
Increase in federal acute care spending under Sanders plan compared to current law for those otherwise covered by Medicare ($ billions)	**$465.9**
Percent increase	77.9%

Sources: Urban Institute analysis of data and estimates from American Hospital Association (2015); Centers for Medicare & Medicaid Services (2013); Congressional Budget Office (2016); Cubanski et al. (2014); Garfield et al. (2015); Jacobson, Huang, and Neuman (2014); Levinson (2015); McArdle, Neuman, and Huang (2014); Mercer (2013); Nonnemaker and Sinclair (2009); Sullivan (2013); and US Department of Health and Human Services (2013).
Note: Here, the term "acute care" includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

Spending on this population would increase under the Sanders plan in three ways: the provision of drug coverage to current-law Medicare enrollees who do not have it ($17.0 billion); increased payment rates for hospital care, bringing payments up to 100 percent of costs ($25.3 billion); and additional spending induced by the elimination of cost-sharing requirements ($21.1 billion).[18] Spending on those otherwise covered by Medicare would decrease under the Sanders plan because of savings related to a prescription drug payment-rate adjustment (-$24.9 billion); this is netted out of the new spending of $38.5 billion.

Consistent with our assumptions regarding acute care for the nonelderly, we assume that acute health care spending on behalf of those otherwise enrolled in Medicare would grow 0.5 percentage points more slowly under the Sanders plan than under current law.[19] Still, under the Sanders plan, federal spending on acute care for those otherwise enrolled in Medicare would be $14.0 trillion from 2017 to 2026 compared with $8.2 trillion under current law. This difference of $5.8 trillion represents a relative increase in spending of 71.4 percent (table 8).

TABLE 8

Federal Acute Health Care Spending for Medicare Beneficiaries under Current Law and under Sanders Plan in 2017 and 2017–2026

2017				2017–2026			
		Difference				Difference	
Sanders plan ($ billions)	Federal spending under current law ($ billions)	($ billions)	%	Sanders plan ($ billions)	Federal spending under current law ($ billions)	($ billions)	%
$1,063.7	$597.8	$465.9	77.9%	$14,020.4	$8,181.9	$5,838.6	71.4%

Sources: Urban Institute analysis of data and estimates from American Hospital Association (2015); Centers for Medicare & Medicaid Services (2013); Congressional Budget Office (2016); Cubanski et al. (2014); Garfield et al. (2015); Jacobson, Huang, and Neuman (2014); Levinson (2015); McArdle, Neuman, and Huang (2014); Mercer (2013); Nonnemaker and Sinclair (2009); Sullivan (2013); and US Department of Health and Human Services (2013).
Notes: The spending growth factor applied to the Sanders plan is 1.060, while the growth factor applied to federal spending under current law is 1.065. Here, "acute care" includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

Long-Term Services and Supports

METHODS

Because the Sanders plan has limited detail related to its proposal to provide universal long-term services and supports (LTSS), we focus on capturing its stated intention: to cover costs for LTSS for those with high-level LTSS needs.[20] For many, LTSS needs are not now covered by government programs or private insurance. We make a series of assumptions that we believe captures the spirit of the proposal. Our estimates are generated using DYNASIM, the Urban Institute's simulation model designed to analyze the distributional consequences of retirement and aging issues, including projections of needs and expenditures for LTSS.[21]

We focus here on assumptions specific to estimating costs for the Sanders proposal. DYNASIM's baseline LTSS assumptions about disability prevalence and service use have been documented elsewhere (Favreault, Gleckman, and Johnson 2015). Because DYNASIM's LTSS model focuses on the population age 65 and older, we use simplifying assumptions derived from literature about the nonelderly LTSS population[22] to scale DYNASIM's estimates for the full age distribution, taking service-use mix into account to approximate total plan costs.

As Medicare acute-care-covered services are accounted for elsewhere in these analyses, our estimates of LTSS benefits under the Sanders proposal do not include postacute stays in nursing facilities or postacute home care that Medicare would cover under current law; these costs are included in the "Acute Health Care for Those with Medicare Coverage under Current Law" section.

We make the following assumptions, which in general we believe to be conservative:

1. The daily benefit rate for the new program would vary by state and type of service (nursing home, home care, or residential care). Program rates for nursing homes are set at 115 percent of recently observed current-law Medicaid rates.[23] We set the rates modestly above the Medicaid rate because existing rates are estimated to fall short of costs of care in some states (Eljay, LLC and Hansen Hunter & Company 2015); further, press accounts suggest that Medicaid beneficiaries can have difficulties finding placements, given some nursing homes' preference for Medicare and other patients that pay higher rates.[24] Nursing home rates are adjusted annually thereafter for wage inflation using the intermediate assumptions of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds (2014). Program rates for home care are assumed to vary both across and within states and to average about 100 percent of current law private payment rates. Home care rates are adjusted annually thereafter for the average of wage and price inflation using the intermediate assumptions of the board of trustees' report. We assume wages grow roughly uniformly for all workers (both LTSS providers and others) and across states.[25]
2. The program would impose some limits on home care use, given that states generally set limits under Medicaid. We currently assume that the maximum daily home care benefit equals half the maximum daily benefit for nursing home care and that benefits are delivered at most five out of seven days per week.[26] Fewer than 10 percent of home care beneficiaries use the maximum amount of care in a given year. More typically, home care beneficiaries use about half the maximum benefit.
3. The new program would pay for home care services related to activities of daily living delivered in homes or residential care facilities (i.e., assisted living facilities), but it would not contribute

toward room and board. This is consistent with most states' treatment of residential care under Medicaid (Caffrey et al. 2012; Mollica 2009). Many people in residential care facilities would receive the maximum annual home care benefit under these assumptions.

4. The cost sharing that Medicaid now requires from some LTSS beneficiaries (e.g., nearly all income excluding a personal needs allowance for those in nursing homes) would no longer be required under the option, consistent with the Sanders campaign's statements about eliminating copayments and deductibles.
5. Only individuals whose disabilities meet the definition in the Health Insurance Portability and Accountability Act (HIPAA)[27] would qualify for LTSS benefits under the new program. We assume that the program would cover virtually all US residents, should they reach this disability threshold at some point in their lives. This would include individuals who do not qualify for Medicare or Social Security benefits under current law, many of whom now receive Supplemental Security Income and Medicaid. It would also include long-duration unauthorized immigrants, consistent with the intent to cover everyone.
6. We assume the benefits under the Sanders plan would begin 14 days after a determination of disability, with disability defined consistently with HIPAA. (Other proposals define deductibles using dollars spent on LTSS or days using formal services.) This assumption decreases the cost of the Sanders plan relative to a shorter waiting period but increases the cost relative to a longer waiting period. Waiting periods in which covered benefits are not provided (also known as elimination or deductible periods) are common in the private long-term care insurance market and in incremental proposals to modify LTSS financing. Given that many LTSS spells are short, this choice has cost and distributional implications.[28]
7. The new program would provide a service reimbursement benefit, not a cash benefit. This would likely affect benefit take-up. Some who would use a cash benefit for home modifications or to support care by friends or family may be less comfortable having formal providers in their homes regularly and instead continue to rely predominantly on family caregivers. (Most analysts suggest assuming effectively universal take-up of cash benefits.) Nonetheless, the new LTSS benefit could substantially increase formal service use relative to current financing arrangements. The potential increase could be large because family caregivers currently provide a large share of LTSS informally.[29] Because of likely limits in supply of formal caregivers and nursing home beds in many regions, we gradually phase in the demand for new services rather than assuming large shares of unmet need would be immediately met and the maximum amount of informal care would immediately be supplemented by formal care.

8. We assume administrative costs of 6 percent of benefit payments, consistent with the cost estimates of the Sanders proposal described above. This is higher than the costs for administering the Social Security Disability Insurance program but far lower than administrative loads in the private long-term care insurance market (Giese and Schmitz 2015).
9. The role of the private long-term insurance market (which we already assume will decline in terms of the share of the population paying premiums and receiving benefits on an age-specific basis) would be extremely limited. A small share of those who have policies may keep part of their insurance in order to be covered for services the new LTSS program would not cover (e.g., the room and board component of residential care, a higher-quality nursing home, or a greater quantity or quality of home care). However, significant transition issues would likely arise for those who have paid large amounts to policies that would mostly duplicate—and in some cases, could be less generous than[30]—the program's new benefit. These may require private insurance companies to offer enrollees or the federal government rebates from reserve funds in exchange for the government absorbing the duplicative liabilities. We ignore transition issues in the present analyses and focus on likely changes to family cash flows in the short run.
10. The Veterans Administration would continue to provide LTSS, and the new Sanders program would not replace those benefits for that population. Home care services provided by the Administration on Aging under the Older Americans Act would be replaced by the Sanders plan.

Results

We estimate that providing a comprehensive LTSS benefit to all US residents without cost sharing as specified in Sanders's proposal would cost $307.9 billion in 2017; this is a 28.6 percent increase in national health expenditures on LTSS over current levels (table 9). The cost of these new benefits would offset current-law state Medicaid spending on long-term care ($73.0 billion) and current-law federal Medicaid spending ($95.8 billion). In addition, households' current out-of-pocket expenses, direct payments to providers, and cost sharing under Medicaid would be eliminated ($62.5 billion). Households would also be relieved of payment for private long-term care insurance ($8.3 billion). Finally, we estimate that health care spending on LTSS services would increase by $68.4 billion under the Sanders plan. This takes into account the additional services individuals would choose to receive and that the market could supply in this time frame. This is not an estimate of the current-law family caregiver burden but reflects only new services that would be received; we anticipate that family

caregiving would remain an important component of LTSS. Increased costs to the federal government, after accounting for federal Medicaid savings, would be $212.1 billion in 2017.

TABLE 9

Estimated Costs and Cost Offsets for LTSS under the Sanders Plan, 2017, 2026, and 2017–2026

Estimated costs and cost offsets for LTSS under the Sanders plan	2017	2026	Total, 2017–2026
New LTSS benefit payments, including administrative expenses ($ billions)	**$307.9**	**$560.3**	**$4,139.6**
Total state Medicaid savings	$73.0	$109.7	$881.7
Total federal Medicaid savings	$95.8	$155.0	$1,202.4
Savings to families (reduced out-of-pocket expenses)	$62.5	$119.2	$872.6
Potential private long-term care insurance offsets (household savings)	$8.3	$10.5	$89.2
Costs for new services that address unmet needs or reduce family caregiver burdens	$68.4	$166.0	$1,093.8
Increased costs to the federal government, after accounting for federal Medicaid savings ($ billions)	**$212.1**	**$405.3**	**$2,937.2**
Percent increase	221.4%	261.5%	244.3%

Source: Authors' calculations from the Dynamic Simulation of Income Model (runid 919).
Note: LTSS = long-term services and supports.

From 2017 to 2026, additional LTSS services under the Sanders plan would cost approximately $1.1 trillion, an increase of 35.9 percent over current-law total national LTSS spending (percentage increase not shown). Federal spending for LTSS over the period would be $4.1 trillion compared to $1.2 trillion in federal spending under current law, a difference of $2.9 trillion, or 244.3 percent of current-law federal spending.

CAVEATS

These estimates focus on annual cash flows over the short run. Thus, we have not addressed the LTSS program's long-range sustainability as analysts typically would do for a social insurance program such as Social Security (which has accrued reserves through the Old-Age, Survivors, and Disability Insurance Trust Fund) or for a private long-term care insurance program that also attempts to fully prefund benefits. After this 10-year window, we would anticipate that costs would grow faster than in previous years as baby boomers reach age 80 and older, when rates of severe disability and LTSS use are much higher. Revenues would correspondingly need to grow rapidly over the ensuing 20 years (roughly 2027–2046).

Discussion

We estimate that the Sanders plan would increase current national health care spending on acute and long-term care by about $518.9 billion (16.9 percent) in 2017 and would increase federal government spending about $2.5 trillion (257.6 percent) in 2017 and $32.0 trillion (232.7 percent) from 2017 to 2026. Our 10-year federal cost estimates are higher than those published earlier this year by Kenneth Thorpe (2016). He estimated total new federal costs of $24.3 trillion over 2017 to 2026. As is the case whenever one projects the costs of new programs, there is uncertainty around these estimates. There are several reasons why components of these estimates may be too low and some reasons why others may be too high.

The following assumptions may tend to underestimate the costs of the program:

- Setting provider payment rates for acute care services at levels consistent with the current law Medicare program may be too restrictive. Payment rates may in fact have to be higher, at least initially and perhaps indefinitely, to be acceptable to providers.
- Setting provider payment rates for long-term care services at only 15 percent above current Medicaid levels may also be inadequate to induce an expansion of provider supply necessary to meet a significant share of the expanded demand that would result from the new program.
- Our assumptions about reductions in drug prices are particularly aggressive and may fall well short of political feasibility.
- We have assumed that supply constraints in the provision of acute care for the nonelderly would be consistent with those inherent in the current law Medicaid program; however, it is possible that the constraints would not be that severe. If that is the case, more demand for medical services would be met and expenditures would be higher, both in term of total national health expenditures and federal costs.
- We do not adjust estimated costs upward to account for the fact that some Medicaid programs impose benefit and service limits under current law, but there would be no such limits under the Sanders plan. Consequently, use of these benefits and services would be higher under the Sanders plan than we have estimated here.
- We did not include a cost estimate for increased utilization of services associated with the move from current or no coverage to first-dollar coverage of new benefits (e.g., dental, vision and hearing, as well as prescription drugs for some beneficiaries) in Medicare.

- We assume that most long-term care services would be provided in the home rather than in more expensive nursing homes and that many people would continue to rely on family members for services rather than taking full advantage of the formal care services that Sanders would make available at no cost. If there is more of a shift form informal to formal care than we have assumed, costs would be higher.
- The elimination of cost sharing for LTSS could lead to a much greater increase in demand than we have assumed.

The following assumptions may tend to overestimate costs:

- Our estimates include costs associated with providing undocumented immigrants with acute care services for the nonelderly and long-term care services equivalent to that of citizens and documented residents (we were not able to estimate costs for providing coverage to elderly undocumented immigrants). If the new program excludes this population, those costs would be subtracted and government spending on uncompensated care would be added.
- Our assumed reduction in the growth of healthcare spending of 0.5 percentage points below current projected growth rates may be too pessimistic. A government-run system may be able to do better. However, large cuts in provider payment rates and even further reductions in annual growth rates would necessarily be politically challenging because of both providers and the supply constraints such cuts likely would create. Some might argue that our estimate of 6 percent administrative costs is too high. For reasons discussed below, we do not believe this to be the case.
- Our estimates would also be lower if we assumed a less generous home care benefit or assumed a longer waiting period for long-term care services. Costs would also be lower if individuals were required to use more of their own resources to finance institutional care as they do today. However, such assumptions seem inconsistent with the broad intent of the proposal.
- We do not assume that some segment of the high-income population would opt out of the single-payer system and finance their care with the purchase of private insurance. It is difficult to know what would happen in such a case—whether individuals would solely rely on private insurance or use a mix of privately and publicly covered services. Both paying higher taxes and purchasing private insurance may not be affordable for many, even among those with high

incomes. But to the extent it would be permitted and occurred, such a shift could increase national health expenditures and private spending while reducing federal spending.

The Sanders plan would have significant benefits for the poor and others with low incomes. They would receive considerably more in health services than they do today, with no out-of-pocket costs. Their employers, however, would pay a payroll tax of 6.2 percent on their earnings. This would ultimately be shifted back onto employees—including low-income employees—in the form of lower wages. Thus, low-income workers, like other workers, would in fact bear some of the costs of financing the plan. Employer contributions to health insurance premiums would also be offset, and presumably those contributions to compensation would be turned into wages or other benefits (Blumberg 1999; Blumberg et al. 2012). Those in need of long-term care services, often a very sick population with high needs, would receive important new benefits.

The 2.2 percent income surtax on taxable income would also affect many low-income people, but upper-middle-income and high-income individuals would bear most of the brunt of financing this plan through large tax increases (Sammartino et al. 2016). Higher-income people, too, would receive the benefits of comprehensive insurance coverage with no cost-sharing requirements and would no longer have to pay premiums for private coverage. However, their benefit improvements would be more modest given their current coverage, and they may find it harder to access providers because of supply constraints.

Some of the new federal costs would be offset by lower tax expenditures related to health insurance. In particular, offsetting employer-sponsored insurance and employers passing that savings back to workers in the form of increased wages would mean that income and payroll tax revenues would increase because insurance contributions are tax exempt but wages are not. Given these changes with the medical expense deduction and other health-related tax preferences, revenues would be expected to increase by $251.2 billion in 2017 and $4.0 trillion between 2017 and 2026.[31]

Analysis by the Urban-Brookings Tax Policy Center indicates that Sanders's revenue proposals, intended to finance all new health and nonhealth spending, would raise $15.3 trillion in revenue from 2017 to 2026 (Sammartino et al. 2016). This amount includes the increased revenue that would be produced by eliminating the tax exclusion for employer-based health insurance discussed above. The total $15.3 trillion that would be raised is approximately $16.6 trillion less than the increased federal cost of his health care plan estimated here, suggesting that fully financing the Sanders approach would require additional sources of revenue be identified, that is, the proposed taxes appear to be too low to fully finance the plan.

We estimate that current state and local spending will be $319.8 billion in 2017 and $4.1 trillion between 2017 and 2026. Because this would be absorbed by the federal government under the Sanders plan, some might suggest requiring states to pay maintenance-of-effort costs to offset the increased federal acute care and long-term care costs. Some dispute exists about whether maintenance-of-effort requirements are legal, however, given *National Federation of Independent Business v. Sebelius*; that decision may call into question whether such payments amount to coercion.

However, many other issues would be raised by a single-payer system. Providers would be seriously affected. Hospitals would see only small financial effects in the aggregate because payment rates would be increased for those otherwise insured by Medicare and Medicaid and revenue from the otherwise uninsured would increase, but they would receive less revenue for providing care to those who would otherwise be privately insured. Different types of hospitals would be advantaged and disadvantaged, depending upon their patient mix. Growth in revenues over time would be slower than under current law, however. Physician incomes would be squeezed by the new payment rates because such rates would be considerably below what physicians are paid by private insurers. Again, whether providers were financial winners or losers from the reform would depend upon their current payer mix. The pharmaceutical and medical device industries would be squeezed perhaps more than is sustainable. Behavioral responses by the range of health care providers to such a vast change are uncertain. If provider incomes fall, additional federal investment in medical education might be necessary to achieve a sufficient level of supply. Choices would need to be made about the treatment of existing private long-term care insurance contracts and the reserves the companies that issued these policies now hold.

We assume a 6 percent administrative cost across the board; this may be too low given the many functions that would need to be carried out, including a range of care management functions, rate setting, bill paying, and oversight responsibilities for a wide variety of providers across the nation. By eliminating copayments, coinsurance, deductibles, and service limits of all types, the Sanders plan would increase demand for services. We have assumed supply constraints such that not all of the increased demand would be met. But the failure to meet all demand could lead to public outcry. Any remaining role for private health insurance would also have to be determined. If higher-income people purchase private insurance, it could give them faster access to desired providers, increasing their satisfaction with the system. Yet it could also lead to longer queues for those relying on the remaining providers, causing dissatisfaction in other quarters.

Finally, moving to a single-payer system would be highly disruptive in the near term. When the ACA required people to give up private insurance plans that were less costly than those available in the reformed nongroup market, some vocal complaints led to quick administrative action to increase

opportunities for people to keep non-ACA compliant plans longer. The ACA's changes to the health insurance system and the number of people affected by those changes has been small compared to the upheaval that would be brought about by the movement to a single-payer system.

Notes

1. "Medicare for All: Leaving No One Behind," Bernie 2016, accessed May 6, 2016, https://berniesanders.com/issues/medicare-for-all/.
2. Ibid.
3. This estimate is for civilian workers (i.e., those in private industry and state and local government) for December 2015. US Bureau of Labor Statistics, "Employer Costs for Employee Compensation," March 10, 2016, http://www.bls.gov/news.release/ecec.nr0.htm.
4. Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026," March 2016, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline.pdf
5. We use the term "acute care" here to include short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.
6. Such inevitable supply constraints were acknowledged in David Himmelstein and Steffie Woolhandler, "On Kenneth Thorpe's Analysis of Senator Sanders' Single-Payer Reform Plan," *Huffpost Politics* (blog), updated January 29, 2016, http://www.huffingtonpost.com/david-himmelstein/kenneth-thorpe-bernie-sanders-single-payer_b_9113192.html.
7. A study in 2015 by the Office of the Inspector General showed that for selected brand-name drugs, per-unit pharmacy costs under Medicaid were less than half of Medicare's, largely because of Medicaid's rebate policies (Levinson 2015).
8. For more information about our estimates of health coverage and costs under current law, see Buettgens and colleagues, "The Cost of ACA Repeal" (forthcoming).
9. Costs for the elderly who are not enrolled in Medicare are not included; this leads to an underestimate of spending.
10. Historical Medigap spending estimates (Jacobson, Huang, and Neuman 2014) were combined with enrollment projections (Congressional Budget Office 2016).
11. Historical out-of-pocket spending estimates based on Cubanski and colleagues (2014) were combined with estimates from Jacobson, Huang, and Neuman (2014) and enrollment projections (Congressional Budget Office 2016).
12. Estimates based on Garfield and colleagues (2015) were combined with Urban Institute analysis of data from the CMS-64 and the Medicaid Statistical Information System. In addition, for all Medicaid spending estimates, we estimate that federal Medicaid payments are 57 percent of total Medicaid spending, and state and local Medicaid payments account for the remaining 43 percent of Medicaid spending.
13. We do not estimate induced spending resulting from first-dollar coverage of these formerly noncovered services; consequently, we recognize that our estimate of spending on dental, vision, and hearing services is low.
14. Estimates based on American Hospital Association (2015) lead to an overall hospital payment rate adjustment of 100/89 = 1.12.
15. No induction factors are applied to the spending estimates of Medicare enrollees who do not currently have prescription drug coverage and would gain prescription drug coverage under the Sanders plan. This leads to an underestimate of spending in this area.

16. As described in the report, this Medicare benefit-spending estimate includes an estimated 6 percent administrative cost.
17. Our figures may underestimate household spending because they do not capture additional premium payments related to Medicare Advantage and Part D that enrollees pay directly to the plans.
18. For Medicare-covered services, some Medicare enrollees lack supplemental coverage through Medigap or employer coverage (or both), and others face cost sharing under the various supplemental coverage arrangements.
19. The growth rates assumed are based on Congressional Budget Office (2016) estimates over this period. The spending growth factor applied under the Sanders plan is computed based on Congressional Budget Office total Medicare spending on gross outlays and is equal to 1.060 ; the growth factor applied to federal spending under current law is based on Congressional Budget Office total Medicare spending on net outlays and is set equal to 1.065.
20. The Sanders plan describes coverage of "the entire continuum of health care...including long-term and palliative care." See Bernie Sanders, "Medicare for All: Leaving No One Behind," https://berniesanders.com/issues/medicare-for-all/.
21. See Favreault, Smith, and Johnson (2015). The analysis presented here projects costs on a cash-flow basis, given the Sanders plan structure.
22. For example, see population-based studies such as Kaye, Harrington, and LaPlante (2010), Medicaid studies such as Eiken and colleagues (2015), and provider studies such as Harris-Kojetin and colleagues (2016).
23. For Medicaid rates, we use composite (often weighted average) rates from the literature (e.g., Eljay, LLC, and Hansen Hunter & Company, PC [2015]), given that prices are often facility-specific within a state.
24. Katie Thomas, "In Race for Medicare Dollars, Nursing Home Care May Lag," *New York Times.* April 14, 2015.
25. In some previous DYNASIM LTSS projections, we have assumed that home care prices grow at the average of wage and price growth, given stagnation in the wages of less-skilled workers.
26. All the estimates in the model are prorated in the first year of disability and in the year of death to account for the share of the year disabled or dead, respectively.
27. HIPAA requires that a person is unable to perform, without substantial assistance from another individual, at least two activities of daily living for at least 90 days because of a loss of functional capacity, or that the person needs "substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment." The specific activities of daily living in the statute are eating, toileting, transferring, bathing, dressing, and continence.
28. We could shift to a longer elimination period (say, 90 to 100 days) to reflect integration with Medicare's current-law deductible period or more cost sharing, but we start with a low value given the spirit of limited cost sharing.
29. In unpublished tables from the National Long-Term Care Survey, Brenda Spillman estimates that roughly 82 percent of those age 65 and older meeting the HIPAA criteria (using a definition of severe cognitive impairment) receive some form of care. Over two-thirds receive informal care; only about one-third receive formal care. Many receive both.
30. Some insurance policies have low daily benefits or lack inflation protection.
31. Calculations based on Sammartino and others (2016).

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Research

The Green New Deal: Scope, Scale, and Implications

DOUGLAS HOLTZ-EAKIN, DAN BOSCH, BEN GITIS, DAN GOLDBECK, PHILIP ROSSETTI | FEBRUARY 25, 2019

Executive Summary

The Green New Deal (GND) is a sweeping policy plan setting out ambitious objectives for energy and economic policy. The breadth of its proposals makes it daunting to assess the GND using the standard tools of policy analysis. Nevertheless, this short paper is an initial foray. We have three broad conclusions:

- The GND's proposed goals, "mobilization," and specific policy projects encompass social and institutional changes far exceeding the narrow policy goals, but these changes are impossible to quantify at this point;
- Many of the policies proposed in the GND are redundant with other aspects in it, which also complicates a precise analysis, as the interactions are difficult to predict; and
- The GND will be very expensive – our initial estimates for the tractable aspects (best thought of as estimating the order of magnitude) are summarized below.

Summary Table
(2020-2029)

Goal	Estimated Cost	Estimated Cost Per Household
Low-carbon Electricity Grid	$5.4 trillion	$39,000
Net Zero Emissions Transportation System	**$1.3 trillion to $2.7 trillion**	**$9,000 to $20,000**
Guaranteed Jobs	$6.8 trillion to $44.6 trillion	$49,000 to $322,000
Universal Health Care	**$36 trillion**	**$260,000**
Guaranteed Green Housing	$1.6 trillion to $4.2 trillion	$12,000 to $30,000
Food Security	**$1.5 billion**	**$10**

1. Introduction

The Green New Deal (GND) is a set of sweeping policy proposals that has received widespread attention. As the name suggests, the heart of the GND is an effort to curb carbon emissions and thus to slow climate change, but the package contains a wide set of other policy proposals that are not directly linked to climate policy: a job guarantee, food and housing security, and a variety of social justice initiatives.

Given the attention the GND has received, it is worth assessing its proposals, yet its breadth makes it daunting to apply the standard tools of policy analysis. Nevertheless, our task in this short paper is to begin this undertaking by providing broad analyses of some of the tractable parts of the GND.

The next section reviews the GND (with the appendix providing excerpts of the GND's exact language). Section 3 contains the meat of our analysis, while Section 4 is a summary and conclusions. We find that the GND would be very expensive. Its social impact, however, would likely exceed its enormous price tag because of its expansive re-engineering of social norms, policy processes, and key institutions.

2. What is the GND?

The GND contains a lengthy elaboration of goals, aspects of "mobilization," and projects. In short, the goals are a pristine environment, quality infrastructure, a strong economy, and justice. To achieve these goals, the GND envisions a "mobilization," yet it is difficult to understand exactly the role of mobilization, which lies between the goals and actual government projects. Clearly it is intended to put some meat on the aspirational goals, identify areas of focus, and generate enthusiasm.

The rubber meets the road, however, with the policy details. For purposes of this paper, we distill this set of concrete projects into proposals for:

1. A 10-year transition to an exclusively low-carbon energy electricity grid;
2. Enough high-speed rail transit available that air travel becomes unnecessary;
3. Guaranteeing union jobs with a family-sustaining wage, adequate family and medical leave, paid vacations, and retirement security to all people of the United States;
4. Universal health care;
5. Guaranteed housing for every American; and
6. Food security for every person in the United States.

For more details and key excerpts from the GND's goals, "mobilization," and projects, see the appendix.

3. Analyzing the GND

Several issues immediately arise in thinking about the six policy proposals. The first is that the breadth of the proposals suggests that there will be large spillovers among them, as well as macroeconomic impacts. This would imply that an ideal analysis would be to consider them simultaneously; below we restrict ourselves to policy-by-policy analyses for our initial evaluation. The sheer scope of these proposals would presumably reduce or eliminate existing federal spending in certain areas, perhaps beyond what we have estimated here.

Obviously, this leaves room to improve on the estimated impacts.

Simultaneously, the GND is curiously redundant. For example, a costly retrofitting of every structure in the United States seems considerably less environmentally beneficial once the electricity grid is completely transformed to use 100 percent clean energy than it would be if undertaken with today's energy mix. Such a retrofit would have no impact on emissions. Similarly, the GND promises to ensure that every person has a guaranteed job, a family-sustaining rate of pay, and benefits such as paid leave and paid vacations. If everyone has good pay with good benefits, why is it simultaneously necessary to provide targeted programs for food, housing, and health care? Some of these objectives appear to be redundant. Nevertheless, we incorporate them into our analysis in an effort to reflect the GND's intent.

A. Clean Energy

We estimate that to transition to a power sector that has net zero emissions of greenhouse gases in 10 years would require a capital investment of $5.4 trillion by 2029. In addition, the annual operation, maintenance, and capital-recovery costs would be $387 billion.[1] We consider this estimate to be conservative in two respects. First, we assume that a low-carbon electricity grid is feasible with only 4 hours of storage available for renewable resources; academic estimates have said a reliable grid requires 12 hours.[2] Second, we assume no new construction of transmission assets is required, even though efficiently siting new renewable assets will require significant transmission infrastructure.

To reach this bottom line, we assume that states without nuclear moratoriums build approximately 50 percent of their needed capacity with nuclear power, and cover the remaining 50 percent with wind, solar, hydro, geothermal electricity, and battery storage. States with nuclear moratoriums are assumed to replace fossil fuels with wind, solar, and storage. This approach raises issues in dispatching electricity, because one needs to cover the difference between available nuclear and peak capacity with both solar and wind resources. Most renewable resources are non-dispatchable, and must be supplemented by storage and other available assets. (For example, if one has 500 megawatts (MW) of nuclear and needs 1000MW total, the solution is to use 500MW nuclear and 500MW solar for part of the day, 500MW nuclear and 500MW wind for a second part, and 500MW nuclear and 500MW storage for the remainder). The estimate incorporates full construction of all available hydro assets, and business-as-usual geothermal construction. The figure also assumes only 4 hours of storage would be available.

To put these costs in perspective, total retail revenue in the electric power sector was $390 billion in 2017.[3] Generation costs were 59 percent of that, and would go from $230 billion to $387 billion each year in the above scenario, about a $157 billion difference, though if $70.5 billion of annual fuel costs are avoided by 2029 the net annual difference falls to $86.5 billion.[4] That increase (accounting for avoided fuel costs) would drive up total electricity costs by 22 percent. With an average monthly electric bill in 2017 of $111, the average household could expect around $295 of increased annual expenditures on electricity. This scenario is likely optimistic, as it assumes no increased costs for electricity generation and storage assets resulting from dramatically increased demand, nor does it consider any growth in transmission assets. Alternatively, the estimated costs could fall if storage assets could be deployed efficiently, but total costs would certainly be in the multiples of trillions of dollars range.

B. High-Speed Rail

The GND envisions enough high-speed rail to make air travel unnecessary. We conclude that the rail itself would cost between $1.1 and $2.5 trillion. This estimate adopts the state of California's 2018 reported capital

cost per mile of system, and multiplies it by the Bureau of Transportation Statistics' (BTS) reported route miles for modes of transportation.[5]-[6] The low figure multiplies track-mile costs by the difference between air and rail; the high figure assumes replacing all air route miles without using existing track. We consider both figures to be conservative estimates because it is not feasible to lay track between points of origin and arrival as the crow flies, which is the way aircraft travel works. The high figure assumes 19,453 miles of track.

In addition to track, the high-speed rail system (HSR) will require its own rolling stock. Assuming that one train replaces three airplanes and that each train costs $71.2 million (roughly what California was intending to spend per train for 16 trains), the total comes to $166.9 billion.[7]

As a matter of perspective, total 2017 revenue in the airline industry was $175.3 billion, with expenses of $153.9 billion.[8] Fuel expenses were $26.3 billion. It would take decades to pay off the capital investment required for HSR, and the fuel savings that would presumably be the most important cost difference would only be a fraction of the total investment required.

C. Guaranteed Jobs

We present four separate cost estimates of the guaranteed employment aspect of the GND, each based on the program outlined by Paul, Darity, and Hamilton in their 2018 paper for the Center on Budget and Policy Priorities (CBPP).[9] We use the same average cost per job figure, $56,000, as employed in their analysis. The table below summarizes the results.

Guaranteed Jobs Summary
($ billions)

Method	2019	2020	2020-2029
1. U-6	$547	$569	$6,762
2. U-6+LFPR	**$598**	**$622**	**$7,396**
3. U-6+LFPR+Workers earning under 473 per week	$2,570	$2,672	$31,777
4. U-6+LFPR+Workers earning under 625 per week	**$3,608**	**$3,750**	**$44,605**

The estimate in the first row follows the same method as in the CBPP report, but uses January 2019 data. It assumes that the U-6 measure of unemployment would be reduced to 1.5 percent. The cost is roughly $547 billion in 2019 and $6.8 trillion from 2020 to 2029.

The second estimate adds to the decline in the U-6 the assumption that, at higher pay, the prime-age labor force participation rate would return to its peak in January 2007 (83.4 percent) and that all of those additional workers would have a government job. That increases the cost to $598 billion in 2019 and $7.4 trillion from 2020 to 2029.

The third row contains an estimate that includes the features of rows one and two, but adds to the cost an assumption that all workers who are currently employed and earn less than $437 per week – the minimum pay proposed by the CBPP report – would switch to the government jobs. That increases the cost to $2.6 trillion in 2019 and $31.8 trillion between 2020 and 2029.

Finally, the bottom row includes workers employed and earning less than $625 per week – the average pay provided by the program according to the CBPP report. That would increase the cost to $3.8 trillion in 2019, $44.6 trillion between 2020 and 2029.[10]

D. Universal Health Care

To analyze the GND promise for universal health care, we build on the estimate by the Center for Health and Economy (H&E) of the Medicare for All proposal by 2016 presidential candidate Bernie Sanders. In particular, we make several assumptions.

- There is Limited Plan Choice. A single-payer system would eliminate consumer choice relative to how insurance is currently administered. Thus there would be no plan choices outside of an actuarial value range that is comparable to the current actuarial value of Medicare.
- Actuarial Values of Plans. Current Medicare beneficiaries receive insurance with an actuarial value in the 70 to 80 percent range. We assume that these are the most bare-bones options and permit the equivalent of current individual market health insurance plans with Gold metal levels.
- Administrative Savings: We adopt the H&E estimate of the decrease in administrative costs.
- Total Government Spending. All costs to the consumer are eliminated by converting all health insurance-related costs into federal spending.

Under these assumptions the universal coverage will cost roughly $36 trillion between 2020 and 2029. In addition to the tax cost and diminished choice, one would expect decreased access to providers, particularly among those who currently have health coverage.

E. Guaranteed Housing

The GND touches upon housing in two notable ways: first, a goal of providing all Americans "*affordable, safe, and adequate housing*," and second, an overarching drive to build or retrofit housing to maximize energy efficiency. Regarding the primary idea of a "housing guarantee," the homeless are the primary focus. Per Department of Housing and Urban Development (HUD) data,[11] nearly 554,000 people experienced homelessness in 2017. Since one-third of those were the part of a family unit, it would take approximately 427,000 units to house this population. The average monthly HUD expenditure per unit[12] of subsidized housing comes out to $693, or $8,316 annually. Simply funding the subsidized housing of this population would cost $3.5 billion annually.

This figure, however, assumes there is available housing across these programs to take in such households. HUD currently estimates that 92 percent of its subsidized housing stock is "occupied." The 8 percent unoccupied share yields nearly 402,000 units – a shortfall of 25,000 households. What would filling that shortfall look like? A recent Government Accountability Office study[13] examined the costs for Low-Income Housing Tax Credit projects. Applying the median California per-unit construction costs (a reasonable proxy considering California's level of environmental standards) of $360,000 yields a price tag of $8.2 billion. These

are, of course, the broadest, most approximate estimates of merely getting a guaranteed roof over a head.

Turning to the greening of housing initiative, the potential costs continue to rise. While each situation is different depending upon the age of the building, existing features, etc., and the exact costs will largely depend upon whatever hard standards a fully realized GND establishes, there are some illustrative estimates available. A 2012 HUD study[14] evaluated the costs involved in having affordable housing meet the "National Green Building Standard." The results varied across a series of case studies and efficiency levels. Assuming the highest level ("Emerald") is a reasonable proxy for a GND rubric, upfront improvement costs ranged from $13,257 to $34,422 per unit. Applying such costs to simply the 5 million currently available HUD-subsidized housing units yields a cost range of between $66.5 billion to $172.8 billion. Applying such costs to all housing units[15] – since the resolution calls for upgrading "all existing buildings" – yields a potential cost of $1.6 trillion to nearly $4.2 trillion.

F. Food Security

There is no comparable program to the GND food security guarantee. One federal response to food access issues is the Healthy Food Financing Initiative (HFFI), which is a public-private partnership designed to drive investment in grocery stores and other fresh food facilities to areas that need them. It provides loans and grants to develop stores and provide employee training. It is based on an initiative in Pennsylvania (the Fresh Foods Financing Initiative [FFFI]) that leveraged $30 million in taxpayer seed money to "improve" access to fresh food for 400,000 Pennsylvania residents. Assuming that this constitutes providing access, it implies a taxpayer cost of about $75 per person.

According to a 2009 federal estimate, there were about 23.5 million people in America in need of improved food access. Assuming the HFFI is as efficient as the FFFI (which seems like the conservative estimate) would put the federal cost at $1.76 billion. The program has been around since fiscal year 2011 and received about $245 million in taxpayer funds. The remainder needed is about $1.5 billion in taxpayer money. This increased access to fresh food, in conjunction with the income guarantees provided elsewhere in the GND, should meet the plan's goal of food security for all Americans.

4. Summary and Conclusions

The Green New Deal is clearly very expensive. Its further expansion of the federal government's role in some of the most basic decisions of daily life, however, would likely have a more lasting and damaging impact than its enormous price tag.

Appendix: Key Excerpts from the Green New Deal

To begin, the GND sets out goals. Specifically, it is "*the duty of the Federal Government to create a Green New Deal:*

- *To achieve net-zero greenhouse gas emissions through a fair and just transition for all communities and workers;*
- *to create millions of good, high-wage jobs and ensure prosperity and economic security for all people of the United States;*

- *to invest in the infrastructure and industry of the United States to sustainably meet the challenges of the 21st century;*
- *to secure for all people of the United States for generations to come –*
  - *clean air and water;*
  - *climate and community resiliency;*
  - *healthy food;*
  - *access to nature; and*
  - *a sustainable environment; and*
- *to promote justice and equity by stopping current, preventing future, and repairing historic oppression of indigenous peoples, communities of color, migrant communities, deindustrialized communities, depopulated rural communities, the poor, low-income workers, women, the elderly, the unhoused, people with disabilities, and youth (referred to in this resolution as 'frontline and vulnerable communities').*"

The GND then lays out a "*10-year national mobilization (referred to in this resolution as the 'Green New Deal mobilization') that will require the following goals and projects:*

- *building resiliency against climate change-related disasters, such as extreme weather, including by leveraging funding and providing investments for community-defined projects and strategies;*
- *repairing and upgrading the infrastructure in the United States, including –*
  - *by eliminating pollution and greenhouse gas emissions as much as technologically feasible;*
  - *by guaranteeing universal access to clean water;*
  - *by reducing the risks posed by climate impacts; and*
  - *by ensuring that any infrastructure bill considered by Congress addresses climate change;*
- *meeting 100 percent of the power demand in the United States through clean, renewable, and zero-emission energy sources, including –*
  - *by dramatically expanding and upgrading renewable power sources; and*
  - *by deploying new capacity;*
- *building or upgrading to energy-efficient, distributed, and 'smart' power grids, and ensuring affordable access to electricity;*
- *upgrading all existing buildings in the United States and building new buildings to achieve maximum energy efficiency, water efficiency, safety, affordability, comfort, and durability, including through electrification;*
- *spurring massive growth in clean manufacturing in the United States and removing pollution and greenhouse gas emissions from manufacturing and industry as much as is technologically feasible, including by expanding renewable energy manufacturing and investing in existing manufacturing and industry;*
- *working collaboratively with farmers and ranchers in the United States to remove pollution and greenhouse gas emissions from the agricultural sector as much as is technologically feasible, including –*
  - *by supporting family farming;*
  - *by investing in sustainable farming and land use practices that increase soil health; and*
  - *by building a more sustainable food system that ensures universal access to healthy food;*
- *overhauling transportation systems in the United States to remove pollution and greenhouse gas emissions from the transportation sector as much as is technologically feasible, including through investment in –*

  - *zero-emission vehicle infrastructure and manufacturing;*
  - *clean, affordable, and accessible public transit; and high-speed rail;*

- *mitigating and managing the long-term adverse health, economic, and other effects of pollution and climate change, including by providing funding for community-defined projects and strategies;*
- *removing greenhouse gases from the atmosphere and reducing pollution by restoring natural ecosystems through proven low-tech solutions that increase soil carbon storage, such as land preservation and afforestation;*
- *restoring and protecting threatened, endangered, and fragile ecosystems through locally appropriate and science-based projects that enhance biodiversity and support climate resiliency;*
- *cleaning up existing hazardous waste and abandoned sites, ensuring economic development and sustainability on those sites;*
- *identifying other emission and pollution sources and creating solutions to remove them; and*
- *promoting the international exchange of technology, expertise, products, funding, and services, with the aim of making the United States the international leader on climate action, and to help other countries achieve a Green New Deal.*"

The GND then moves into specific projects. Specifically: "*To achieve the Green New Deal goals and mobilization, a Green New Deal will require the following goals and projects:*

- *providing and leveraging, in a way that ensures that the public receives appropriate ownership stakes and returns on investment, adequate capital (including through community grants, public banks, and other public financing), technical expertise, supporting policies, and other forms of assistance to communities, organizations, Federal, State, and local government agencies, and businesses working on the Green New Deal mobilization;*
- *ensuring that the Federal Government takes into account the complete environmental and social costs and impacts of emissions through –*
  - *existing laws;*
  - *new policies and programs; and*
  - *ensuring that frontline and vulnerable communities shall not be adversely affected;*
- *providing resources, training, and high-quality education, including higher education, to all people of the United States, with a focus on frontline and vulnerable communities, so that all people of the United States may be full and equal participants in the Green New Deal mobilization;*
- *making public investments in the research and development of new clean and renewable energy technologies and industries;*
- *directing investments to spur economic development, deepen and diversify industry and business in local and regional economies, and build wealth and community ownership, while prioritizing high-quality job creation and economic, social, and environmental benefits in frontline and vulnerable communities, and deindustrialized communities, that may otherwise struggle with the transition away from greenhouse gas intensive industries;*
- *ensuring the use of democratic and participatory processes that are inclusive of and led by frontline and vulnerable communities and workers to plan, implement, and administer the Green New Deal mobilization at the local level;*

- *ensuring that the Green New Deal mobilization creates high-quality union jobs that pay prevailing wages, hires local workers, offers training and advancement opportunities, and guarantees wage and benefit parity for worker affected by the transition;*
- *guaranteeing a job with a family-sustaining wage, adequate family and medical leave, paid vacations, and retirement security to all people of the United States;*
- *strengthening and protecting the right of all workers to organize, unionize, and collectively bargain free of coercion, intimidation, and harassment;*
- *strengthening and enforcing labor, workplace health and safety, antidiscrimination, and wage and hour standards across all employers, industries, and sectors;*
- *enacting and enforcing trade rules, procurement standards, and border adjustments with strong labor and environmental protections –*
    - *to stop the transfer of jobs and pollution overseas; and*
    - *to grow domestic manufacturing in the United States;*
- *ensuring that public lands, waters, and oceans are protected and that eminent domain is not abused;*
- *obtaining the free, prior, and informed consent of indigenous peoples for all decision that affect indigenous peoples and their traditional territories, honoring all treaties and agreements with indigenous peoples, and protecting and enforcing the sovereignty and land rights of indigenous peoples;*
- *ensuring a commercial environment where every businessperson is free from unfair competition and domination by domestic or international monopolies; and*
- *providing all people of the United States with –*
    - *high-quality health care;*
    - *affordable, safe, and adequate housing;*
    - *economic security; and*
    - *clean water, clean air, healthy and affordable food, and access to nature."*

[1] This assumes that capital costs are recovered over 20 years.

[2] Energy & Environmental Science, "Geophysical constraints on the reliability of solar and wind power in the United States" https://pubs.rsc.org/en/content/articlelanding/2018/ee/c7ee03029k#!divAbstract

[3] https://www.eia.gov/electricity/sales_revenue_price/pdf/table3.pdf

[4] Energy Information Administration, Annual Energy Outlook 2018, Table 8
https://www.eia.gov/energyexplained/images/charts/major_comp_average_elec_price-large.jpg

[5] California High Speed Rail 2018 Business Plan, page 114,
http://www.hsr.ca.gov/docs/about/business_plans/2018_BusinessPlan.pdf

[6] Bureau of Transportation Statistics, Passenger Transportation Infrastructure: 2000, 2010, and 2013, https://www.bts.gov/archive/publications/passenger_travel_2015/chapter3/table3_1

[7] California High Speed Rail 2018 Business Plan, page 44, http://www.hsr.ca.gov/docs/about/business_plans/2018_BusinessPlan.pdf

[8] Bureau of Transportation Statistics, 2017 Annual U.S. Airline Financial Data, https://www.bts.gov/newsroom/2017-annual-and-4th-quarter-us-airline-financial-data

[9] https://www.cbpp.org/research/full-employment/the-federal-job-guarantee-a-policy-to-achieve-permanent-full-employment

[10] The CBPP report proposed that guaranteed jobs pay a minimum rate of $24,600 per year, or $473 per week, and an average rate of $32,500 per year, or $625 per week. AAF calculated the number of workers who currently earn under $473 per week and $625 per week using the Current Population Survey's March 2018 Annual Social and Economic Supplement.

[11] https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf

[12] https://www.huduser.gov/portal/datasets/assthsg.html; Query: "2017 Based on 2010 Census"

[13] https://www.gao.gov/assets/700/694541.pdf

[14] https://www.huduser.gov/publications/pdf/evaluation_of_affordablehousing.pdf

[15] https://www.census.gov/programs-surveys/ahs/data/interactive/ahstablecreator.html; Query: National, 2017, "General Housing"

The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals

Final Report

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American Hospital Association
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March 12, 2019

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About KNG Health Consulting, LLC

KNG Health Consulting, LLC, is a health economics and policy consulting company assisting clients across all sectors of the healthcare industry. The company's work focuses on two main practice areas: Healthcare Reform and Payment Innovation; and Evaluation and Health Economics. In the HRPI practice, KNG Health's experts work with our clients to estimate the effects of a wide-range of healthcare reform and payment innovation policies, ranging from modeling innovative state and federal proposals to reduce health insurance premiums to facilitating learning systems for providers on alternative payment models. In the EHE practice, KNG Health's experts conduct studies on the efficiency, effectiveness, and value of medical interventions using big and small data, applying careful research designs, and translating findings into actionable results.

KNG Health is a small, woman- and minority-owned business located in the Washington, DC metropolitan area.

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Executive Summary

Key Findings

- We used a micro-simulation model to estimate the effects of the Medicare-X Choice Act[1] on health insurance coverage and healthcare spending. Medicare-X Choice would make a public health insurance plan fully available on the health exchanges beginning in 2024 and reimburse providers using Medicare rates.
- We project public plan enrollment of 40.7 million in 2024, with approximately 90 percent of enrollees coming from individuals currently insured on the non-group market or through employer-sponsored insurance (ESI).
- Of the 29.0 million currently uninsured, Medicare-X Choice would result in 5.5 million gaining coverage. By comparison, additional support of the Affordable Care Act would result in 9.1 million uninsured persons gaining coverage.
- Nationally, healthcare spending would be reduced by $1.2 trillion (7%) over the 10-year period from 2024 to 2033, with spending for hospital services being cut by $774 billion -accounting for almost two-thirds of the total spending reduction.
- The Medicare-X Choice reductions in healthcare spending and increases in coverage would be financed through reductions in provider payments, given that Medicare rates are significantly less than payments by commercial payers.
- Medicare-X Choice would compound financial stresses already faced by the nation's hospitals, potentially impacting access to care and provider quality. MedPAC estimates Medicare hospital margins will be -11 percent in 2018. Moreover, the Congressional Budget Office has projected that between 40 and 50 percent of hospitals could have negative margins by 2025 under current law.
- While Medicare-X Choice would increase insurance coverage, the gains are modest relative to what could likely be achieved through strengthening existing components of the Affordable Care Act.

Access to affordable health care coverage continues to be a major public concern. While many Americans have gained coverage since the enactment of the Affordable Care Act (ACA) through, for example, health insurance marketplaces and state Medicaid expansions, approximately 27 million non-elderly individuals living in the U.S. remained uninsured in 2017, up slightly from 2016.[2] In 2017, Members of the 115th Congress introduced eight legislative proposals to expand public health insurance coverage. Seven of the eight proposals would make Medicare or a Medicare-like public plan option available to a larger population than currently has access to Medicare or other public insurance. The other proposal (Medicare-for-All) would create a single-payer healthcare system.

In this study, we model the effects of the Medicare-X Choice Act on coverage and healthcare spending. Although not as expansive as Medicare-for-All, Medicare-X Choice would allow any

[1] S. 1970. 115th Congress. 2017. Accessed at https://www.congress.gov/115/bills/s1970/BILLS-115s1970is.pdf.
[2] Key Facts about the Uninsured Population. Kaiser Family Foundation. Accessed at https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population.

individual to voluntarily enroll in a public plan offered on each health exchange. As a result, the Medicare-X Choice public plan's reach would be broader than Medicare "buy-in" proposals that only allow certain age groups (e.g., age 55-64) to purchase Medicare. Under Medicare X-Choice, the public plan would reimburse providers using Medicare rates, which are significantly less than commercial rates and, for hospitals, fall below the cost of providing care.[3] We assess the impact of Medicare-X Choice on coverage and healthcare spending by projecting the take-up of the new public plans among the uninsured and those with commercial health insurance.

Methods. We used the KNG Health Reform Model (KNG-HRM) to estimate individual and family insurance coverage decisions. The KNG-HRM is a microsimulation model that uses a parameterized utility function to determine individual insurance coverage choices. The model is based on data from the 2017 U.S. Census Bureau's American Community Survey (ACS), which is a large national survey of households. In the model, individuals consider several coverage options, maximizing utility for their family or "health insurance unit (HIU)." For the non-group market and those uninsured at baseline, changes from the status quo policy trigger a dynamic, iterative process with HIUs selecting new coverage choices and premiums being recalculated until a new equilibrium is reached. For this study, we expanded the KNG-HRM to incorporate coverage decisions of individuals on employer-sponsored insurance (ESI). For individuals receiving coverage through their employer, we used baseline premiums for ESI (updated over time for cost inflation) and assumptions on employer-covered share of premiums to model the decision to stay on ESI or select an alternative coverage option. Each individual's utility is a function of healthcare consumption; out-of-pocket spending including premiums, cost-sharing reduction (CSR) subsidies and tax credits; and variance in out-of-pocket spending (to capture the value of insurance to mitigate risk of unexpectedly high healthcare expenditures). We do not model competition among health plans and, instead, assume that the availability of plans would be unaffected by the introduction of a public plan on the exchanges.

We estimated healthcare utilization based on an individual's demographics and imputed health status, including general health, presence of select chronic conditions, physical function, and cost-sharing requirements. We convert healthcare utilization into total and out-of-pocket spending by multiplying use rates by prices. Commercial insurer prices were obtained from publicly-available data from the Health Care Cost Institute (HCCI). We developed comparable Medicare prices using studies from the Congressional Budget Office (CBO) and other sources that compare commercial provider payment rates to Medicare rates.

Key Findings. We find that national enrollment in the public plan would be 40.7 million in 2024 and would increase slightly to 42.3 million by 2033 (Table ES1). Under Medicare-X Choice, the number of uninsured and the commercially insured on the non-group market would fall by 5.5 and 12.6 million in 2024, respectively, while enrollment in employer-sponsored insurance would fall by 22.6 million. About ninety percent of the enrollment in the public plans would comprise individuals who were either covered under ESI or on a commercial non-group plan in the

[3] June 2018 Data Book. Medicare Payment Advisory Commission. Chart 6-19. Accessed at https://bit.ly/2EMwQ2Y.

baseline. While most of the enrollment in the public plan comes from those previously with ESI, the public plan take-up rate is highest (67%) among those with commercial non-group insurance.

Table ES1. Change in Insurance Coverage Status in 2024 and 2033

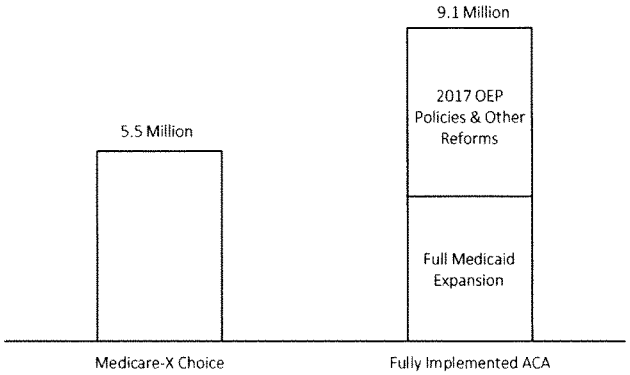
			Change in Coverage under Medicare-X Choice			
Source of Coverage	Baseline		Coverage Change		Percent Change	
	2024	2033	2024	2033	2024	2033
Employer	152.7 M	154.9 M	-22.6 M	-21.4 M	-15%	-14%
Non-Group	21.1 M	21.3 M	-12.6 M	-14.0 M	-60%	-66%
Uninsured	29.0 M	31.2 M	-5.5 M	-6.9 M	-19%	-22%
Public			40.7 M	42.3 M	n/a	n/a

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: n/a = Not Applicable. Components may not sum to totals because of rounding.

We compare estimated reductions in the number of uninsured under Medicare-X Choice in 2024 to the impact of a fully-implemented ACA (Figure ES1). Specifically, we update estimates reported by the Urban Institute on insurance coverage in 2019 and the impact of Medicaid expansion in non-expansion states and insurance coverage policies in effect during the 2018 Open Enrollment Period (OEP) as compared to the 2017 OEP.[4,5] We used estimates directly from the Urban Institute studies but updated for projected population growth between 2019 and 2024. We find that a fully implemented ACA would result in a reduction of 9.1 million in the uninsured, while Medicare-X Choice would result in a reduction of 5.5 million.

[4] Buettgens M. The Implications of Medicaid Expansion in the Remaining States: 2018 Update. The Urban Institute. Accessed at https://urbn.is/2QnkqGg.
[5] Blumberg LJ, Buettgens M, Wang R. Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending. The Urban Institute. Accessed at https://urbn.is/2G07k8E.

Figure ES1. Reductions in Number of Uninsured under Medicare-X Choice and Fully Implemented ACA



Source: KNG Health analysis of the KNG-Health Reform Model and data from the Urban Institute.

We estimate considerable reductions in healthcare spending of 7 percent under Medicare-X Choice over the 10-year period from 2024 to 2033 (Table ES2). Spending on individuals who are uninsured in the baseline is projected to increase by 9 percent in 2024, however, increased spending on the uninsured would be more than offset by spending reductions among those who are enrolling in the public plan but previously insured through private insurance. While hospital-based services represent 47 percent of total baseline healthcare spending, these services would account for roughly 67 percent of the reduction in total spending. Overall, we estimate that hospitals would experience a 10-percent reduction in payments among the relevant population.

Table ES2. Spending by Type of Service in Baseline and Under Medicare-X Choice

			Change in Spending by Service (1-Year and 10-Year)			
Type of Service	Baseline		Dollars		Percent	
	2024	2024-33	2024	2024-33	2024	2024-33
Hospitalizations	$260 B	$3,103 B	-$30 B	-$370 B	-11%	-12%
Hospital Outpatient Visits	$135 B	$1,594 B	-$13 B	-$163 B	-10%	-10%
Emergency Department	$84 B	$1,013 B	-$9 B	-$117 B	-11%	-12%
Other Hospital	$141 B	$1,682 B	-$10 B	-$124 B	-7%	-7%
Physician Visits	$90 B	$1,073 B	-$6 B	-$86 B	-7%	-8%
Prescription Drugs	$263 B	$3,125 B	$1 B	$7 B	0%	0%
Other Non-Hospital	$352 B	$4,199 B	-$24 B	-$309 B	-7%	-7%
Total	**$1,325 B**	**$15,789 B**	**-$92 B**	**-$1,161 B**	**-7%**	**-7%**

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Spending excludes populations covered by public coverage (e.g., Medicaid, TRICARE). Components may not sum to totals because of rounding.

Conclusions. Medicare-X Choice would result in significant changes in the health insurance landscape, with 36.5 million[6] people leaving private coverage for the new government-run public option, and 5.5 million individuals without insurance gaining coverage. While we estimate material reductions in the number of uninsured, most of those choosing coverage under a public plan would come from those currently covered under a commercial non-group plan or ESI. We estimate reductions in total healthcare spending due to reduced payments to providers, given the large differences in prices between Medicare and commercial insurers. For hospitals and other providers, the introduction of Medicare-X Choice would reduce revenue without commensurate reductions in costs. Although the increase in the number of insured individuals would increase revenue from the formerly uninsured, higher spending from this group would not be enough to offset the lost revenue from shifts between private and public insurance coverage.

For hospitals, the introduction of a public plan that reimburses providers using Medicare rates would compound financial stresses already faced by the sector, potentially impacting access to care and provider quality. CBO projects that between 40 and 50 percent of hospitals could have negative margins by 2025 under current law.[7] Given that Medicare pays hospitals below their costs (e.g., the Medicare Payment Advisory Commission estimates that Medicare inpatient margins will be -11 percent in 2018), Medicare-X Choice would be expected to increase the number of hospitals with negative margins.[8] While hospitals may attempt to shift some costs to commercial insurers, the ability to do this under a public plan may be limited because of the study's projected significant take-up by those in the non-group market. Policymakers should have a clear understanding of potential effects on patient access, provider payment, the commercial insurance market, and ESI (desired as well as unintended) when considering proposals to expand Medicare coverage.

[6] The 36.5 million represents movement out of the private insurance market and does not account for the 1.5 million uninsured moving into the private insurance market (see Table 2 within main report). The net change in private insurance coverage is a reduction in 35.2 million (22.6 million reduction in employer coverage plus 12.6 million reduction in non-group coverage - Table ES1).

[7] Projecting Hospitals' Profit Margins Under Several Illustrative Scenarios. Congressional Budget Office. September 2016. Accessed at https://www.cbo.gov/publication/51919.

[8] Report to Congress - Medicare Payment Policy. Medicare Payment Advisory Commission (MedPAC). March 2018. Accessed at https://bit.ly/2Hr3Srn.

I. Introduction

Access to affordable health care coverage continues to be a major public concern. While many Americans have gained coverage since the enactment of the Affordable Care Act (ACA) through, for example, health insurance marketplaces and state Medicaid expansions, approximately 27 million non-elderly individuals living in the U.S. remain uninsured in 2017, up slightly from 2016.[9] The impact of the ACA on the uninsured differs across states with rates of uninsured ranging from 4 percent in the District of Columbia to 20 percent in Texas.[10] The reasons for this variation include: some states' declining to expand Medicaid, variation in exchange plans' premium levels, and the effectiveness of individual incentives to purchase coverage, such as the individual mandate (when it was in effect) and subsidies.

In 2017, members of the 115th Congress introduced eight legislative proposals intended to expand public health insurance coverage. Seven of the eight proposals would make Medicare or a public plan option available to a larger population than currently has access to Medicare or other public insurance (hereafter, collectively referred to as "Medicare expansion proposals"). Generally, the Medicare expansion proposals can be grouped into three types:

1. Single-payer health insurance program (Medicare-For-All: S. 1804; H.R. 676);
2. Public plan option (e.g., Medicare-X Choice Act: S. 1970; H.R. 4094);
3. Medicare buy-in option for older adults (The Medicare at 55 Act: S. 1742; Medicare Buy-In and Health Care Stabilization Act: H.R. 3748).

While the scope of each plan differs, a key similarity is that providers would be paid using Medicare rates, which are significantly less than commercial rates and, for hospitals, fall below the cost of providing care.[11] Thus, the impact of these proposals on healthcare providers is uncertain. On the one hand, expanding public insurance options could increase insurance coverage and reduce hospitals' and health systems' charity and uncompensated care costs. On the other hand, hospitals may see reductions in revenue to the extent that the policies crowd out private health insurance. Such concerns are intensified by long-term projections that show Medicare payments to hospitals dropping steeply relative to private payers over time.[12] To the extent the Medicare expansion policies negatively impact hospital and other provider revenues, the policies may not have their desired effects, due to reduced patient access or other unintended consequences.

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[9] Key Facts about the Uninsured Population. Kaiser Family Foundation. Accessed at https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population.

[10] Health Insurance Coverage of Nonelderly 0-64. Kaiser Family Foundation. Accessed at https://www.kff.org/other/state-indicator/nonelderly-0-64.

[11] June 2018 Data Book. Medicare Payment Advisory Commission (MedPAC). Chart 6-19. Accessed at https://bit.ly/2EMwQ2Y.

[12] John D. Shatto and M. Kent Clemens, Office of the Actuary, Centers for Medicare & Medicaid Services. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2018TRAlternativeScenario.pdf.

In this study, we model the effects of the Medicare-X Choice Act on coverage and healthcare spending. Although not as expansive as Medicare-for-All, Medicare-X Choice would allow any individual (other than those eligible for Medicare) to voluntarily enroll in a public plan offered on each health exchange. As a result, Medicare-X Choice's reach would be broader than other Medicare "buy-in" proposals that only allow certain age groups (e.g., age 55-64) to purchase Medicare. We assess the impact of Medicare-X Choice on coverage and healthcare spending by projecting the take-up of the new public plans among the uninsured and those with commercial health insurance.

II. Approach Overview

We modeled the effects of Medicare-X Choice by estimating insurance coverage changes due to the introduction of the new public plan, characterizing the utilization of healthcare services for those individuals whose health insurance status changes, and then estimating the effects on healthcare spending. We used the KNG Health Reform Model (KNG-HRM) to estimate individual and family insurance coverage decisions. We extended the model to incorporate healthcare utilization estimates based on individual health status and estimates of prices for healthcare services by payer. We provide an overview of our approach in the sections below (see Appendix for further detail).

a. Overview of KNG Health Reform Model (KNG-HRM)

The KNG-HRM is a microsimulation model that uses a parameterized utility function to determine individual insurance coverage choice. The model is based on data from the U.S. Census Bureau's American Community Survey (ACS), with significant inputs from the U.S. Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (MEPS), the U.S. Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), and other sources.[13,14,15] In our model, individuals consider several coverage decisions, maximizing utility for their "health insurance unit (HIU)." For non-group and public plans, changes from status quo policy result in a dynamic, iterative process with HIUs selecting new coverage choices and premiums being recalculated until a new equilibrium is reached. An individual's utility is a function of healthcare consumption; out-of-pocket spending including premiums, cost-sharing reduction (CSR) subsidies and tax credits; and variance in out-of-pocket spending (to capture the value of insurance to mitigate risk of unexpectedly high healthcare expenditures). The utility model is based on the RAND COMPARE model.[16] Similar to RAND, we

[13] American Community Survey. US Census Bureau. Accessed at https://www.census.gov/programs-surveys/acs/

[14] Medical Expenditure Panel Survey. Agency for Healthcare Research and Quality. Accessed at https://meps.ahrq.gov/mepsweb.

[15] Behavioral Risk Factor Surveillance System. US Center for Disease Control and Prevention. Accessed at https://www.cdc.gov/brfss/index.html.

[16] C. Eibner and J. Liu, Options to Expand Health Insurance Enrollment in the Individual Market (The Commonwealth Fund, October 2017). Accessed at https://www.commonwealthfund.org/publications/fund-reports/2017/oct/options-expand-health-insurance-enrollment-individual-market.

include a calibration factor that varies with, for example, income group and by college student status (defined as individuals between 18 and 35 years old and in school). These factors are set so that insurance coverage take-up in the baseline period approximates empirical patterns under status quo policy.

Chronic Conditions and Health Status. We imputed general health status, smoking status, and the presence of eight chronic conditions for each ACS respondent, based on age, race, sex, state of residence, education, and disability status. The included chronic conditions were obesity, diabetes, asthma, skin cancer, other cancer, heart attack, angina, and stroke. Incidence rates for the chronic conditions were estimated in the BRFSS using a series of logistic regression models. We then applied the regression coefficients from the BRFSS to the ACS. Our approach accounted for two-way correlations across condition categories.

Healthcare Utilization. We estimate healthcare utilization and spending for each individual in the ACS, based on an individual's demographics and imputed health status, including general health, presence of select chronic conditions, and disabilities. We estimate a series of zero inflated Poisson (ZIP) regressions using the MEPS with healthcare use as the dependent variable (number of prescription medications, hospital discharges, outpatient department physician visits, office-based physician visits, and emergency room visits). We include age, race, gender, geographic region, household size, perceived health status, smoking status, chronic condition indicators, and disability indicators as explanatory variables. We then evaluate the regression model estimated in MEPS for each respondent in the ACS using factors in the ACS or imputed to the ACS (see online Appendix at www.knghealth.com). When imputing utilization in the ACS, we apply adjustments to replicate the two-way correlations in utilization across service categories that are empirically observed in the MEPS.

Healthcare Prices. We convert healthcare utilization into spending by multiplying use rates by prices. Commercial insurer prices were obtained from publicly available data from the Health Care Cost Institute (HCCI). We developed comparable Medicare prices using studies from the Congressional Budget Office (CBO) and other sources that compare commercial provider payment rates to Medicare (See Appendix). In addition, we allow both commercial and Medicare prices to vary geographically. For commercial prices, we use the HCCI Healthy Marketplace Index (HMI) to develop a commercial price index by geographic area and imputed an index value for geographic areas not included in the HMI. To account for geographic and provider variation in Medicare prices, we use the input price and policy adjustments under the Medicare fee schedules (e.g., wage index, indirect medical education, and geographic practice cost index).

Because of scheduled productivity adjustments under current law, Medicare payment rates are expected to fall relative to other payers. We incorporate these expected changes when projecting future prices based on estimates from the CMS Office of the Actuary.[17]

Uninsured Prices. There is limited data available on prices paid by uninsured populations. People without health insurance coverage are often billed charges, but then receive discounts through charity care programs. Following analyses of the AHA Annual Survey data for hospital services and estimates in the literature, we assume that the uninsured pay rates comparable to Medicare for hospital services and rates comparable to commercial payers for other services.[18,19]

Premiums. Coverage decisions are made to maximize utility for the HIU. When new policies or events upset the status quo equilibrium, individuals change their coverage category, leading to shifts in the average healthiness of local risk pools. The model dynamically adjusts non-group and public plan premiums to account for these shifts, prompting all individuals to reevaluate their coverage decisions. When a new equilibrium is reached, we observe coverage decisions and premiums. In the baseline, we establish premiums for only one plan in each state, with the plan assumed to be at the silver-metal level. Total premiums are calculated based on the expected plan liability in the rating area and inflated to account for administrative costs. Family premiums are assigned using the Marketplace age- and tobacco-rating rules. The model does not dynamically estimate employer premiums.

Projections. We use information on demographic trends from the U.S. Census Bureau, which reports population projections by combinations of single year of age, sex, race, Hispanic status, and native status.[20] We also adjust health spending and income in future years, relying on CBO's projections of CPI-M and CPI-U, respectively.

b. Modeling Medicare-X Choice

The introduction of new public plans such as Medicare-X Choice fits naturally into our KNG-HRM framework. We assess each individual's eligibility based on factors already known in the model – marketplace eligibility, documentation status, and incarceration status. For eligible individuals, we add an additional coverage option to their choices, and they make decisions to maximize utility as usual. Elements of program design such as benefit generosity, premiums (net of subsidies), and cost sharing impact the utility from any choice.

Assumptions Affecting Changes in Insurance Coverage Type. For purpose of modeling the effects of Medicare-X Choice, we assume no impact for those currently enrolled in Medicaid or

[17] John D. Shatto and M. Kent Clemens, Office of the Actuary, Centers for Medicare & Medicaid Services. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2018TRAlternativeScenario.pdf.

[18] Melnick and Fonkych. Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices? Health Affairs. 2008. Accessed at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.2.w116.

[19] Gruber and Rodriguez, How Much Uncompensated Care Do Doctors Provide? Journal of Health Economics. 2007. Accessed at https://economics.mit.edu/files/6423.

[20] 2017 National Population Projections Datasets. U.S. Census Bureau. Accessed at https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html.

Medicare. That is, we assume no change in enrollment in those programs between the baseline and after introduction of Medicare-X Choice. For individuals currently enrolled in ESI, we do allow movement from employer coverage to other options (public plan, non-group, or uninsured). However, we impose some limitations on this movement. First, we apply the public plan eligibility criteria and prevent ineligible individuals on ESI to move onto a public plan. Second, we do not allow ESI policyholders to move off employer coverage while non-policyholders in their health insurance unit remain on employer coverage. Third, consistent with ACA requirements, individuals on ACA-compliant and affordable employer coverage are not eligible for premium or cost-sharing subsidies for non-group or public plans. However, individuals on employer coverage are eligible for employer subsidies and benefit from paying ESI premiums with pre-tax dollars. We include these employer subsidies and ESI tax benefits in our choice model. While we allow movement from employer coverage to other options at the individual level, in other respects we treat the ESI market as static. We do not adjust ESI premiums based on changing risk pools as some individuals choose other options. Moreover, we do not model firm behavior, holding constant firms' decisions regarding ESI offer, ESI premium subsidies, and compensation levels. Therefore, our findings do not reflect potential impacts of Medicare-X Choice on ESI premiums or availability of employer coverage.

Changes in Utilization of Services and Healthcare Spending. Changes in the distribution of health insurance coverage after the introduction of an expanded Medicare program drive estimated changes in total utilization of healthcare services over the study period. For the uninsured, the Oregon Health Insurance Experiment provides an estimate on the change in utilization as individuals move from being uninsured to Medicaid, which we used to predict changes in utilization rates for uninsured populations moving onto a public plan.[21] We assume no change in utilization rates for privately insured populations moving onto the public plan. We also assume no change in utilization rates over time. Finally, healthcare spending changes because of the different prices paid to providers by the uninsured, under the public plan, and commercial insurance.

Drug Prices. Under the Medicare-X Choice Act, the Department of Health and Human Services Secretary would have authority to negotiate drug prices.[22] In prior analyses, the Congressional Budget Office has expressed skepticism that granting authority for the Secretary to negotiate drug prices in Medicare would yield savings, unless Medicare used a restrictive formulary or some other mechanism to create bargaining leverage with drug companies.[23] We assume that drug prices paid by commercial plans and the government under Medicare-X Choice would be comparable. Therefore, we used our estimate of commercial drug prices for drug prices under the public plan.

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[21] Finkelstein A, Taubman S, Wright B, et al. The Oregon Health Insurance Experiment: Evidence from the First Year. Quarterly Journal of Economics. 2012. Accessed at https://www.nber.org/papers/w17190.

[22] The proposal also provides the Secretary the authority to negotiate drug prices under Medicare Part D. However, individuals eligible for Medicare Part A and B are not eligible for the Medicare-X Choice plan; we assume no direct impact of Medicare Part D drug prices on drug prices for the public plans.

[23] Cubanski, J. and Neuman, T. Searching for Savings in Medicare Drug Price Negotiations. Kaiser Family Foundation. April 2018. Issue Brief. Accessed at http://files.kff.org/attachment/issue-brief-searching-for-savings-in-medicare-drug-price-negotiations

Reinsurance. The Medicare-X Choice Act allows for the development of a reinsurance mechanism to reduce premiums, although the Medicare-X Choice Act does not specify features of the reinsurance proposal. During its initial years, the ACA established a reinsurance program from 2014 to 2016. In the last year (2016 - the least generous) the program covered 50 percent of claims costs exceeding $90,000 and capped at $250,000. The American Academy of Actuaries estimated that this would reduce net claims by 4 to 6 percent.[24] Under the ACA, the reinsurance program was funded, at least in part, by a fee on all health plans and third-party administrators (to access self-insured plans). However, the reinsurance program directed funds to plans on the exchanges. Under Medicare-X Choice, the reinsurance program may be funded by fees on those health plans that would benefit. Thus, the fees could be expected to offset the impact of the reinsurance program on premiums. Because of uncertainty regarding the source of the fees, we assumed that premiums for non-public plans in the non-group market would be reduced by half of what the American Academy of Actuaries estimated the impact of the 2016 ACA Reinsurance program would have on net claims (2.5%).

c. Estimating the Coverage Impact of a Fully Implemented ACA

Though the ACA provided enhanced Federal Funds to support states in expanding their Medicaid program, fourteen states have continued to opt out of the Medicaid coverage expansion. In a 2018 report, the Urban Institute estimated that if these states expanded Medicaid coverage to all adults with incomes below 138 percent of the Federal Poverty Level, the number of uninsured would reduce by 4.1 million in 2019.[25] In a separate report, the Urban Institute estimated the effects on insurance coverage from recent policy changes, such as repeal of the individual mandate, defunding the cost-sharing reduction payments, and reduced Federal investment in advertising and enrollment assistance.[26] This analysis found that moving from insurance coverage policies in effect during the 2017 Open Enrollment Period (OEP) to policies in effect during the 2018 OEP would result in 4.7 million additional uninsured people in 2019. These findings suggest that under a fully implemented ACA scenario, where all states adopted the Medicaid expansion and the Federal government reverted to 2017 OEP policies, there would be 8.8 million fewer uninsured people in 2019. Our own model suggests that the number of uninsured will increase by 4.1 percent between 2019 and 2024 under current law. This suggests that a fully implemented ACA would increase insurance coverage by 9.1 million in 2024.

[24] American Academy of Actuaries. Drivers of 2016 Health Insurance Premium Changes. August 2015. Issue Brief.
[25] Buettgens M. The Implications of Medicaid Expansion in the Remaining States: 2018 Update. The Urban Institute. Accessed at https://urbn.is/2QnkqGg.
[26] Blumberg LJ, Buettgens M, Wang R. Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending. The Urban Institute. Accessed at https://urbn.is/2G07k8E.

III. Key Findings

Changes in Insurance Coverage. We estimate that by 2024 approximately 173.8 million individuals will be insured through either an employer or a plan in the non-group market with another 29.0 million uninsured in the baseline. By 2033 without any changes in policy, the number of individuals in ESI and non-group would grow by 2.4 million and the uninsured would grow by 2.2 million (Table 1). Under Medicare-X Choice, we estimate that public plan participation would be 40.7 million in 2024 and 42.3 million in 2033.

Table 1. Change in Insurance Coverage Status – 2024 and 2033

			Change in Coverage under Medicare-X Choice			
Source of Coverage	Baseline		Coverage Change		Percent Change	
	2024	2033	2024	2033	2024	2033
Employer	152.7 M	154.9 M	-22.6 M	-21.4 M	-15%	-14%
Non-Group	21.1 M	21.3 M	-12.6 M	-14.0 M	-60%	-66%
Uninsured	29.0 M	31.2 M	-5.5 M	-6.9 M	-19%	-22%
Public			40.7 M	42.3 M	n/a	n/a

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: n/a = Not Applicable. Components may not sum to totals because of rounding.

We estimate that take-up of the public plan, on a percentage basis, is high among those currently on commercial non-group coverage and, while smaller, significant among the uninsured and those on ESI in the baseline. Under the Medicare-X Choice plan, the uninsured and the commercially insured on the non-group market would fall by a net reduction of 5.5 and 12.6 million in 2024, respectively (Table 1). These reductions reflect a take-up of the public plan of:

- 22.3 million from the employer market (15 percent of the employer market);
- 14.2 million from the non-group market (67 percent of the non-group market); and
- 4.2 million uninsured (14 percent of all uninsured)

Overall, we estimate a reduction in the uninsured of 5.5 million with the introduction of the Medicare-X Choice plan, with 4.2 million gaining coverage under the public plan and 1.5 million gaining non-group coverage (Table 2). Thus, under Medicare-X Choice, there would be 23.5 uninsured individuals in 2024 and 24.3 uninsured individuals in 2033. We observe some differences in take-up rates across states among the uninsured, those in a commercial non-group plan, and those on ESI at baseline (Appendix Table A2).

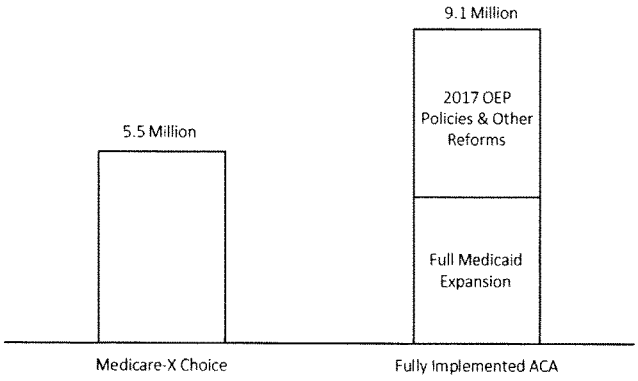
Table 2. Take-up of Public Plan among the Uninsured, Commercially Insured Individuals on the Non-Group Market, and ESI in 2024

		Coverage Levels	
Baseline Coverage	**Post Coverage**	**Baseline**	**Medicare-X Choice**
Employer	Employer	152.7 M	130.1 M
	Non-Group		0.2 M
	Public		22.3 M
	Uninsured		0.1 M
Non-Group	Non-Group	21.1 M	6.8 M
	Public		14.2 M
	Uninsured		0.1 M
Uninsured	Uninsured	29.0 M	23.3 M
	Public		4.2 M
	Non-Group		1.5 M

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Components may not sum to totals because of rounding.

We compare estimated reductions in the number of uninsured under Medicare-X Choice in 2024 to the impact of a fully implemented ACA (Figure 1). We find that a fully implemented ACA would result in 9.1 million fewer uninsured individuals, compared with 5.5 million fewer uninsured individuals under Medicare-X Choice. Under a fully implemented ACA, ESI enrollment would fall by approximately 1 percent. By comparison, we project a 15-percent decline in ESI under Medicare-X Choice. This difference in ESI crowd-out may reflect ACA design elements that specifically target the uninsured population, while being minimally disruptive to the existing private insurance market.

Figure 1. Reductions in Number of Uninsured under Medicare-X Choice and Fully Implemented ACA



Source: KNG Health analysis of the KNG-Health Reform Model and data from the Urban Institute.

Changes in Healthcare Spending. In our baseline, we estimate total healthcare spending of $1.3 trillion in 2024 among those with ESI coverage, non-group coverage, or among those individuals who are uninsured (Table 3). We project this to grow to $1.9 trillion by 2033 due to population changes and price inflation. Under Medicare-X Choice, spending would fall by $1.2 trillion over the ten-year period. The spending reductions occur among populations who previously had private coverage and are the result of lower prices under the public plan. For those who previously had ESI and non-group coverage, spending would fall by 4 percent and 29 percent, respectively. The larger non-group spending impact is driven by both higher per-person spending and higher take-up rates among that population. Among those uninsured in the baseline, we estimate spending would increase by 9 percent, which is driven by higher service utilization rates for those gaining insurance coverage. This increase in spending for the originally uninsured partially offsets the reduction in spending among the other groups.

Table 3. Spending by Original Source of Coverage in Baseline and Under Medicare-X Choice

Original Source of Coverage	Baseline		Impact	
	2024	2024-2033	2024	2024-2033
Employer	$1,026 B	$12,153 B	-$40 B	-$474 B
Non-Group	$222 B	$2,698 B	-$59 B	-$775 B
Uninsured	$77 B	$938 B	$7 B	$88 B
Total	**$1,325 B**	**$15,789 B**	**-$92 B**	**-$1,161 B**

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Spending excludes populations covered by public coverage (e.g., Medicaid, TRICARE). Components may not sum to totals because of rounding.

Effects on spending by category of service. While hospital-based services (e.g., hospitalizations, hospital outpatient visits, emergency department visits, and other hospital services) represent 47 percent of total baseline healthcare spending, these services would account for 67 percent of the reduction in total healthcare spending. In total, under Medicare-X Choice, hospitals would experience a $774 billion reduction in payments for the studied population between 2024 and 2033. These reductions translate into a 10-percent reduction in payments to hospitals. Spending would fall for all types of healthcare services with the exception of prescription drugs, which would increase slightly. The pattern in drug spending is driven by two factors. First, we assumed that prescription drug prices are constant across Medicare, commercially insured, and uninsured populations. Second, we assumed that prescription drug use would increase for the uninsured as they gain coverage under the Medicare-X Choice proposal.

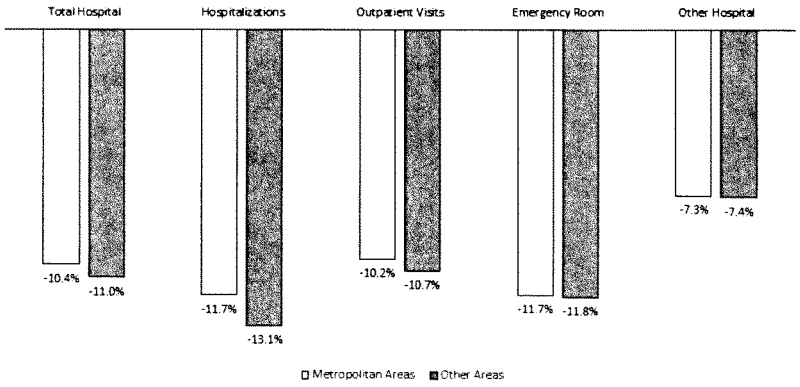
Table 4. Spending by Type of Service in Baseline and Under Medicare-X Choice

Type of Service	Baseline		Change in Spending by Service (1-Year and 10-Year)			
			Dollars		Percent	
	2024	2024-2033	2024	2024-2033	2024	2024-2033
Hospital	$620 B	$7,392	-$62 B	-$774 B	-10%	-10%
Hospitalizations	$260 B	$3,103 B	-$30 B	-$370 B	-11%	-12%
Hospital Outpatient Visits	$135 B	$1,594 B	-$13 B	-$163 B	-10%	-10%
Emergency Department	$84 B	$1,013 B	-$9 B	-$117 B	-11%	-12%
Other Hospital	$141 B	$1,682 B	-$10 B	-$124 B	-7%	-7%
Non-Hospital	$705 B	$8,397	-$30 B	-$388 B	-4%	-5%
Physician Visits	$90 B	$1,073 B	-$6 B	-$86 B	-7%	-8%
Prescription Drugs	$263 B	$3,125 B	$1 B	$7 B	0%	0%
Other Non-Hospital	$352 B	$4,199 B	-$24 B	-$309 B	-7%	-7%
Total	**$1,325 B**	**$15,789 B**	**-$92 B**	**-$1,161 B**	**-7%**	**-7%**

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Spending excludes populations covered by public coverage (e.g., Medicaid, TRICARE). Components may not sum to totals because of rounding.

Effects on spending by location type. Medicare-X Choice would produce larger relative impacts to hospital spending in non-metropolitan areas (outside metropolitan areas, mixed areas) than in metropolitan areas. Figure 2 illustrates these differential relative impacts. Since 81 percent of baseline hospital spending occurs in metropolitan areas, Medicare-X Choice would produce larger absolute impacts to hospital spending in metropolitan areas than non-metropolitan areas.

Figure 2. Differences in Spending Impacts between Metropolitan Areas and Other Areas under Medicare-X Choice



Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Spending excludes populations covered by public coverage (e.g., Medicaid, TRICARE)

IV. Conclusions

In this study, we model the effects of the Medicare-X Choice Act, which would introduce a public plan on the health insurance exchange markets. We estimated the effects on insurance coverage and healthcare spending using the KNG-Health Reform Model and after incorporating geographic variation in both healthcare utilization and prices. We estimate that public plan participation would be 40.7 million in 2024, which would include 36.5 million who were previously insured in private plans. Medicare-X Choice reduces the number of uninsured by 5.5 million, 4.2 million of whom would gain coverage in the new public option, and 1.5 million who would gain non-group coverage. The public plan take-up rates are the highest among those previously covered on the non-group market and are projected to be 67 percent. We estimate a 7-percent reduction ($1.2 trillion) in overall healthcare spending for the studied populations, but a 9-percent increase ($88 billion) in spending for those who would otherwise be uninsured. Reductions in spending are predominantly driven by a shift from private to public coverage and the lower Medicare provider payment rates that would apply. Hospital-based services would be disproportionately affected by the policy and would experience a 10-percent reduction in payments among the relevant population.

For hospitals, the introduction of a public plan that reimburses providers using Medicare rates would compound financial stresses they are already facing, potentially impacting access to care and provider quality. CBO projects that between 40 and 50 percent of hospitals could have negative margins by 2025 under current law.[27] Given that Medicare already pays hospitals below their costs (e.g., the Medicare Payment Advisory Commission estimates that Medicare hospital margins will be -11 percent in 2018), Medicare-X Choice would be expected to increase the number of hospitals with negative margins. While hospitals may attempt to shift some costs to commercial insurers, the ability to do this under a public plan may be limited because of the potentially significant take-up by those in the non-group market. Policymakers should have a clear understanding of potential effects on patient access, provider payment, the commercial insurance market, and ESI (desired as well as unintended) when considering proposals to expand Medicare coverage.

[27] Projecting Hospitals' Profit Margins Under Several Illustrative Scenarios. Congressional Budget Office. September 2016. Accessed at https://www.cbo.gov/publication/51919.

V. Appendix

a. Sensitivity Analysis and Limitations

Our findings are dependent on several key assumptions but are particularly sensitive to assumptions on price and utilization levels under the public plan option. Within our model, significant take-up in the public plan option is driven by lower premiums and lower out-of-pockets costs relative to private insurance, which is a result of lower prices paid to providers under the public option. However, for some categories of services, the risk-adjusted Medicare-to-commercial price ratio is unknown. Lastly, while we assume that utilization for previously-insured public plan enrollees does not change, utilization could conceivably change for this population and such trends could also affect price levels. In particular, we might expect utilization under Medicare-X Choice to be higher than under commercial plans, because commercial insurers use utilization review, narrow networks, and other tools to control healthcare use and the public plan may not. Conversely, significantly lower prices could reduce provider participation, which might hinder access to care and decrease utilization under Medicare-X Choice. In addition, the Medicare-X Choice proposal would allow Medicare prices to increase by up to 25 percent in rural areas. Table A1 illustrates how assumptions related to price levels and utilization affect public plan take-up within our model.

Table A1. Sensitivity of Medicare-X Choice 2024 Coverage Impacts to Price and Utilization Assumptions

	Midpoint Scenario	25% Lower Public Plan Prices	25% Higher Public Plan Prices	25% Higher Public Utilization
Employer	-22.6 M	-24.5 M	-21.3 M	-22.8 M
Non-Group	-12.6 M	-12.6 M	-11.8 M	-11.9 M
Uninsured	-5.5 M	-6.5 M	-4.6 M	-5.3 M
Public	40.7 M	43.5 M	37.8 M	40.0 M

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Components may not sum to totals because of rounding.

Prior studies on the impact of the introduction of a public plan show a range of estimates. In November 2013, the CBO reported its estimates of the impact of adding a public plan to the health insurance exchanges.[28] The public plan considered by CBO was similar to the public plan under Medicare-X Choice: (1) the public plan would have to charge premiums that fully covered its costs, including administrative expenses; and (2) the payment rates to providers would be based on Medicare rates. CBO estimated that the number of uninsured would fall by 2 million and ESI coverage would fall by about the same amount. In 2018, researchers from the Urban Institute proposed the "Healthy America Program."[29] Under this proposal, there would be a new

[28] Add a "Public Plan" to the Health Insurance Exchanges. Congressional Budget Office. Accessed at https://www.cbo.gov/budget-options/2013/44890.
[29] Linda J. Blumberg, John Holahan, Stephen Zuckerman. The Healthy America Program. The Urban Institute. Accessed at https://www.urban.org/sites/default/files/publication/98432/2001826_2018.05.11_healthy_america_final_9.pdf.

national public plan option, enhanced premium and cost-sharing subsidies, and tax penalties for remaining uninsured. The authors characterize the proposal as more comprehensive than Medicare-X Choice. Under the Healthy America Program, the ESI population is estimated to fall by 18 million, non-group coverage by 14 million, and the uninsured by 16 million.

Like the Urban Institute, we estimate a significantly larger effect of a public plan on the uninsured and ESI than CBO. Our estimates of reductions in non-group coverage are comparable to the Urban Institute (-13 M vs. -13 M). However, we project greater fall off of ESI coverage (-18 M vs -23 M) and smaller reductions in the number of uninsured (-16 M vs. -6 M). The differences in the impact on the uninsured can be explained, at least in part, by the tax penalties and enhanced premium and cost sharing subsidies in the Healthy America Program. The reason for our higher estimate of ESI crowd out from a public plan is less clear. The Urban Institute estimates ESI premiums dynamically. To the extent a public plan reduces ESI premiums because of a healthier risk pool, Urban's model would make ESI more attractive to consumers than in our model. Our results indicate that take-up of the public plan for those on ESI in the baseline is sensitive to the public plan prices paid to providers. The differential between commercial and Medicare prices used by the Urban Institute is unclear.

Our analysis has several limitations. We do not consider the diversity of plan design in the non-group market, instead imposing homogenous plan designs within each market representative of typical marketplace plan features in the status quo. We do not model competition among health plans and, in fact, model a single, representative plan for each state. The introduction of a public plan in each market, as under Medicare-X Choice, could create competitive pressures and lower premiums for commercial plans. As a result, these plans may look more attractive to consumers than our model would suggest. In addition, we made a series of simplifying assumptions to assess the effects of a public plan on ESI coverage. First, we held ESI premiums fixed at baseline levels (only updating for medical inflation). In practice, ESI premiums may change with introduction of a public plan, making ESI more or less attractive as compared to the baseline. Second, we do not model non-economic considerations that could reduce ESI drop-off, such as behavioral inertia or a cultural preference for employer coverage over public coverage. As noted above, we assume no impact on use of healthcare services from take-up of the public plan by those previously insured on the non-group market or ESI. In assessing geographic differences in the relationship between commercial and Medicare prices, we relied on data populated for select areas. For many areas (particularly small markets), the relationship is imputed, by taking the nearest area for which we have data or, in areas without nearby data, a broader regional average.

b. Additional Study Methods

Price Assumptions. Medicare payment rates are generally lower than those set by commercial payers. This suggests that populations moving from commercial to public plans that use Medicare fee schedules would likely reduce provider reimbursement. Consequently, our model must incorporate price differentials between Medicare and commercial plans. To estimate the

magnitude of this differential, we reviewed studies that compared Medicare and commercial prices for the same set of services. In 2017 and 2018, the Congressional Budget Office (CBO) released two studies comparing prices for commercial and Medicare hospital admissions and physician care. In their analysis of hospitals using data from the Health Care Cost Institute (HCCI), CBO found that commercial insurers paid 89 percent more than Medicare for inpatient hospitalizations.[30] The findings were similar for both medical and surgical admissions.

CBO also found that commercial insurers paid more than Medicare for physician services but did not report an overall average difference.[31] We used the service taxonomy provided by the HCCI to classify the twenty physician services analyzed by CBO into four physician service categories: office visits, surgical services, radiology services, and other professional services.[32] Within a service category, we computed an unweighted average commercial-to-Medicare payment ratio for all reported services in the category. Next, we linked these average ratios to commercial per-capita spending amounts from the HCCI. We then computed an overall mean commercial-to-Medicare payment ratio by computing the average commercial-to-Medicare payment ratios across the four service categories, weighted by the per-capita spending amount in each service category. This calculation resulted in an overall commercial-to-Medicare ratio of 1.49 for physician services.

Table A2. Calculation of Overall Physician Commercial-to-Medicare Payment Ratio

Service Category	Commercial Per Capita Spending	Mean Commercial-to-Medicare Payment Ratio
Office Visits	$385.91	1.12
Surgical Services	$280.63	1.70
Radiology Services	$133.58	2.17
Other Professional Services	$523.26	1.47
Weighted Mean Commercial-to-Medicare Ratio		1.49

Sources: Maeda 2017; Health Care Cost Institute Annual Report
Categories: Office Visits: 99203, 99213, 99214; Surgical services: 17311, 19081, 27130, 27447, 29881, 45385, 47562, 58558, 66984; Radiology services: 70553, 74183, 77418, 78815; Other Professional: 92928, 93000, 93458, 99232

CBO has not released an analysis comparing differences in commercial and Medicare payment rates for outpatient hospital services. In a 2017 Report to Congress, the Medicare Payment

[30] An Analysis of Private-Sector Prices for Hospital Admissions. Congressional Budget Office. 2017. Accessed at https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf.
[31] An Analysis of Private-Sector Prices for Physicians' Services: Working Paper 2018-01. Congressional Budget Office. 2018. Accessed at https://www.cbo.gov/publication/53441.
[32] HCCI Professional Service Categories – CPT Procedure Codes. Health Care Cost Institute. 2016. Accessed at https://www.healthcostinstitute.org/research/research-resources.

Advisory Commission (MedPAC) stated that commercial rates "are often far more than 50 percent above Medicare rates."[33] A 2010 study from the Center for Studying Health System Change found that private insurer rates for hospital outpatient services were between 134 percent and 266 percent of Medicare rates across eight studied markets.[34] This is consistent with public filing reports from California insurers which showed commercial outpatient rates that were 200 percent more than Medicare.[33] We will assume that the inpatient commercial-to-Medicare payment ratio estimated by CBO (1.89) is also applicable in the outpatient setting, which is on the lower end of the range reported in published research.

[33] Report to the Congress: Medicare Payment Policy Chapter 3. Medicare Payment Advisory Commission. 2017. Accessed at http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch3.pdf.

[34] Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power. Center for Studying Health System Change. 2010. Available at http://www.hschange.org/CONTENT/1162/.

c. Additional Results

Table A3. State-level Coverage Impacts in 2024

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	Baseline 2024			Impact 2024			
	Employer	Non-Group	Uninsured	Employer	Non-Group	Uninsured	Public
AK	0.3 M	0.0 M	0.1 M	0.0 M	0.0 M	0.0 M	0.1 M
AL	2.1 M	0.3 M	0.5 M	-0.3 M	-0.1 M	-0.1 M	0.5 M
AR	1.2 M	0.2 M	0.2 M	-0.2 M	-0.1 M	0.0 M	0.3 M
AZ	3.1 M	0.4 M	0.7 M	-0.5 M	-0.3 M	-0.1 M	0.9 M
CA	17.9 M	2.9 M	2.9 M	-2.5 M	-1.7 M	-0.5 M	4.8 M
CO	2.6 M	0.4 M	0.4 M	-0.4 M	-0.2 M	-0.1 M	0.7 M
CT	1.8 M	0.2 M	0.2 M	-0.3 M	-0.1 M	0.0 M	0.4 M
DC	0.3 M	0.1 M	0.0 M	0.0 M	0.0 M	0.0 M	0.1 M
DE	0.5 M	0.0 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
FL	8.3 M	2.1 M	2.9 M	-1.1 M	-1.4 M	-0.6 M	3.1 M
GA	4.8 M	0.7 M	1.4 M	-0.8 M	-0.4 M	-0.2 M	1.4 M
HI	0.8 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
IA	1.6 M	0.2 M	0.1 M	-0.2 M	-0.1 M	0.0 M	0.3 M
ID	0.7 M	0.2 M	0.2 M	-0.1 M	-0.1 M	0.0 M	0.2 M
IL	6.6 M	0.8 M	0.9 M	-1.0 M	-0.5 M	-0.2 M	1.7 M
IN	3.3 M	0.4 M	0.5 M	-0.5 M	-0.2 M	-0.1 M	0.8 M
KS	1.5 M	0.2 M	0.2 M	-0.2 M	-0.1 M	0.0 M	0.4 M
KY	1.9 M	0.2 M	0.2 M	-0.3 M	-0.1 M	0.0 M	0.4 M
LA	1.9 M	0.3 M	0.4 M	-0.3 M	-0.2 M	-0.1 M	0.5 M
MA	3.6 M	0.4 M	0.2 M	-0.6 M	-0.3 M	0.0 M	0.9 M
MD	3.2 M	0.3 M	0.4 M	-0.6 M	-0.2 M	-0.1 M	0.9 M
ME	0.6 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
MI	4.8 M	0.5 M	0.5 M	-0.7 M	-0.4 M	-0.1 M	1.1 M
MN	3.1 M	0.3 M	0.2 M	-0.5 M	-0.3 M	-0.1 M	0.9 M
MO	2.9 M	0.4 M	0.5 M	-0.4 M	-0.3 M	-0.1 M	0.8 M
MS	1.2 M	0.2 M	0.4 M	-0.2 M	-0.1 M	-0.1 M	0.4 M
MT	0.4 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
NC	4.6 M	0.8 M	1.2 M	-0.7 M	-0.5 M	-0.2 M	1.4 M
ND	0.4 M	0.1 M	0.0 M	-0.1 M	0.0 M	0.0 M	0.1 M
NE	1.0 M	0.1 M	0.2 M	-0.1 M	-0.1 M	0.0 M	0.3 M
NH	0.7 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
NJ	4.9 M	0.5 M	0.7 M	-0.7 M	-0.3 M	-0.2 M	1.2 M
NM	0.7 M	0.1 M	0.2 M	-0.1 M	0.0 M	0.0 M	0.2 M
NV	1.5 M	0.2 M	0.4 M	-0.2 M	-0.1 M	0.0 M	0.3 M
NY	9.0 M	1.2 M	1.1 M	-1.3 M	-0.5 M	-0.2 M	2.0 M
OH	5.7 M	0.5 M	0.7 M	-0.8 M	-0.3 M	-0.1 M	1.2 M
OK	1.5 M	0.2 M	0.4 M	-0.2 M	-0.1 M	-0.1 M	0.4 M
OR	1.9 M	0.3 M	0.3 M	-0.3 M	-0.2 M	-0.1 M	0.5 M
PA	6.3 M	0.7 M	0.7 M	-0.9 M	-0.5 M	-0.1 M	1.5 M
RI	0.5 M	0.1 M	0.0 M	-0.1 M	0.0 M	0.0 M	0.1 M
SC	2.1 M	0.3 M	0.6 M	-0.3 M	-0.2 M	-0.1 M	0.6 M
SD	0.4 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.1 M
TN	3.1 M	0.4 M	0.6 M	-0.5 M	-0.3 M	-0.2 M	0.9 M
TX	13.3 M	1.8 M	5.3 M	-2.0 M	-1.0 M	-1.0 M	4.0 M
UT	2.0 M	0.3 M	0.3 M	-0.3 M	-0.2 M	-0.1 M	0.5 M
VA	4.2 M	0.6 M	0.7 M	-0.6 M	-0.4 M	-0.1 M	1.1 M
VT	0.3 M	0.0 M	0.0 M	0.0 M	0.0 M	0.0 M	0.0 M
WA	3.6 M	0.4 M	0.5 M	-0.6 M	-0.3 M	-0.1 M	0.9 M
WI	3.1 M	0.3 M	0.3 M	-0.4 M	-0.1 M	-0.1 M	0.6 M
WV	0.7 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
WY	0.3 M	0.0 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
US	**152.7 M**	**21.1 M**	**29.0 M**	**-22.6 M**	**-12.6 M**	**-5.5 M**	**40.7 M**

Table A4. State-level Coverage Impacts in 2033

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	Baseline 2024			Impact 2024			
	Employer	Non-Group	Uninsured	Employer	Non-Group	Uninsured	Public
AK	0.3 M	0.0 M	0.1 M	0.0 M	0.0 M	0.0 M	0.1 M
AL	2.1 M	0.3 M	0.5 M	-0.3 M	-0.2 M	-0.1 M	0.6 M
AR	1.2 M	0.2 M	0.3 M	-0.2 M	-0.1 M	0.0 M	0.3 M
AZ	3.4 M	0.4 M	0.8 M	-0.5 M	-0.3 M	-0.2 M	1.0 M
CA	18.0 M	2.9 M	3.2 M	-2.3 M	-2.0 M	-0.6 M	4.9 M
CO	2.5 M	0.4 M	0.4 M	-0.4 M	-0.2 M	-0.1 M	0.7 M
CT	1.8 M	0.2 M	0.2 M	-0.3 M	-0.1 M	0.0 M	0.5 M
DC	0.4 M	0.1 M	0.0 M	0.0 M	0.0 M	0.0 M	0.1 M
DE	0.5 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
FL	8.6 M	2.2 M	3.1 M	-1.1 M	-1.5 M	-0.7 M	3.4 M
GA	4.9 M	0.7 M	1.5 M	-0.7 M	-0.4 M	-0.3 M	1.5 M
HI	0.9 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
IA	1.5 M	0.2 M	0.1 M	-0.2 M	-0.1 M	0.0 M	0.3 M
ID	0.7 M	0.2 M	0.2 M	-0.1 M	-0.1 M	0.0 M	0.2 M
IL	6.7 M	0.8 M	1.0 M	-0.9 M	-0.5 M	-0.2 M	1.7 M
IN	3.3 M	0.4 M	0.6 M	-0.4 M	-0.2 M	-0.1 M	0.8 M
KS	1.5 M	0.2 M	0.3 M	-0.2 M	-0.1 M	0.0 M	0.4 M
KY	1.9 M	0.2 M	0.2 M	-0.3 M	-0.1 M	0.0 M	0.4 M
LA	1.9 M	0.3 M	0.4 M	-0.3 M	-0.2 M	-0.1 M	0.5 M
MA	3.6 M	0.4 M	0.2 M	-0.5 M	-0.3 M	0.0 M	0.8 M
MD	3.3 M	0.3 M	0.4 M	-0.6 M	-0.3 M	-0.1 M	0.9 M
ME	0.6 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
MI	4.8 M	0.5 M	0.5 M	-0.6 M	-0.3 M	-0.1 M	1.1 M
MN	3.1 M	0.3 M	0.3 M	-0.4 M	-0.2 M	-0.1 M	0.8 M
MO	2.9 M	0.4 M	0.5 M	-0.4 M	-0.3 M	-0.1 M	0.8 M
MS	1.1 M	0.2 M	0.4 M	-0.2 M	-0.1 M	-0.1 M	0.4 M
MT	0.4 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.1 M
NC	4.9 M	0.8 M	1.3 M	-0.7 M	-0.5 M	-0.3 M	1.5 M
ND	0.4 M	0.1 M	0.0 M	-0.1 M	0.0 M	0.0 M	0.1 M
NE	1.0 M	0.1 M	0.2 M	-0.1 M	-0.1 M	0.0 M	0.3 M
NH	0.7 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
NJ	5.1 M	0.5 M	0.8 M	-0.7 M	-0.3 M	-0.2 M	1.2 M
NM	0.8 M	0.1 M	0.2 M	-0.1 M	-0.1 M	0.0 M	0.2 M
NV	1.6 M	0.2 M	0.4 M	-0.2 M	-0.1 M	-0.1 M	0.4 M
NY	8.6 M	1.2 M	1.2 M	-1.2 M	-0.7 M	-0.2 M	2.1 M
OH	5.6 M	0.5 M	0.7 M	-0.7 M	-0.3 M	-0.2 M	1.2 M
OK	1.6 M	0.2 M	0.4 M	-0.2 M	-0.1 M	-0.1 M	0.4 M
OR	1.9 M	0.3 M	0.3 M	-0.3 M	-0.2 M	-0.1 M	0.5 M
PA	6.2 M	0.7 M	0.7 M	-0.8 M	-0.5 M	-0.2 M	1.5 M
RI	0.5 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
SC	2.1 M	0.3 M	0.6 M	-0.3 M	-0.2 M	-0.1 M	0.6 M
SD	0.4 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
TN	3.2 M	0.4 M	0.7 M	-0.5 M	-0.3 M	-0.2 M	1.0 M
TX	14.2 M	1.9 M	5.9 M	-2.0 M	-1.2 M	-1.4 M	4.6 M
UT	2.2 M	0.3 M	0.4 M	-0.3 M	-0.2 M	-0.1 M	0.6 M
VA	4.3 M	0.6 M	0.8 M	-0.6 M	-0.4 M	-0.2 M	1.1 M
VT	0.3 M	0.0 M	0.0 M	0.0 M	0.0 M	0.0 M	0.0 M
WA	3.7 M	0.5 M	0.5 M	-0.5 M	-0.3 M	-0.1 M	0.9 M
WI	3.0 M	0.3 M	0.3 M	-0.4 M	-0.2 M	-0.1 M	0.7 M
WV	0.7 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
WY	0.3 M	0.0 M	0.1 M	0.0 M	0.0 M	0.0 M	0.1 M
US	**154.9 M**	**21.3 M**	**31.2 M**	**-21.4 M**	**-14.0 M**	**-6.9 M**	**42.3 M**

Table A5. State-level Spending Impacts by Original Source of Coverage in 2024
Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	Baseline 2024				Impact 2024			
	Employer	Non-Group	Uninsured	Total	Employer	Non-Group	Uninsured	Total
AK	2.2 B	0.3 B	0.2 B	2.7 B	-0.1 B	-0.1 B	0.0 B	-0.2 B
AL	14.1 B	3.9 B	1.4 B	19.4 B	-0.5 B	-0.7 B	0.2 B	-1.0 B
AR	6.8 B	1.7 B	0.6 B	9.2 B	-0.2 B	-0.3 B	0.0 B	-0.4 B
AZ	17.7 B	3.6 B	1.7 B	22.9 B	-0.8 B	-0.9 B	0.1 B	-1.5 B
CA	115.2 B	29.1 B	6.8 B	151.1 B	-6.3 B	-9.1 B	0.8 B	-14.5 B
CO	15.4 B	3.5 B	1.0 B	19.8 B	-0.8 B	-0.9 B	0.1 B	-1.7 B
CT	12.5 B	2.1 B	0.5 B	15.1 B	-0.4 B	-0.4 B	0.0 B	-0.8 B
DC	2.5 B	0.5 B	0.1 B	3.0 B	-0.1 B	-0.1 B	0.0 B	-0.1 B
DE	3.2 B	0.4 B	0.1 B	3.7 B	-0.1 B	-0.1 B	0.0 B	-0.2 B
FL	58.0 B	23.7 B	7.7 B	89.4 B	-2.2 B	-7.3 B	0.6 B	-8.9 B
GA	29.7 B	7.0 B	3.7 B	40.3 B	-1.2 B	-1.8 B	0.3 B	-2.8 B
HI	4.6 B	0.6 B	0.1 B	5.4 B	-0.3 B	-0.2 B	0.0 B	-0.5 B
IA	9.7 B	1.6 B	0.3 B	11.7 B	-0.3 B	-0.2 B	0.0 B	-0.4 B
ID	4.5 B	2.0 B	0.5 B	7.0 B	-0.2 B	-0.7 B	0.0 B	-0.8 B
IL	44.4 B	7.7 B	2.5 B	54.6 B	-1.5 B	-2.0 B	0.2 B	-3.3 B
IN	25.0 B	4.1 B	1.5 B	30.5 B	-0.9 B	-1.3 B	0.2 B	-2.1 B
KS	8.9 B	2.0 B	0.6 B	11.6 B	-0.3 B	-0.5 B	0.1 B	-0.8 B
KY	13.0 B	2.1 B	0.6 B	15.8 B	-0.4 B	-0.4 B	0.1 B	-0.8 B
LA	11.9 B	2.7 B	1.1 B	15.7 B	-0.4 B	-0.5 B	0.1 B	-0.8 B
MA	23.4 B	3.7 B	0.5 B	27.6 B	-0.7 B	-0.7 B	0.0 B	-1.3 B
MD	17.4 B	2.4 B	1.0 B	20.8 B	-0.4 B	-0.3 B	0.1 B	-0.7 B
ME	5.2 B	1.3 B	0.3 B	6.8 B	-0.1 B	-0.3 B	0.1 B	-0.4 B
MI	33.0 B	5.2 B	1.3 B	39.5 B	-0.8 B	-1.2 B	0.1 B	-2.0 B
MN	18.3 B	2.6 B	0.6 B	21.6 B	-0.7 B	-0.7 B	0.1 B	-1.3 B
MO	20.3 B	4.9 B	1.5 B	26.7 B	-0.6 B	-1.3 B	0.1 B	-1.8 B
MS	7.8 B	2.6 B	1.0 B	11.5 B	-0.2 B	-0.7 B	0.1 B	-0.8 B
MT	2.9 B	1.0 B	0.2 B	4.1 B	-0.1 B	-0.3 B	0.0 B	-0.4 B
NC	32.9 B	9.1 B	3.2 B	45.1 B	-1.3 B	-2.8 B	0.3 B	-3.8 B
ND	2.5 B	0.6 B	0.1 B	3.2 B	-0.1 B	-0.1 B	0.0 B	-0.1 B
NE	6.9 B	1.5 B	0.4 B	8.8 B	-0.2 B	-0.4 B	0.0 B	-0.6 B
NH	5.0 B	0.7 B	0.2 B	5.9 B	-0.1 B	-0.2 B	0.0 B	-0.3 B
NJ	35.8 B	5.9 B	2.0 B	43.7 B	-1.3 B	-1.8 B	0.2 B	-2.9 B
NM	5.2 B	1.1 B	0.4 B	6.7 B	-0.2 B	-0.3 B	0.0 B	-0.5 B
NV	9.0 B	1.4 B	0.9 B	11.2 B	-0.4 B	-0.4 B	0.1 B	-0.7 B
NY	69.5 B	12.5 B	3.0 B	85.0 B	-2.1 B	-2.6 B	0.4 B	-4.3 B
OH	40.7 B	5.8 B	1.8 B	48.4 B	-1.3 B	-1.4 B	0.2 B	-2.5 B
OK	10.0 B	2.6 B	1.3 B	14.0 B	-0.3 B	-0.5 B	0.2 B	-0.7 B
OR	12.5 B	3.2 B	0.7 B	16.4 B	-0.6 B	-1.0 B	0.1 B	-1.5 B
PA	44.1 B	9.1 B	1.9 B	55.1 B	-1.4 B	-2.3 B	0.2 B	-3.4 B
RI	2.9 B	0.5 B	0.1 B	3.5 B	-0.1 B	-0.1 B	0.0 B	-0.1 B
SC	13.6 B	3.7 B	1.6 B	18.9 B	-0.6 B	-1.1 B	0.1 B	-1.5 B
SD	3.0 B	0.8 B	0.1 B	3.9 B	-0.1 B	-0.2 B	0.0 B	-0.3 B
TN	19.2 B	4.7 B	1.8 B	25.7 B	-0.7 B	-1.3 B	0.2 B	-1.8 B
TX	93.8 B	18.9 B	14.7 B	127.5 B	-4.6 B	-5.6 B	1.3 B	-8.9 B
UT	11.0 B	2.4 B	0.7 B	14.1 B	-0.5 B	-0.6 B	0.1 B	-1.1 B
VA	27.6 B	6.0 B	2.1 B	35.8 B	-1.1 B	-1.8 B	0.2 B	-2.6 B
VT	2.1 B	0.3 B	0.1 B	2.5 B	-0.1 B	0.0 B	0.0 B	-0.1 B
WA	22.7 B	4.1 B	1.1 B	27.8 B	-1.0 B	-1.2 B	0.1 B	-2.1 B
WI	20.6 B	3.3 B	0.8 B	24.6 B	-0.7 B	-0.6 B	0.1 B	-1.2 B
WV	6.1 B	0.9 B	0.3 B	7.4 B	-0.2 B	-0.1 B	0.1 B	-0.2 B
WY	1.6 B	0.3 B	0.1 B	2.1 B	-0.1 B	-0.1 B	0.0 B	-0.2 B
US	**1,025.8 B**	**221.9 B**	**77.0 B**	**1,324.7 B**	**-39.8 B**	**-59.4 B**	**7.3 B**	**-91.9 B**

Table A6. State-level Spending Impacts by Original Source of Coverage in 2024-2033

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	Baseline 2024-2033				Impact 2024-2033			
	Employer	Non-Group	Uninsured	Total	Employer	Non-Group	Uninsured	Total
AK	26.4 B	3.9 B	2.2 B	32.5 B	-1.5 B	-1.8 B	0.4 B	-2.9 B
AL	164.4 B	46.9 B	16.7 B	228.1 B	-5.7 B	-12.1 B	1.7 B	-16.1 B
AR	79.8 B	20.3 B	7.7 B	107.7 B	-2.0 B	-3.3 B	0.5 B	-4.7 B
AZ	218.5 B	44.5 B	21.1 B	284.1 B	-9.9 B	-11.4 B	1.6 B	-19.7 B
CA	1,367.0 B	354.2 B	82.7 B	1,804.0 B	-73.8 B	-119.7 B	9.3 B	-184.2 B
CO	177.4 B	40.9 B	11.3 B	229.6 B	-9.7 B	-12.6 B	1.1 B	-21.1 B
CT	146.9 B	25.2 B	6.6 B	178.8 B	-4.5 B	-5.9 B	0.6 B	-9.8 B
DC	29.8 B	6.1 B	0.8 B	36.7 B	-0.8 B	-1.2 B	0.1 B	-2.0 B
DE	37.2 B	5.0 B	1.5 B	43.7 B	-1.5 B	-1.1 B	0.1 B	-2.5 B
FL	696.2 B	294.2 B	94.5 B	1,084.8 B	-26.9 B	-94.2 B	7.7 B	-113.5 B
GA	352.2 B	85.6 B	44.8 B	482.7 B	-15.0 B	-24.3 B	3.7 B	-35.6 B
HI	60.1 B	8.3 B	1.6 B	70.0 B	-3.3 B	-3.1 B	0.1 B	-6.3 B
IA	111.5 B	18.7 B	3.8 B	134.0 B	-3.1 B	-3.2 B	0.3 B	-5.9 B
ID	53.0 B	23.8 B	5.6 B	82.3 B	-2.2 B	-7.8 B	0.5 B	-9.6 B
IL	528.4 B	94.9 B	30.7 B	653.9 B	-17.6 B	-25.2 B	2.6 B	-40.2 B
IN	291.2 B	49.1 B	17.3 B	357.5 B	-10.0 B	-16.5 B	1.9 B	-24.6 B
KS	104.6 B	23.9 B	7.7 B	136.2 B	-3.9 B	-6.2 B	0.6 B	-9.5 B
KY	151.2 B	24.7 B	7.4 B	183.4 B	-4.8 B	-5.7 B	0.6 B	-10.0 B
LA	139.5 B	31.5 B	13.0 B	184.0 B	-4.4 B	-6.5 B	0.9 B	-9.9 B
MA	274.8 B	44.8 B	5.8 B	325.4 B	-7.8 B	-8.6 B	0.6 B	-15.8 B
MD	207.8 B	29.4 B	12.4 B	249.6 B	-5.7 B	-4.4 B	0.9 B	-9.2 B
ME	59.8 B	15.1 B	3.5 B	78.4 B	-1.6 B	-3.7 B	0.6 B	-4.7 B
MI	384.4 B	61.8 B	15.8 B	461.9 B	-9.6 B	-14.5 B	1.5 B	-22.6 B
MN	214.8 B	31.3 B	7.3 B	253.4 B	-8.1 B	-7.9 B	0.9 B	-15.1 B
MO	236.6 B	57.0 B	17.9 B	311.6 B	-6.9 B	-15.8 B	1.6 B	-21.1 B
MS	92.1 B	30.6 B	12.4 B	135.1 B	-3.0 B	-9.3 B	1.1 B	-11.1 B
MT	33.2 B	11.8 B	2.2 B	47.2 B	-1.3 B	-4.1 B	0.3 B	-5.1 B
NC	399.3 B	112.8 B	39.4 B	551.6 B	-15.8 B	-36.1 B	3.3 B	-48.6 B
ND	29.4 B	6.6 B	1.3 B	37.3 B	-0.9 B	-1.2 B	0.2 B	-1.9 B
NE	80.2 B	17.9 B	5.4 B	103.4 B	-2.9 B	-4.9 B	0.5 B	-7.3 B
NH	57.3 B	8.6 B	2.2 B	68.1 B	-1.7 B	-2.6 B	0.3 B	-4.1 B
NJ	429.3 B	73.9 B	25.2 B	528.3 B	-15.5 B	-21.9 B	2.7 B	-34.7 B
NM	63.9 B	14.3 B	5.5 B	83.6 B	-2.4 B	-4.6 B	0.5 B	-6.4 B
NV	110.0 B	17.5 B	10.7 B	138.2 B	-4.6 B	-4.6 B	0.7 B	-8.5 B
NY	797.0 B	149.5 B	35.6 B	982.2 B	-24.8 B	-36.3 B	4.2 B	-56.8 B
OH	473.9 B	68.7 B	21.2 B	563.8 B	-15.5 B	-18.7 B	2.2 B	-32.0 B
OK	118.1 B	31.1 B	15.7 B	164.9 B	-3.8 B	-7.0 B	1.9 B	-9.0 B
OR	147.2 B	38.8 B	8.4 B	194.4 B	-6.5 B	-12.8 B	0.9 B	-18.4 B
PA	513.8 B	107.7 B	22.4 B	643.9 B	-15.8 B	-31.6 B	2.3 B	-45.2 B
RI	33.6 B	6.6 B	1.5 B	41.7 B	-1.0 B	-0.9 B	0.2 B	-1.7 B
SC	160.3 B	43.6 B	18.6 B	222.4 B	-6.6 B	-12.8 B	1.6 B	-17.8 B
SD	34.6 B	8.9 B	1.7 B	45.2 B	-1.3 B	-2.5 B	0.2 B	-3.7 B
TN	230.6 B	57.7 B	21.9 B	310.2 B	-8.5 B	-16.0 B	1.9 B	-22.6 B
TX	1,147.5 B	239.7 B	183.6 B	1,570.9 B	-58.0 B	-73.9 B	15.7 B	-116.2 B
UT	137.9 B	29.8 B	9.6 B	177.3 B	-6.8 B	-7.7 B	0.8 B	-13.7 B
VA	328.2 B	73.0 B	25.2 B	426.5 B	-12.5 B	-22.3 B	2.1 B	-32.7 B
VT	24.2 B	3.9 B	0.8 B	28.8 B	-0.6 B	-0.6 B	0.1 B	-1.0 B
WA	269.9 B	50.9 B	12.9 B	333.7 B	-12.5 B	-15.4 B	1.2 B	-26.8 B
WI	238.9 B	38.8 B	9.0 B	286.7 B	-8.1 B	-8.2 B	1.1 B	-15.1 B
WV	70.9 B	10.2 B	3.9 B	85.0 B	-2.2 B	-1.2 B	1.0 B	-2.4 B
WY	18.6 B	3.7 B	1.8 B	24.1 B	-0.9 B	-1.1 B	0.2 B	-1.9 B
US	**12,153 B**	**2,698.0 B**	**937.9 B**	**15,789 B**	**-473.8 B**	**-775.0 B**	**87.6 B**	**-1,161.2 B**

Table A7. State-level Spending Impacts by Service Category

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	Hospital Spending				Non-Hospital Spending			
	2024		2024-2033		2024		2024-2033	
	Baseline	Impact	Baseline	Impact	Baseline	Impact	Baseline	Impact
AK	1.4 B	-0.1 B	17.1 B	-1.8 B	1.3 B	-0.1 B	15.3 B	-0.8 B
AL	8.4 B	-0.7 B	98.5 B	-10.9 B	11.0 B	-0.4 B	129.6 B	-5.8 B
AR	3.5 B	-0.2 B	41.8 B	-2.6 B	5.6 B	-0.1 B	66.0 B	-1.3 B
AZ	10.4 B	-1.0 B	129.0 B	-12.9 B	12.5 B	-0.4 B	155.1 B	-6.0 B
CA	78.4 B	-10.4 B	937.7 B	-130.6 B	72.7 B	-5.0 B	866.2 B	-64.4 B
CO	9.4 B	-1.2 B	109.6 B	-14.6 B	10.4 B	-0.6 B	120.1 B	-7.5 B
CT	7.0 B	-0.5 B	83.2 B	-6.0 B	8.1 B	-0.3 B	95.6 B	-3.7 B
DC	1.6 B	-0.1 B	19.0 B	-1.4 B	1.5 B	-0.1 B	17.7 B	-0.8 B
DE	1.6 B	-0.1 B	19.4 B	-1.6 B	2.1 B	-0.1 B	24.3 B	-1.0 B
FL	41.3 B	-6.4 B	501.1 B	-80.1 B	48.1 B	-3.1 B	583.8 B	-39.9 B
GA	17.0 B	-1.6 B	204.0 B	-21.0 B	23.3 B	-0.8 B	278.7 B	-10.6 B
HI	2.8 B	-0.3 B	36.5 B	-4.3 B	2.6 B	-0.2 B	33.5 B	-2.2 B
IA	5.1 B	-0.3 B	58.2 B	-3.8 B	6.6 B	-0.2 B	75.8 B	-2.7 B
ID	3.4 B	-0.6 B	39.8 B	-7.3 B	3.6 B	-0.3 B	42.5 B	-3.8 B
IL	25.5 B	-2.2 B	305.6 B	-26.5 B	29.1 B	-1.1 B	348.3 B	-14.2 B
IN	14.7 B	-1.5 B	171.5 B	-16.9 B	15.9 B	-0.6 B	186.0 B	-7.6 B
KS	5.2 B	-0.5 B	61.2 B	-6.4 B	6.4 B	-0.3 B	75.0 B	-3.2 B
KY	6.9 B	-0.5 B	80.1 B	-6.4 B	8.9 B	-0.3 B	103.3 B	-3.2 B
LA	6.6 B	-0.5 B	77.3 B	-5.7 B	9.1 B	-0.2 B	106.7 B	-3.1 B
MA	12.8 B	-0.9 B	151.2 B	-10.5 B	14.8 B	-0.6 B	174.2 B	-8.0 B
MD	8.2 B	-0.4 B	98.5 B	-5.1 B	12.6 B	-0.2 B	151.1 B	-3.3 B
ME	3.4 B	-0.2 B	39.4 B	-3.1 B	3.4 B	-0.1 B	39.0 B	-1.6 B
MI	18.2 B	-1.3 B	212.7 B	-15.3 B	21.3 B	-0.6 B	249.2 B	-7.8 B
MN	9.6 B	-0.8 B	112.7 B	-9.4 B	12.0 B	-0.6 B	140.7 B	-6.6 B
MO	12.5 B	-1.2 B	145.9 B	-13.8 B	14.2 B	-0.5 B	165.6 B	-6.3 B
MS	5.2 B	-0.5 B	61.2 B	-7.2 B	6.3 B	-0.2 B	73.9 B	-2.9 B
MT	2.1 B	-0.3 B	24.6 B	-3.9 B	2.0 B	-0.2 B	22.6 B	-1.8 B
NC	20.4 B	-2.5 B	249.8 B	-30.9 B	24.7 B	-1.2 B	301.8 B	-15.5 B
ND	1.5 B	-0.1 B	17.5 B	-1.3 B	1.7 B	-0.1 B	19.8 B	-0.8 B
NE	4.1 B	-0.4 B	47.7 B	-4.8 B	4.7 B	-0.2 B	55.7 B	-2.7 B
NH	2.7 B	-0.2 B	31.0 B	-2.5 B	3.2 B	-0.1 B	37.1 B	-1.5 B
NJ	21.2 B	-1.9 B	256.7 B	-21.9 B	22.5 B	-0.9 B	271.7 B	-10.7 B
NM	3.5 B	-0.3 B	42.9 B	-4.7 B	3.3 B	-0.2 B	40.7 B	-2.3 B
NV	5.4 B	-0.4 B	66.0 B	-5.4 B	5.9 B	-0.2 B	72.2 B	-2.1 B
NY	41.7 B	-2.9 B	483.2 B	-38.3 B	43.3 B	-1.6 B	498.9 B	-22.3 B
OH	23.0 B	-1.7 B	268.6 B	-21.0 B	25.3 B	-0.7 B	295.2 B	-9.2 B
OK	6.0 B	-0.4 B	71.4 B	-5.5 B	7.9 B	-0.2 B	93.6 B	-2.1 B
OR	8.0 B	-1.0 B	94.7 B	-12.8 B	8.4 B	-0.6 B	99.8 B	-7.1 B
PA	26.5 B	-2.5 B	309.2 B	-32.3 B	28.7 B	-1.2 B	334.7 B	-16.0 B
RI	1.5 B	-0.1 B	17.3 B	-1.1 B	2.1 B	-0.1 B	24.4 B	-0.7 B
SC	8.1 B	-1.0 B	95.1 B	-11.6 B	10.8 B	-0.5 B	127.3 B	-5.7 B
SD	2.0 B	-0.2 B	23.0 B	-2.5 B	1.9 B	-0.1 B	22.2 B	-1.3 B
TN	10.4 B	-1.1 B	126.1 B	-13.9 B	15.3 B	-0.5 B	184.0 B	-7.1 B
TX	58.8 B	-5.6 B	724.8 B	-71.7 B	68.7 B	-1.9 B	846.1 B	-26.2 B
UT	6.8 B	-0.8 B	85.4 B	-9.5 B	7.3 B	-0.4 B	91.9 B	-4.8 B
VA	16.1 B	-1.8 B	192.2 B	-21.9 B	19.7 B	-0.9 B	234.3 B	-11.5 B
VT	1.3 B	-0.1 B	14.5 B	-0.7 B	1.2 B	0.0 B	14.4 B	-0.4 B
WA	13.3 B	-1.4 B	160.3 B	-17.8 B	14.5 B	-0.7 B	173.4 B	-9.8 B
WI	10.9 B	-0.8 B	127.2 B	-9.3 B	13.7 B	-0.5 B	159.5 B	-6.6 B
WV	3.4 B	-0.1 B	39.4 B	-1.5 B	4.0 B	-0.1 B	45.6 B	-0.7 B
WY	0.9 B	-0.1 B	10.9 B	-1.2 B	1.1 B	0.0 B	13.2 B	-0.4 B
US	**619.7 B**	**-62.0 B**	**7,391.6 B**	**-773.6 B**	**705.0 B**	**-29.9 B**	**8,397.2 B**	**-387.6 B**

Table A8. State-level Take-up of Medicare-X Choice in 2024 by Baseline Coverage

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	ESI	Non-Group	Uninsured
AK	13%	78%	41%
AL	15%	50%	8%
AR	15%	72%	12%
AZ	16%	70%	15%
CA	14%	65%	12%
CO	16%	63%	13%
CT	15%	67%	12%
DC	11%	49%	7%
DE	17%	74%	14%
FL	14%	73%	17%
GA	15%	70%	11%
HI	14%	82%	16%
IA	14%	38%	7%
ID	14%	74%	15%
IL	15%	73%	14%
IN	14%	75%	17%
KS	15%	69%	13%
KY	15%	65%	12%
LA	15%	67%	10%
MA	16%	74%	15%
MD	18%	75%	21%
ME	13%	55%	9%
MI	14%	74%	13%
MN	16%	84%	41%
MO	14%	75%	17%
MS	14%	77%	17%
MT	15%	77%	30%
NC	15%	72%	14%
ND	15%	44%	13%
NE	14%	75%	24%
NH	15%	82%	27%
NJ	15%	70%	17%
NM	13%	55%	6%
NV	14%	64%	11%
NY	14%	52%	9%
OH	14%	59%	12%
OK	14%	55%	10%
OR	15%	71%	15%
PA	14%	68%	15%
RI	17%	40%	7%
SC	14%	75%	17%
SD	16%	78%	15%
TN	15%	78%	24%
TX	15%	67%	16%
UT	15%	63%	13%
VA	15%	67%	14%
VT	12%	35%	3%
WA	15%	66%	10%
WI	14%	47%	10%
WV	14%	24%	3%
WY	18%	72%	17%

Mr. WOMACK. And with that, Mr. Chairman, I yield back.
[The prepared statement of Steve Womack follows:]

Ranking Member Steve Womack (R-AR) Opening Remarks at Hearing on One-Size-Fits-All Health Care Systems

Thank you, Chairman Yarmuth, and thank you to Deputy Director Mark Hadley and his team for joining us today.
We're here to discuss a sobering report developed by CBO – at the request of our Chairman – that details some of the risks of imposing a one-size-fits-all, government-run health care system – as proposals like Medicare-for-All would do.

What's noticeably missing from the report is a cost estimate for specific proposals. My friends across the aisle did not ask for that, and I think I know why.

While the score would be useful, we already know how much a one-size-fits-all health care system would cost the American people. Independent analyses from economists across the ideological spectrum – including George Mason University, the Urban Institute, and the American Action Forum – have projected single-payer-type proposals such as Medicare-for-All to cost at least $32 trillion.

That number bears repeating. *At least* $32 trillion – on top of what we're already spending on health care. That's *at least* $10 trillion more than our nation's astronomically high $22 trillion debt. That's roughly $10,000 *per every American per year* and is equivalent to 11 percent of gross domestic product (GDP) each year.

CBO states very clearly in its report that "government spending on health care would increase substantially under a single-payer system."

How could the federal government pay for these substantial spending increases?

The report outlines four methods.

The government could impose tax hikes.

It could increase premiums.

It could rely more heavily on cost-sharing, which is another way of saying out-of-pocket-costs such as co-pays.

Or it could just add this enormous price tag to our existing debt without any pay-fors at all. If you're someone who subscribes to Modern Monetary Theory, maybe the debt doesn't matter to you. That's of course not the way I see it.

Putting aside discussions about how to finance such a costly proposal, this report has been especially helpful in showing that these ideas will never work in America.

Imposing a single-payer health care system would eliminate private insurance – that includes the health care 158 million Americans receive through their employer or their union. The CBO report even warns that under this type of system, "patients would not have a choice of insurer or health benefits … [and] the public plan might not address the needs of some people."

Further, the CBO report also explicitly points out the broader impact the proposal could have on health care.

For example, by reducing payment rates for providers – that is, payments for doctors, hospitals, and so on – the report explains there will not only be a reduction in the quality of care, there will be a reduction in the supply of care, hampering access to the treatments and services people need.

It's clear proposals like Medicare-for-All will chase a lot of doctors out of health care. That's not only my strong opinion. It's backed up by hard facts.

These are just a few of the findings from the CBO report. And I expect to discuss many more with our witnesses today.

I hope my colleagues and the public will listen carefully. The consequences of what health care could become under a Democrat-controlled government will be articulated very clearly here today.

With that in mind, I urge all of my colleagues not to look at this report in isolation, but rather to look at this report in the context of existing proposals – including the Medicare-for-All Act of 2019.

Toward that end, when considering other proposals, the other side admits that more limited expansions of existing federal programs – a Medicare buy-in or Medicaid buy-in, for example – are in fact a step toward single-payer, government-run health care.

They admit this openly. This is the direction some lawmakers want to take your health care – and it will have consequences that ripple through the most personal aspects of American life, from fewer doctors and longer wait times to less access and no choices.

That's why this conversation today is so important. With that, Mr. Chairman, I yield back.

Chairman YARMUTH. I thank the gentleman for his opening statement.

In the interest of time, if any other members have opening statements, you may submit those statements in writing for the record.

I would like to thank our witnesses for being here this morning.

Mr. Hadley, the Committee has received your written statement, and it will be made part of the formal hearing record. You will have 10 minutes to deliver your oral remarks. You may begin when you are ready.

STATEMENT OF MARK HADLEY, DEPUTY DIRECTOR, CONGRESSIONAL BUDGET OFFICE, ACCOMPANIED BY DR. JESSICA BANTHIN, DEPUTY ASSISTANT DIRECTOR FOR HEALTH, RETIREMENT, AND LONG-TERM ANALYSIS, CONGRESSIONAL BUDGET OFFICE, AND DR. JEFFREY KLING, ASSOCIATE DIRECTOR FOR ECONOMIC ANALYSIS, CONGRESSIONAL BUDGET OFFICE

STATEMENT OF MARK HADLEY

Mr. HADLEY. Chairman Yarmuth, Ranking Member Womack, and Members of the Committee, thank you for inviting me and my colleagues to come and testify today about the Congressional Budget Office's recent work on single-payer health care systems.

Some Members of Congress have proposed establishing a single-payer health care system in the United States. Many more people would probably have health insurance as a result. But the government would take much more control over the health care system. The effects of such a system on its participants and total health care spending could vary greatly, depending on the details of the system's structure and operation.

Earlier this month, CBO released a report on single-payer health care systems. That report describes the primary features of single-payer health care systems and discusses some of the considerations for establishing such a system in the United States. It represents our first step in a broader effort to support you as you consider the issue and build our capacity to estimate the cost of specific proposals.

I want to convey two main points this morning.

First, moving to a single-payer system would be a major undertaking. It would involve significant changes for all participants, individuals, providers, insurers, employers, and manufacturers of drugs and medical devices.

Because health care spending currently accounts for one-sixth of the nation's economic activity, those changes could significantly affect the overall U.S. economy, and the transition toward a single-payer system could be complicated, challenging, and potentially disruptive.

Second, to establish a single-payer system, lawmakers would need to make many decisions and would face complex tradeoffs. The first figure in our report, which you have in front of you is a handout, identifies some of the major questions that would need to be answered.

With the balance of my time, I will focus on three sets of issues that illustrate the complexities involved in designing a single-payer system.

The first set of issues relates to coverage. In a single-payer system that achieved universal coverage, everyone eligible would receive health insurance coverage with a specified set of benefits regardless of their health status. People who currently have private insurance would enroll in a public plan.

Under the current system, an average of 30 million people per month are projected to be uninsured in 2019. Most of those people are U.S. citizens and would be covered by a public plan under a single-payer system.

Policymakers would have a lot of choices to make about how to extend coverage, particularly if each state administered a separate plan. One of those choices would be whether noncitizens who are not lawfully present would be eligible, 11 million people in 2019, and about half of them have insurance under the current system.

The second set of issues relates to cost. Under a single-payer system, the government, federal or state, would pay a larger share of all national health care costs.

In 2017, private sources, such as businesses and households, contributed just under half of the $3.5 trillion of total national health care spending. Shifting such a large amount of expenditures from private to public sources would significantly increase government spending and would require substantial additional government resources.

Total national health care spending on a single-payer system might be more or less than it is under the current system, depending on key features of the new system, including the services covered, patients' cost-sharing requirements, provider payment rates, and administrative costs. And I will turn to each of those briefly.

The benefit package could be designed to cover services that are typically covered by private insurance and Medicare. Alternatively, it could be expanded to cover additional services, such as dental, vision, hearing, or long-term services and supports. Expanding the benefit package to cover additional services would tend to increase health care spending.

Cost-sharing affects beneficiaries' financial well-being and total health care spending. People use more care when their cost is lower, so having a lower or no cost-sharing requirement would tend to increase the use of services and lead to additional health care spending.

Under a single-payer system, provider payment rates could be based on rates paid by Medicare, Medicaid, commercial insurance, or some other measure. Medicare payment rates are substantially lower than commercial payment rates on average. If provider payment rates were set at Medicare's rates rather than average commercial rates, then total national health care spending would be lower. But the amount of care supplied and the quality of that care might diminish.

When fully implemented, a single-payer system would probably have lower administrative costs than the current system because it would consolidate administrative tasks and eliminate insurer profits.

To give a sense of scale, the federal government's cost of administering the Medicare program accounted for 1.4 percent of total Medicare expenditures in 2017. When you include the administrative cost of Medicare Advantage and part D plans, total administrative costs for the Medicare program accounted for about 6 percent of its expenditures. By comparison, private insurers' administrative costs averaged about 12 percent in 2017.

But other possible features of a single-payer system, including efforts to coordinate patient care and eliminate fraudulent spending, could add administrative costs.

A single-payer system could affect the cost to providers and individuals in other ways. It could reduce the amount of uncompensated care, for example, and unlike private insurers, which can experience substantial enrollee turnover, a single-payer system would have no turnover.

For that reason, a single-payer system would have a greater incentive to invest in preventive measures that have been shown to reduce costs. Whether the system would act on that incentive is unknown.

The final set of issues relates to people's access to health care.

An expansion of insurance coverage under a single-payer system would help more people receive more health care. People who are currently uninsured would receive coverage, and some people who already have coverage would use additional services, particularly if those had lower out-of-pocket costs.

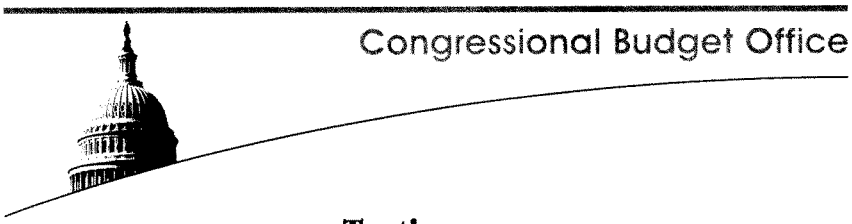
Whether the supply of providers would be adequate to meet the greater demand would depend on various components of the system. If the supplies of services was not sufficient to meet the demand for care, patients would face increased wait times and reduced access to care. The government, however, could implement policies to encourage the provision of services, and in the longer run, providers might deliver more care more efficiently.

Under a single-payer system, people who are currently covered by private insurance might have more providers available to choose from. Participants would not have a choice of insurer or health benefits, however. The public plan would provide the same set of health care services to everyone eligible, so it might not address the needs of some people.

For example, the public plan might not be as quick to cover new treatments and new technologies as would a system of competing private insurers. Policymakers could try to design the single-payer system to mitigate such risks.

As I said at the start of my testimony, CBO has worked to build our capacity to support this Committee and the Congress as you consider these issues. We look forward to being helpful to you and your staff. My colleagues and I are happy to answer your questions. Thank you.

[The prepared statement of Mark Hadley follows:]



Testimony

Key Design Components and Considerations for Establishing a Single-Payer Health Care System

Mark Hadley
Deputy Director

Before the
Committee on the Budget
United States House of Representatives

May 22, 2019

This document is embargoed until it is delivered at 10:00 a.m. (EDT) on Wednesday, May 22, 2019. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

Chairman Yarmuth, Ranking Member Womack, and Members of the Committee, thank you for inviting me and my colleagues to testify about the Congressional Budget Office's recent work on single-payer health care systems.

Some Members of Congress have proposed establishing a single-payer health care system in the United States. Many more people would probably have health insurance as a result—but the government would take much more control over the health care system. The effects of such a system on its participants and total health care spending could vary greatly depending on the details of the system's structure and operation.

Earlier this month, CBO released a report on single-payer health care systems.[1] That report describes the primary features of single-payer health care systems and discusses some of the considerations for establishing such a system in the United States. It represents our first step in a broader effort to support you as you consider the issue and to build our capacity to estimate the costs of specific proposals.

I want to convey two main points this morning.

First, moving to a single-payer system would be a major undertaking. It would involve significant changes for all participants—individuals, providers, insurers, employers, and manufacturers of drugs and medical devices. Because health care spending currently accounts for about one-sixth of the nation's economic activity, those changes could significantly affect the overall U.S. economy. And the transition toward a single-payer system could be complicated, challenging, and potentially disruptive.

Second, to establish a single-payer system, lawmakers would need to make many decisions and would face complex trade-offs.

The first figure in our report, which you also have in front of you as a handout, identifies some of the major questions that would need to be answered (see Figure 1).

1. Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System* (May 2019), www.cbo.gov/publication/55150.

With the balance of my time, I will focus on three sets of issues that illustrate the complexities involved in designing a single-payer system.

Coverage

In a single-payer system that achieved universal coverage, everyone eligible would receive health insurance coverage with a specified set of benefits regardless of their health status. People who currently have private insurance would enroll in a public plan.

Under the current system, an average of 30 million people per month are projected to be uninsured in 2019. Most of those people are U.S. citizens and would be covered by a public plan under a single-payer system. Policymakers would have a lot of choices to make about how to extend coverage, particularly if each state administered a separate plan. One of those choices would be whether noncitizens who are not lawfully present would be eligible. An average of 11 million people per month are expected to be in that category in 2019, and about half of them have health insurance under the current system.

Costs

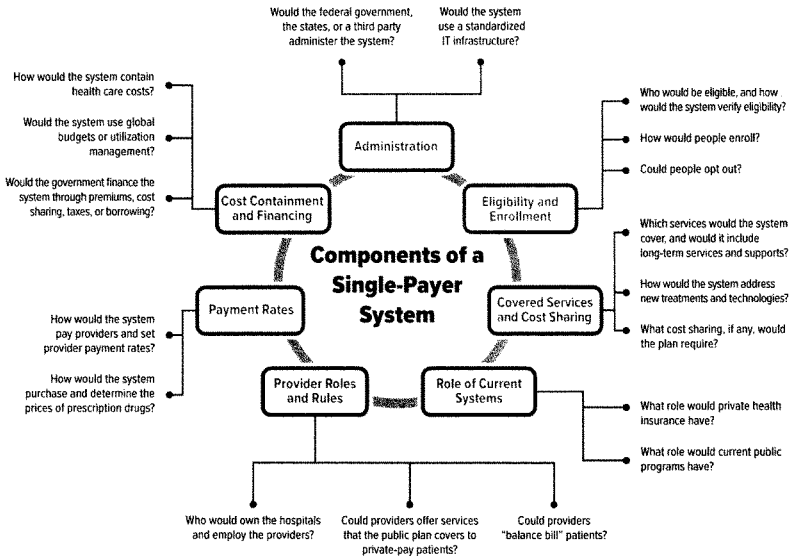
Under a single-payer system, the government (federal or state) would pay a larger share of all national health care costs. In 2017, private sources such as businesses and households contributed just under half of the $3.5 trillion of total national health care spending. Shifting such a large amount of expenditures from private to public sources would significantly increase government spending and require substantial additional government resources.

Total national health care spending under a single-payer system might be more or less than it is under the current system depending on the key features of the new system, including the services covered, patients' cost-sharing requirements, provider payment rates, and administrative costs:

- **Services Covered.** The benefit package could be designed to cover services that are typically covered by private insurance or by Medicare. Alternatively, it could be expanded to cover additional services, such as long-term services and supports. Expanding the benefit package to cover additional services would tend to increase health care spending. A single-payer

Figure 1.

Designing a Single-Payer Health Care System



Source: Congressional Budget Office.

IT = information technology.

system would also need a way to decide which new treatments and technologies it would cover.

- **Cost-Sharing Requirements.** Cost sharing affects beneficiaries' financial well-being and total health care spending. People use more care when their cost is lower, so no cost sharing would tend to increase the use of services and lead to additional health care spending.

- **Payment Rates.** Under a single-payer system, provider payment rates could be based on the rates paid by Medicare, Medicaid, or commercial insurers—or they could be set at some other level. Medicare payment rates are substantially lower than commercial payment rates, on average. If provider payment rates were set at Medicare's rates rather than average commercial rates, then total national health care spending would be lower. But the amount of care supplied and the quality of that care might diminish.

- **Administrative Costs.** When fully implemented, a single-payer system would probably have lower administrative costs than the current system, because it would consolidate administrative tasks and eliminate insurers' profits. To give a sense of scale,

the federal government's cost of administering the Medicare program accounted for 1.4 percent of total Medicare expenditures in 2017. When the administrative costs of Medicare Advantage and Part D plans are included, total administrative costs for the Medicare program accounted for about 6 percent of its expenditures. By comparison, private insurers' administrative costs averaged about 12 percent in 2017. But other possible features of a single-payer system, including efforts to coordinate patient care and eliminate fraudulent spending, could add to administrative costs.

A single-payer system could affect costs to providers and individuals in other ways. It could reduce the amount of uncompensated care, for example. Moreover, unlike private insurers, which can experience substantial enrollee turnover, a single-payer system would have no turnover. For that reason, a single-payer system would have a greater incentive to invest in preventive measures that have been shown to reduce costs. Whether the system would act on that incentive is unknown.

Access to Health Care Services

An expansion of insurance coverage under a single-payer system would help more people receive more health care. People who are currently uninsured would receive coverage, and some people who already have coverage would use additional services if benefits were more generous than under their current coverage. Whether the supply of providers would be adequate to meet the greater demand would depend on various components of the system. If the supply of services was not sufficient to meet the demand for care, patients might face increased wait times and reduced access to care. The government, however, could implement policies to encourage the provision of services, and in the longer run, providers might deliver care more efficiently.

Under a single-payer system, people who are currently covered by private insurance might have more providers available to choose from. Participants would not have a choice of insurer or health benefits, however. The public plan would provide the same set of health care services to everyone eligible, so it might not address the needs of some people. For example, the public plan might not be as quick to cover new treatments and technologies as would a system with competing private insurers. Policymakers could try to design the single-payer system to mitigate such risks.

As I said at the start of my testimony, CBO has worked to build our capacity to support this committee and the Congress as you consider these issues, and we look forward to being helpful to you and your staff. My colleagues and I are happy to answer your questions. Thank you.

This testimony was prepared by Mark Hadley, Jared Maeda, and Xiaotong Niu. Helpful contributions were made by Jessica Banthin, Sarah Masi, and Lyle Nelson. In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, the testimony contains no recommendations.

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Chairman YARMUTH. Thank you, Mr. Hadley. I appreciate your testimony.

And now we begin the question and answer period. And I now recognize the gentlelady from Connecticut, Ms. DeLauro, for five minutes.

Ms. DELAURO. Thank you very much, Mr. Chairman.

And I thank our panel and our speaker this morning.

I think it is fair to say that the shared goal of my Democratic colleagues on health care is looking at the way in which we achieve universal health coverage in the U.S.

Now, we do have several iterations. The one that I have introduced is Medicare for America, which ensures universal, affordable, high quality health care coverage by building both on Medicare and Medicaid and to expand that covered benefits and services.

Under the current system, health care benefits are largely dependent on your ZIP Code in Medicare. What we try to do is to fix that in this legislation.

Universal coverage needs to include long-term services and support, because we have got millions of Americans who live with disabilities and those taking care of an aging loved one. So we can't keep long-term services and supports separate from our health care system.

Third, what we try to do is to achieve the universal coverage through a combination of individuals and employers choosing Medicare for America, auto-enrolling Americans at birth, and the uninsured into Medicare for America and employer-sponsored insurance. We look at trying to bring the cost down for families. Premiums cost no more than 8 percent of individuals' or households' monthly income. There are no deductibles. And it simplifies cost sharing and will, in fact, bring down cost for families.

We ban private contracting, which has created that two-tier system of health care in America, one tier for people with health insurance and another for the wealthy who can afford to pay for their care without any insurance.

And just a couple of items. Student loan forgiveness program for health care providers that accept Medicare for America forgives 10 percent of student loan debt each year for a health care provider, an institution, for a provider that accepts Medicare for America payment rates. So we want to make sure that there are health care providers.

And finally, a workforce development program for individuals who work in home and community-based long-term services and supports. So we are going to increase the number or try to increase of number of caregivers to be able to take care of the increasing number of seniors and those disabled.

Let me just, going back to benefit design, you know, which is a tremendous concern when you consider any universal coverage plan. If you live in Connecticut or Mississippi, Utah or California, everywhere an American should have comprehensive, affordable health care.

In Connecticut, our Medicaid program covers things like dental care for adults. Alabama, Texas does not. Missouri, Pennsylvania does not cover physical therapy. Connecticut does. Arkansas covers eyeglasses for adults. California does not.

Just correct me if I am wrong. A single-payer system that delegates benefit design to the states could lead to inequalities. If this is true, what safeguards need to be put in place to ensure that benefits are standard across the country for all enrollees?

Mr. HADLEY. Yes. As we said in the report, in the section on administration, one of the key questions is whether this would be administered by the states or the federal government. And there can be lots of variation that policymakers choose from how that would be done. So even if a program were administered by the state level, it could delegate some authority to states to make some decisions. Alternatively, if there was a program administered by the states, the federal government could supervise and highly regulate the benefit design.

Ms. DELAURO. Doesn't that—just a final question because I have used my time—but doesn't that continue this patchwork that we have in this country with regard to health care services and the inclusion of long-term services of the disabled?

I think one of the fundamental problems is that, again, it is your ZIP Code that is a determination of what kind of care and what kind of services that you get. Doesn't it make more sense to have something that is uniform and that it is directed centrally?

Mr. HADLEY. Well, we don't make policy recommendations, but it is a policy choice for you all to decide whether there would be one uniform set across the country or whether it would be controlled at a more local level.

Ms. DELAURO. Well, I understand that we do make policy, but I am sure that you have got views that I would have hoped that you might share with us as to how we do get to standardized care for people in this country. But thank you very, very much.

Mr. Chairman, I yield back, and I thank you.

Chairman YARMUTH. I thank the gentlelady.

I now yield five minutes to the gentleman from Ohio, Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

And I want to thank the panel for joining us today. I appreciate the opportunity to move past the, quote, "free health care" tagline and talk about the actual reality of implementing Medicare for All.

I am an IT guy, spent 30 years in information technology before coming to Congress. Mr. Hadley, in your report, you describe a standardized IT system that implements portable electronic medical records.

So question number one. In the U.S., we have a lot of different health IT systems that would have to be merged together to achieve a standardized system. Would this be similar to what the VA and DoD are trying to do today?

Mr. HADLEY. Yes, Congressman, they are trying to create a system so that DoD and VA's medical records can be interoperable, meaning they can be transferred between the two organizations with a minimal amount of transactional work done to interrupt them.

Mr. JOHNSON. So it is a similar process.

How many records are being merged in the VA and DoD systems? And if we were to cover every single American under a single-payer IT system, how many records would that be?

Mr. HADLEY. I don't have the exact number of the records at VA that are being merged, but if we were covering the entire United states, it would be—the population is 329 million people, substantially more than are covered by the VA and DoD now.

Mr. JOHNSON. Well, I have the number here for you. It is about 18 million records is what the VA and DoD are doing.

It is my understanding that since 2011, the VA and DoD have been attempting to merge their electronic health records with a 10-year estimated cost of $16.1 billion.

What are some of the challenges a national standardized IT system would face?

Mr. HADLEY. Well, I think the key one is going to be interoperability. But there has been an attempt over the last several years to have more providers move to having more electronic medical records, but they sort of diverged into different directions when they did that. And so at the moment they are having real problems having those systems talk to each other.

Mr. JOHNSON. Yeah. I certainly agree with that. Interoperability is rarely thought about up front, and it winds up biting us in the backside at the end.

Do you have any idea on cost? I mean, if the VA is spending $16.1 billion over 10 years for 18 million records, have you got any idea what the cost of a standardized system to cover everybody in this country would be?

Mr. HADLEY. I don't at this time. The system that you are describing would be similar to the one that is in Taiwan, but there are many countries that don't have a fully developed system that is similar to that one.

Mr. JOHNSON. Okay. Let's talk about security a little bit. You know, if such a system were implemented, would the security of the databases and the networks that house such a system and records, would that be a concern for you?

Mr. HADLEY. Yes, absolutely. I would expect the government would invest heavily in trying to protect those systems.

Mr. JOHNSON. Okay. Is there a precedent for large-scale government data breaches in government-run databases?

Mr. HADLEY. Yes, Congressman.

Mr. JOHNSON. Okay. Yeah. Because we saw that in 2015, both OPM and VA experienced data breaches which exposed an estimated 22 million and 26.5 million people's personal data, respectively.

Is it necessary for the government to manage all of the electronic health records——

Mr. HADLEY. No.

Mr. JOHNSON.——to run a system of this size?

Mr. HADLEY. It could be run in different ways. It could be a simpler design of electronic records. So, for example, it could be more like a billing system, such as we see with Medicare fee-for-service.

Mr. JOHNSON. Okay. What would happen if there was no central database? You talk about interoperability, and we saw early on in the journey for an electronic health record the lack of interoperability and how that was being such a negative around our health care community.

If there was no central database, with all the problems of cost and security and interoperability that we just described, would quality of care decrease in such a system?

Mr. HADLEY. Well, so, yes, I think you would be foregoing some of the benefits you might get from such a system, and those would include patient care coordination, but also eliminating duplicative services.

Mr. JOHNSON. You know, one of the things—and I will wrap up here, Mr. Chairman—one of the things that is widely known by IT professionals is that the lifecycle cost of a system is one number. Seventy-five percent of that lifecycle cost is in operations and maintenance.

The easy part, believe it or not, as complicated as this is, the easy part is the upfront part of designing and implementing. Seventy-five percent of the cost is in the operations and maintenance, and I submit that it is a monstrous cost to do what we are talking about here.

Thanks, Mr. Hadley.

Chairman YARMUTH. The gentleman's time has expired.

I now recognize the gentleman from Massachusetts, Mr. Moulton, for five minutes.

Mr. MOULTON. Mr. Chairman, health care is a human right. Everyone in America deserves good, affordable health care. And we all know that that is not the case today.

I was having a health care debate with a Republican colleague not too long ago, and I asked him if he thought that the children of billionaires, say, Donald Trump's children, should have better health care than the marines I served with in Iraq. He considered the implications of the question for a minute and then said: Yes, if they can pay for better health care, then they should have it.

Well, I disagree. I don't think that the sons of billionaires should have better health care than the sons and daughters of America who risk their lives for our freedom. I think veterans deserve the best health care in the world, period. Frankly, in the greatest country this world has ever seen, all Americans deserve the best health care in the world.

Now, Democrats agree on this, but we do have differences on how we get there. Perhaps the closest model for a single-payer system in America today is the VA. When I was elected to Congress, I made a commitment to go to the VA myself, to continue going there with my fellow veterans, because I said, "Look, until we fix this system, I am going to go through what they are going through and see it firsthand."

Well, I have seen the good, the bad, and the ugly of single-payer health care at the VA. There are some things the VA does really well. For example, the VA negotiates prescription drug prices, which Medicare does not do, and that means our prescription prices are lower and the system is very efficient.

I also had surgery not too long ago at the VA. And after the surgery, I was sent home with the wrong medications.

Now, they were supposed to give me a strong painkiller, and they just sent me home with a bottle of Advil, which was not what the prescription was for.

But imagine if it had been the other way around, where I was supposed to get a moderate drug and instead was sent home with something much more powerful or addictive.

We have all heard the stories of veterans literally dying on waiting lists. That day I checked in at the VA, first of all, they couldn't find my record, and they said they couldn't prove I was a veteran but would consider taking me as a humanitarian case. Then I sat down next to a Vietnam vet who had been sitting there for five hours.

Personally, I think President Obama had it right, which is to have a public option, and that is what he had in Obamacare before Congress took it out, a public option that competes against existing private insurance options.

I don't think the American public would be thrilled if the new President and the new Congress came in and said, "You know what? We are going to just put FedEx and UPS out of business because we don't like that competition in the postal system." No, competition is good. And just like we have options for delivering packages, I think we should have options for delivering health care.

Yale economist Zack Cooper found that if you stay in a hospital facing no competition that your bill will be $1,900 higher on average than if there are four or more competitors. Reasonable regulation and competition among providers improves outcome for health care recipients, and I believe the same is true for health care coverage.

Mr. Hadley, the report suggests that substitutive private insurance, which seems to be the closest analogy to the program I am advocating, might also improve the quality of care for people in both private and public plans. Can you share how competition among private and public insurance plans could increase outcomes, improve outcomes, and lower costs, and share a little bit of your evidence for that?

Mr. HADLEY. Sure. As we discuss in the report, one of the ways in which you might have an increase in quality from having substitutive insurance is that if the substitutive insurance selected providers based on their quality. Then you might see other providers, all providers, competing with each other to be selected, and through that competition having an increase in quality overall.

Mr. MOULTON. Great. Mr. Hadley, thank you very much.

I believe that competition is good. It is American, and it should be part of our health care system, and I thank you for your work on this report.

With that, Mr. Chairman, I yield back.

Chairman YARMUTH. The gentleman's time has expired.

I now recognize the gentleman from Texas, Mr. Flores, for five minutes.

Mr. FLORES. Thank you, Chairman Yarmuth and Republican Leader Womack for holding today's important hearing to discuss what the government takeover of America's health care system would look like for hard-working American families.

The conclusions that we can draw from the CBO report confirm what we already know, and that is that this type of upheaval abandons free market principles, severely restricts the incentive for young Americans to join the health care field, and then leaves the

American people with no choice, longer wait times for treatment, a rationing of care, and significantly higher taxes.

This flawed thought process would build the single largest bureaucracy in the history of this country to control a sixth of our economy.

Mr. Hadley, I thank you and your colleagues for being here.

My first question is this. Do you feel a feel for what the aggregate spending would be for a single-payer system? I know you don't have a bill to look at, but what do you have? What would that be like?

Mr. HADLEY. We don't have an estimate yet, in part because it would depend on so many of the design choices that you could make in terms of who is covered and what kind of services they receive.

Mr. FLORES. Thank you.

In the report, the CBO states that the transition toward a single-payer system could be complicated, challenging, and potentially disruptive. Can you spend about 20 seconds on each of those terms, complicated, challenging, and potentially disruptive?

Mr. HADLEY. So it would be complicated. We talk about some of the complications in the design choices. But in the transition, particularly if you are moving so many people from one insurance plan to another, there would be an initial upheaval as you try to reassign all of those people and get them enrolled in the new plan.

In terms of disruption, depending on the payment rates and the services that are covered, there would be shifts in the economy for who would be employed, and there would be shifts in the demand for different goods and services, and so it would affect the overall economy as well.

Mr. FLORES. We just heard some comments about the VA. It was called the good, the bad, and the ugly. And one of the single largest set of issues that we have to deal with in constituent services back in the district are VA claims.

And so the VA takes care of roughly 9 million Americans. It has a bureaucracy of about 378,000 federal employees to do that. So the ratio of beneficiaries to federal employees is about one to 24.

If we were to use that same ratio to cover 372 million Americans, would that imply—I mean, that implies a federal bureaucracy of about 16 million people, compared to the Department of Defense, which is the currently largest federal agency with 2 million people.

What is the accurate number of bureaucrats we would be looking to hire to take care of Americans' health care?

Mr. HADLEY. Again, I don't have an answer for that, in part because we don't know how the system would change from—if you look back in history, in 2017, the total health care spending was $3.5 trillion all in.

Mr. FLORES. I guess, suffice it to say it could be massive. It could be easily the single largest federal bureaucracy in the government.

Mr. HADLEY. You could end up with many more people working for the federal government, but also having federal contractors plays a significant role and might also be an option for policymakers.

Mr. FLORES. Do you have a feel for what the improper payments are from Medicare percentage-wise, for every dollar of Medicare payments, what the improper payments are?

Mr. HADLEY. I don't have that number in front of me.

Mr. FLORES. Okay. But we do have a significant percentage of improper payments coming out of Medicare today. Is there any reason to assume, if you had a government-run health care system, that you would have a lower percentage of improper payments on the $3.5 trillion dollars of health care spending?

Mr. HADLEY. Well, it depends again on the choices and the system. One of those choices is how much they are going to invest in making sure that there are not improper payments. You know, some improper payments are simply because of the failure of paperwork and other ones are the result of fraud. And depending on how much investment there is in fraud prevention, it could be higher or lower than we have today.

Mr. FLORES. But you still have the government running this, and so you would have to assume that suddenly the government gets a whole lot better at something it has struggles with today, and you are creating something massively larger—not you. I am talking about the federal government creating something massively larger than the VA today or than the Medicare system that we have today.

The CBO report states that in a federally administered single-payer system the associated cash flows would be federal transactions, in CBO's view, and the spending and revenues for this system would appear in the federal budget. Can you explain this further?

Mr. HADLEY. Sure. One of the issues that we face when we are thinking about the government interacting with a sector of the economy is the extent of government control and at what point should those be considered part of the federal budget.

Under a single-payer system, it is clear that those would be governmental, and to the extent that it is administered at the federal level, then there would be no question that all of those are federal payments. So all of the spending that would occur from such a system would show as federal spending and then, depending on the financing that is used to help pay for that——

Mr. FLORES. I want to be respectful of my colleagues' time, so I will submit all of my questions—the rest of my questions supplementally, and you can answer them supplementally. But if we had a government shutdown, theoretically, all the health care payments could stop.

I yield back.

Chairman YARMUTH. The gentleman's time is expired.

I now yield five minutes to the gentleman from Texas, Mr. Doggett.

Mr. DOGGETT. Thank you.

A great nation should not have millions without access to quality health care, yet we have over 30 million Americans that lack health insurance. In my home state of Texas, one out of every four working adults are uninsured. This is just unacceptable.

And out-of-control health care costs are impacting families who have employer coverage. Over half of Americans with such cov-

erage say that they or family members skipped or postponed needed care because of cost.

More and more Americans are finding that their health insurance deductible is bigger than their bank account, and a single illness can put someone into bankruptcy. Half of patients with cancer diagnoses deplete their life savings within two years.

Americans have so much skin in the game that they are getting third degree burns. The system is unsustainable and unacceptable. And amidst it all, the bright spot is Medicare.

Contrary to Republican attacks, the seniors on Medicare aren't languishing on waiting lists, and they are not being denied the care they need. Far from it. Medicare provides our seniors with guaranteed cost-effective coverage that they can always count on.

I know many people who would love to be on Medicare. They are just a little too young.

To be sure, Medicare has some gaps. That is why I have introduced bills to expand coverage to include dental, vision, and hearing, and why I focused on prescription price gouging. A Medicare for All system would begin by making Medicare more comprehensive for those who rely upon it today.

Congresswoman Jayapal is the leading advocate for Medicare for All. I salute her and Congresswomen DeLauro and Schakowsky for their Medicare for America proposal and Congressman Higgins for his Medicare buy-in proposal.

Each of these has some merit. We cannot transform health care overnight. We will need to phase it in. And none of these proposals is perfect. But each one has value.

Since efforts to improve the Affordable Care Act have been blocked for eight long years, we need to move expeditiously to achieve universal coverage. A single-payer Medicare for All program would be a highly effective means of accomplishing this goal.

In contrast, today's naysayers don't have any plan at all. They have had eight years to present an alternative to Obamacare, and what do we have? Republican nothing care.

And their great leader, President Trump, has promised a big, beautiful health care plan that cuts costs and provides better health care for everyone. But wait, that is the same plan and almost the same words that he offered in 2016 before he began attacking protection for preexisting conditions. And now he says he has a secret plan that must remain under wraps until after he is reelected.

A translation of the attacks that these Republicans are making on Medicare for All amounts to this: Democrats want to take over your health care coverage and make it as bad as Medicare is today. Well, I know a lot of Americans who say: Throw us into that Medicare briar patch.

Here in the Budget Committee, we are certainly concerned about a sustainable system. There is no free lunch. The cost projected for our current health care system is $50 trillion over the next decade. We are paying that bill. It is a question of how we pay for it and how we get quality services for it.

Mr. Hadley, is it true that the government is already paying for most of the health care spending in the United States?

Mr. HADLEY. Yes. In 2017, the private sector contributed just under half.

Mr. DOGGETT. And doesn't the report that you have given us explain how a Medicare for All system could be financed more progressively than what we have today? With more progressive financing, isn't there a potential for many middle-class and low-income working people to actually pay less for Medicare for All than they do today for insurance through their employer?

Mr. HADLEY. Yes. Depending on the design of the system, you could change how progressive it is.

Mr. DOGGETT. As Chairman of the House Ways and Means Committee Health Subcommittee, I have been particularly focused on the high cost of prescription drugs. I am pleased that both the Medicare for America bill and the Medicare for All bill have both incorporated verbatim the text of my Medicare Negotiation and Competitive Licensing Act as the best strategy to deal with these pharmaceutical monopolies.

This is a bill sponsored by most House Democrats. It offers a unique American solution to a unique American problem that we are having to pay about the highest prices for prescription drugs anywhere in the world.

We propose negotiation and competitive licensing to deal with these monopolies. It is essential that the Congress move forward on that this year and that it be included to deal with one of the most pressing health care problems our families face today.

And I yield back.

Chairman YARMUTH. The gentleman's time has expired.

I now yield five minutes to the gentleman from Utah, Mr. Stewart.

Mr. STEWART. Thank you, Mr. Chairman, and to the witnesses.

I am going to go to kind of quickly because there is a lot I want to cover. But before I begin, I want to say that as a Republican, I love talking about this, because I think we have got solutions that will help.

But again and again and again, I hear my Democratic colleagues talk about how bad and how the system is failing Americans, which is a dramatic admission on their part, I think, because it is an admission that Obamacare failed, because the current law of the land is Obamacare. And I think it is a fair thing to point that out, you know.

And essentially what they are saying is, yeah, Obamacare isn't very good, but give us $32 trillion and another chance, and this time we will fix it, and this time we will fix it for real.

In my last election, I talked a lot about this. It was an issue we discussed all the time. And I didn't spend much time talking about the $32 trillion price tag or the fact that you have to double taxes for virtually every American and every American business to pay for it. I think there is a more devastating aspect to Medicare for All, and that is the thing I want to focus on today.

Quoting from the CBO report: "Because the public plan would provide a specified set of health care services to everyone eligible, participants would not have a choice of insurer or health benefits."

Something like 60 percent, I think it depends on who you talk to, but it is close, 60 percent of Americans get their insurance from

a private insurance now. They are possessive of that. They should be. They want to protect their choice and their option of providing and buying a private plan.

Under the single-payer system, what do you mean when you say that, quote, "Participants would not have a choice of insurer or health benefits"? Can you describe that quickly?

Mr. HADLEY. Sure. We mean that the government, whether it is federal or state, would set the benefits, and it would be one set of benefits for all participants.

Mr. STEWART. One set, no choice. Is that true?

Mr. HADLEY. Correct, as we anticipate it.

Mr. STEWART. You either opt in or you opt in. Those are your choices. That's it.

Mr. HADLEY. Yeah. That is a choice for policymakers. They could choose to allow people to opt out or to——

Mr. STEWART. Well, and I am going to get to the opt out in just a second. But, I mean, this is the key to this, and this is what most Americans don't realize. It compels them. They have no choice.

Right now, many of them think: Hey, Medicare for All, that sounds wonderful, we should provide that for people. And then you say: But you will not be able to have private insurance. It is taking away your private insurance. You are compelled to go on the government program.

Is that an overstatement to say that?

Mr. HADLEY. Well, it depends on the design of the system.

Mr. STEWART. Right. But under the Medicare for All proposal as we understand it now?

Mr. HADLEY. You would have one set of benefits from the government.

Mr. STEWART. Thank you. Okay. Thank you.

It eliminates private insurance. And I will quote again from the CBO report: "By contrast, proposals to establish single-payer systems often prohibit substitutive"—i.e., private—"insurance because of concerns it might interfere with the operation of the public plan."

Well, again, I think that is where most Americans go sideways on this. I think most of us—look, I think all of us want to provide insurance for those who don't. I don't know a single person who doesn't want to achieve that goal. But I also know that something like 60 percent of Americans don't want to lose their private insurance and don't want to be held outside of the law if they were to choose to do that.

Now, let's suppose that they did, and this is my second point. Quoting again from the CBO report—because some nations do allow them to opt out, but here is what happens. The rich opt out and buy private insurance and leave the rest of us to suffer under the government program.

Quoting the CBO report: "In England, private insurance gives people access to private providers, faster access to care, or coverage for complementary or alternative therapies"—which the government doesn't cover—"but participants must pay for it separately in addition to paying for their individual required tax contributions to the NHS."

So let me ask you this. This is a blazingly obvious question, but I want it on the record. If you provide for people to opt out after you have raised their taxes and doubled them in order to pay for it, who is going to be able to afford to do that?

Mr. HADLEY. If they are required to pay those taxes and they were also then required to purchase insurance separately, then it would eliminate a lot of people from being able to purchase that kind of insurance.

Mr. STEWART. Except for the elites and the wealthy. Is that true? Is that an overstatement, do you think?

Mr. HADLEY. I don't know about the elites, but I will go with the wealthy.

Mr. STEWART. Okay. That sounds fair.

Look, under a single-payer system, using England as a model, you do have the rich opt out. That's clear. They opt out, they buy extra insurance through a private sector, and they ultimately receive better care for that.

So you have the option of that, or you have the option of where I started, and that is that you compel people, and I think most Americans reject that.

And my time is up. I yield back my time.

Thank you for your response.

Chairman YARMUTH. The gentleman's time has expired.

I now yield five minutes to the gentleman from New York, Mr. Morelle.

Mr. MORELLE. Yes. Thank you, first of all, Mr. Chairman, for organizing this very important conversation. I have the privilege of serving on the House Rules Committee, so this is the second hearing that I have been involved in that relates to proposed changes in the Medicare system.

I am going to dispense with my opening comments other than to say this. First of all, I appreciate very much this report. I think people on all sides of this debate, and I think we are all spending a lot of time thinking about how to get to the right place, whether it is more public investment, whether it is a private system. There are many different options. I think my colleague in front, Mr. Doggett, I think did a good job of sort of identifying them.

But the one thing your report points out—and the first part of it is, it is maddening because you don't get any answers, right. We all would love to have answers here, and we would like you to help give us the answers.

But I think the thing that it does point out is there are so many considerations to get here, and with many things there could be unintended consequences if you don't think through how to get to wherever you want to go.

And so this is really a very good map, and I appreciate the report. There are a lot of questions I think each of us have. I have several, and in just a couple minutes here I would like to get through a couple of them.

First, you know, it occurs to me, and you do touch on this, that if you were to design a system that was a single-payer or a public system from the start, one of the choices you could make, and there would be some logic to this, is the question of not only the insurers

being public, but also the providers being public. You do touch on this a little bit.

I just want to ask you if you could just talk a little bit about what you see as the opportunities and challenges of working on the other end and operating essentially public hospitals and government-employed health care providers, which is sort of like how we have in care for the military. So there are some advantages to that. If you could just talk about that, because this seems to be part of a logic of this, that might be one way to approach it.

Mr. HADLEY. Sure. There are many different ways, as we discuss in the report, that you might compensate providers, and one of those options is to have salaried physicians, and that is an option that you see in some countries, particularly physicians who are working in hospitals.

One of the questions then is about their incentives to provide care and whether you can design that payment mechanism as a way to encourage them to both provide more services and also focus on patient health outcomes.

Mr. MORELLE. Are you suggesting that might be a challenge for publicly operated as opposed to privately?

Mr. HADLEY. In both cases, it's a choice for how you structure the incentives, but it is an important consideration for both public and private.

Mr. MORELLE. Right.

Mr. HADLEY. You know, in a fee-for-service situation that we have in many parts of our current system the incentive is to provide more care and to continue to provide more services, and there are studies that show that the incentive to do that goes beyond what is optimal.

Mr. MORELLE. May I stop you for a second, because it leads into one other, the next thing that I wanted to ask you about, which is sort of the concept of global budgeting.

So it does seem to me, if you have a fee-for-service system, it is hard to have a control on cost. But this is, obviously, if it is going to be a public system, whether it's fully a public system or an expanded public system, cost is a big issue. Your CBO report earlier this year on the size of the deficit and the accumulated debt of the United States does raise some questions about cost containment if you expand the public system.

So have you given thought—I am not familiar. You mention in the report the Maryland system, I am only vaguely familiar with it, where they have essentially gone to global budgeting. But there are risks in that.

I assume, at the end of the day, that those risks for overruns on cost will be borne by the United States. Is there another way of doing that? Would you penalize hospitals or providers potentially?

Mr. HADLEY. Yes. In England, where they had a global budgeting system, they used that to constrain the growth of health care costs, and it was successful in doing that. But one of the consequences was that many of the providers ended up running deficits in some of those years. And then there were also increases in wait times.

Mr. MORELLE. I want to also just touch on briefly, in just the last few seconds, you note in the report, and this is pretty well established, that the Medicare administrative costs are 1.4 percent,

Medicare, with Medicare Advantage and part D, 6 percent administrative costs, and then private insurers 12 percent.

Are those apples-to-apples comparison? And would you need to go to a public system to reduce administrative costs on the private insurance side?

Mr. HADLEY. So one of the reasons why we presented both numbers is they are not exactly apples to apples. The 6 percent number is the full cost of the Medicare program, but if you are trying to use that to figure out what Medicare is compared to the private insurers, then 6 percent to 12 works very well. If you are trying to figure out what would happen under a different system with less investment, it is not as useful of a number for that purpose.

Mr. MORELLE. Thank you.

I yield back my time, Mr. Chair.

Chairman YARMUTH. The gentleman's time has expired.

I now yield five minutes to the gentleman from Texas, Mr. Roy.

Mr. ROY. Thank you, Mr. Chairman. I appreciate it.

Mr. Hadley, I appreciate your time and that of your colleagues being here to testify before us today.

I certainly agree with my colleagues, I think on both sides of the aisle, that the American people deserve the best health care in the world by virtue of our being Americans and by virtue of our using our ingenuity and by using our system that is before us to be able to produce that great health care.

We could have that care. But, unfortunately, my Democrat colleagues believe in the magic health care fairy and believe that where there is unlimited funding and believe that there won't be any rationing in such a system.

And they then scare the American people about coverage. They focus on coverage as being this sort of magic variable, when they talk about insurance coverage or government coverage, as opposed to health care, as opposed to focusing on the one thing that matters, which is an individual in this county and their families being able to go to a doctor and get care.

And that is going to happen much more effectively if we drive down the cost of care and increase the one-to-one relationship between doctors and patients instead of focusing all of our time on government bureaucracies, and, frankly, with all due respect, insurance bureaucracies in which the system we have today is essentially single-payer health care being managed by insurance companies, ineffectively and inefficiently, by government strangulation by regulation.

I love that my Democrat colleagues are racing to push for health care reform, especially Senate Democrat candidates for President who are now racing for Medicare for All, universal coverage, VA for all, whatever branding they want to come up with, on the back 10 years into a system created by Democrats that apparently isn't doing very well, and therefore, needs a new system.

Mr. Hadley, let me ask you a question. Where in the Constitution is the phrase dental plan found?

Mr. HADLEY. It is not.

Mr. ROY. Uh-huh. How about prescription drugs?

Mr. HADLEY. No.

Mr. ROY. Standard of care?

Mr. HADLEY. No.

Mr. ROY. Copay?

Mr. HADLEY. No.

Mr. ROY. Right. And so my question here is, is when we are talking about my colleague that was talking about states and talking about how we weren't going to allow states to be able to provide and make decisions that are best for the people in their home states, this question came up about, you know, how we need a standard of care nationwide.

And my point is just simply this: How many people are in the United States, roughly?

Mr. HADLEY. Roughly 329 million.

Mr. ROY. Right. How many in Texas, do you know?

Mr. HADLEY. I don't have that number.

Mr. ROY. About 28 million. How many in California? About 40 million.

And people talk about comparing systems. How many are in Singapore? It is about 6 million. How many are in Switzerland, 7 or 8 million? Right.

We are comparing apples and oranges around the world when we are trying to compare one health care system to another. And our system was designed to be a Federalist system where we can have differences of opinion, where we can have health care systems that vary state to state.

Let's take Texas. Texas is very different than Maine. My colleague, Mr. Doggett, he knows that very well, right?

How many people of the current uninsured population are people who are present in the United States illegally? What estimate do you all have for that?

Mr. HADLEY. I am sorry, could you repeat the question?

Mr. ROY. How many people, of the people who are of the uninsured population in the United States, are people who are present illegally in the United States?

Mr. HADLEY. Roughly 6 million.

Mr. ROY. Okay. And I have seen different numbers, ranging up to 30 percent of those who are uninsured, that number, et cetera. It is a sizeable piece of the pie, and particularly in a state like, say, Texas or California, that have heavy populations of those who are present illegally. Is that true?

Mr. HADLEY. Yeah. As I said in the opening statement, there are roughly 11 million people who are here unlawfully, and about half of them have health insurance.

In slide 3, on the back side of your handout, we walk through the components of who the uninsured are. And my colleague, Dr. Banthin, can speak to those.

Mr. ROY. Well, without going deeply into that, just in my limited time, I just wanted to highlight the fact that states vary, we have different populations. And I would just add that a significant portion—for example, in Texas, when we talk about the uninsured, part of the reason we have a significant uninsured population problem is that we have a significant number of illegals, illegally present in the United States in Texas, because this body refuses to do its job to secure the border.

Let me ask a couple more quick questions with the limited time I have left. Is it true that the report states that under a single-payer system, if the number of providers was not sufficient to meet demand, patients might face increased wait times and reduced access to care?

Mr. HADLEY. Yes.

Mr. ROY. Would you agree with the following numbers? According to an analysis done by the Fraser Institute, wait times in Canada, a single-payer system, is 8.7 weeks for a specialist after referral from a general practitioner. The analysis stated wait times of 4.3 weeks for a CT scan, 10.6 weeks for an MRI scan, 3.9 weeks for an ultrasound.

Do those sound right?

Mr. HADLEY. My colleagues are more familiar with those numbers than I am. But sort of in—to characterize generally, in the United States we have lower wait times for specialists in elective surgeries than in other countries.

Mr. ROY. When I was diagnosed with cancer, I got treatment within 10 days of the time I got cancer treatment.

Thank you.

Chairman YARMUTH. The gentleman's time has expired.

I now recognize the gentleman from Nevada, Mr. Horsford, for five minutes.

Mr. HORSFORD. Thank you very much, Mr. Chairman, for giving us this opportunity to discuss this very critical issue.

I want to be clear, I support universal access to health care, and I am committed to working with my colleagues to achieve this goal. I commend my colleague, Congresswoman Jayapal, for her work and advocacy for her Medicare for All proposal, and the many other proposals that a number of my colleagues have offered.

I believe that we must work together to protect health care coverage for individuals who like their current health care plans, expand coverage for Americans who still need it, and to bring down health care costs for everyone.

I want to just get to a number of the questions that I believe have to be answered in order for us to ever reach a single-payer system.

First, though the Affordable Care Act has played a significant role in insuring many more Americans, particularly through Medicaid expansion, the Congressional Budget Office estimates that 29 million Americans were still uninsured in 2018, 11 percent of U.S. residents under age 65.

My home state of Nevada was one of the first states to expand Medicaid under the Affordable Care Act. In fact, my governor at the time, Governor Brian Sandoval, was the first Republican governor in the nation to expand Medicaid.

Since that time, our uninsured rate declined 42.1 percent from 2013 to 2016. Nevada was ranked number two for the highest rate of uninsured before we passed that expansion. Twenty percent of our children were uninsured before the expansion of the Affordable Care Act and Medicaid; today only 8 percent.

So I reject my colleagues who say that the Affordable Care Act is not meeting its goals.

More than 640,000 Nevadans rely on Medicaid, which provides health coverage to children, pregnant women, parents, seniors, and individuals with disabilities.

My question: How many of these 29 million uninsured Americans who fall into the so-called coverage gap might have coverage if all states moved towards Medicaid expansion?

Mr. HADLEY. So could we have slide 3, and then Dr. Banthin will walk through.

So in 2019, we project the number of uninsured will be 30 million people.

Dr. BANTHIN. So, roughly, 4 million across the country fall into the category they live below 100 percent of poverty and they live in a state that did not expand Medicaid.

Mr. HORSFORD. And why those states choose to deny their residents coverage is beyond me.

Employer-sponsored health care benefits were achieved through a long and rich history of collective bargaining. Today, 49 percent of Nevadans receive their health care through their employer. Many of them were negotiated benefits. They gave up wage increases in order to have the health care that they have earned.

Can you speak to how individuals who receive their health care through their employer would be impacted by a single-payer system?

Dr. BANTHIN. Yes. It depends, of course, on the design of the system. If they received public coverage as a replacement for their employer-provided coverage, then we would expect that employers who spend quite a bit on that coverage would return—that is part of their employee compensation—they would return that to employees, or most of it, in the form of wages or other benefits, other tax-favored benefits.

But we would have to analyze the full effect of that change because employees may then, of course, face higher taxes to pay for the national health insurance, and that would depend on the design of the whole scheme.

Mr. HORSFORD. Thank you.

In your report you note that the transition toward a single-payer system could be complicated, challenging, and potentially disruptive.

Health care spending in the United States currently accounts for about one-sixth of the nation's GDP. Those changes could significantly affect the overall U.S. economy.

What factors should we take into consideration in order to avoid a major disruption from occurring within our health care market?

Mr. HADLEY. So some of the questions about how you would get there depend critically on where you are trying to get to. And so the design of the plan, how you want it to be structured in terms of who is covered, what services they would receive, are critically important, and how you are going to compensate providers.

Another question then is, who is it that you are most concerned about disrupting? So, for example, if it is the employees who are currently employed by private health insurance companies, you could look to having a longer time period before switching over to a single-payer system, so there could be kind of more notice and

warning. You could also have job retraining programs for those people.

If it is for doctors and other providers, you could look at how you structure the payment rates. You could, for example, bring down payment rates only to the level that has been brought down by the administrative savings that they are facing because they are only dealing with one payer, as opposed to the current system where they are dealing with many payers.

Chairman YARMUTH. The gentleman's time has expired.

I now yield five minutes to the gentleman from Pennsylvania, Mr. Meuser.

Mr. MEUSER. Thank you, Mr. Chairman.

And thank you, Colonel Womack.

And thank you, Mr. Hadley and the Congressional Budget Office, for being with us.

I speak with my constituents in my district in Pennsylvania on health care quite regularly. We very often discuss three priorities that are important to their families. Those are the ability to choose their own doctor, quality, and affordability. I would like to focus my questions on these areas.

First, regarding choice. Deputy Director Hadley, page six, your submitted report says, and I quote: "Participants would not have a choice of insurers or health benefits. Compared with the options available under the current system, the benefits provided by the public plan might not address the needs of some people," close quote.

Can you expand on what you meant by that?

Mr. HADLEY. Sure. So as I go on to say, one of the issues is about technology and how quickly a new set of insurers might adopt technology and changes in treatment patterns. And so, for example, you might expect that if there were competing private insurers, that one or two of them at least would have adopted the new technology, and that would cause the others to follow. And so you would expect, in general, you might have faster adoption of new technologies than you would with one-payer.

Mr. MEUSER. So more is better and competition is good.

Regarding quality, I have often heard the Canadian health care system described as: It is terrific until you get very sick.

People want to be able to go to the doctor of their choice and know that the care they are receiving is excellent. I am concerned that when the single-payer system removes choice, as we have just discussed will happen, people will not be able to choose the doctor that best suits their particular and personal health needs.

Have you analyzed how the single-payer system could and would negatively impact the quality of care that people receive?

Mr. HADLEY. Well, so we have thought about both doctor choice and quality of care. So let me go through doctor choice first.

So it is possible that if you had a single-payer system there might be more doctors to choose from because essentially all of the narrow networks would be combined and all providers would be in one network, depending on design choices.

In terms of the overall quality, it depends on so many of the other factors. But if there is a mismatch between the demand for care and the supply of care, then you would end up with increased

wait times and problems with access to care. And to build on that just a little bit, that might mean, for example, needing to travel further distances to see doctors.

Mr. MEUSER. So based on models that we are aware of, quality would be compromised?

Mr. HADLEY. Unfortunately, I can't answer that directly. It depends on the design of the system.

But the extent to which you are expanding coverage and expanding the services that are covered and reducing copays, those would all tend to increase the demand for services. But if the total cost isn't being controlled by reducing provider payment rates, that would tend to cause a mismatch between supply and demand.

Mr. MEUSER. Let's talk about affordability. I am concerned about the affordability of a government-mandated and run health care system both for patients and the American taxpayer.

To pay for implementation of a government-run system, what would be, coming from the Congressional Budget Office, some of the ways that the revenues would be generated?

Mr. HADLEY. We discuss three ways it could be financed, through cash flows, and then there is a kind of a half. So you could have additional copays or other cost-sharing by individuals. There could be premiums paid or taxes in some form or other.

And then the half is, you could have deficit financing that would postpone when those services would be paid for and shifted to another generation.

Mr. MEUSER. All right. In a system with no cost-sharing, such as copays and premiums, run entirely by the federal government, the only method to generate revenue would be taxes or deficit spending? No copays, no premiums, all paid for?

Mr. HADLEY. If no copays and no premiums——

Mr. MEUSER. Right. And this system I described in my last question is what H.R. 1384 is all about, a bill cosponsored by 108 of my Democrat colleagues, including 10 from this Committee, the Medicare for All Act of 2019. The bill contains no cost-sharing; thus taxes are the only way to pay for it.

We know from independent studies that this will cost roughly an additional $32 trillion over the next 10 years. That is an average of $10,000 per person. A family of four in my district would be paying $40,000 for such a plan, on top of what we are paying now. That is simply not sustainable.

Based upon your testimony here today, a single-payer system would result in the elimination—minimizing choice, quality would be suspect, and $10,000 per person in new taxes. Certainly not affordable.

One can conclude a government-run single-payer health system creates a monopoly that will expand the role of the federal government at the expense of patients and taxpayers.

I do appreciate the CBO taking the time to join us this morning, and I urge my Democrat colleagues to work with us to develop a plan that will actually deliver on what is being asked for by the American taxpayer—choice, quality, and affordability. Government takeover of health care will make our system and many of us sick, $32 trillion sicker, not better.

Thank you, Mr. Chairman. I yield back.

Chairman YARMUTH. The gentleman's time has expired.

I now yield five minutes to the gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. Chairman, we have been hearing a lot of complaints about the Affordable Care Act, but we did note that, as one of my colleagues pointed out, that after a decade of trying, the best the Republicans could come up with was a plan that had 20-something million fewer insured, costs go up 20 percent the first year, covers less, and you may well lose protections for your preexisting conditions—and they actually passed it.

Let me ask a series a questions, if I can get as many in as I can. We just heard that this Medicare for All will cost an additional $32 trillion. What we just heard, additional.

But, Mr. Hadley, I thought I heard you say that that was not in addition to, but in lieu of what we are presently spending on health care, and the total expenditures for health care may, in fact, go down—maybe up—but it would be in lieu of what we are presently spending, not in addition to.

Mr. HADLEY. First of all, I want to say that that is an estimate that was not produced by CBO. But also, yes, under the current system, looking back historically at 2017, total health expenditures were $3.5 trillion for that year.

Mr. SCOTT. One year. Ten years would be—go ahead.

Mr. HADLEY. So 10 years would be, expressed in those year's dollars, would be on the order of $35 trillion.

Mr. SCOTT. But that additional cost of whatever the Medicare for All will cost will be in lieu of, not in addition to?

Mr. HADLEY. Some of the estimates that are out there are looking at what the total health care spending would be, and some of them are looking at what the net cost to the government would be under that system.

Mr. SCOTT. But it is in lieu of what we are spending now as a nation, not in addition to. Is that right?

Mr. HADLEY. That is correct.

Mr. SCOTT. Okay. Now, you mentioned less administrative expenses under a Medicare for All. Medicare, as I understand you said, was 1.4 percent administrative, just Medicare itself, and private sector was 12 percent. Is that what you said?

Mr. HADLEY. The federal government's cost for Medicare was 1.4 percent.

Mr. SCOTT. Okay.

Mr. HADLEY. So when you include Medicare Advantage and part——

Mr. SCOTT. Well, just what government had control over was 1.4.

Now, we also heard there are a lot of improper expenditures under Medicare. And does the private sector have any improper expenses?

Mr. HADLEY. Yes.

Mr. SCOTT. Okay.

You mentioned that prevention—investments in prevention are—there is a disincentive because of turnover. You prevent long-term expenses and they go with another insurance company.

Is there also a disincentive for prevention because the private sector is worried about the quarterly earnings, in that if you had a Medicare for All, there would be more of a—again, more of an incentive to invest in long-term prevention?

Mr. HADLEY. It is possible, depending on the design of the system, whether you give the system the authority to act on that incentive.

Mr. SCOTT. The public option, when the public option was considered and passed the House and lost in the Senate, there was a complaint that the public option would constitute unfair competition, which I interpreted as could provide a better product at a lower price. And the conclusion of some is, we couldn't have that. And the conclusion of others is, that is exactly what we want to do.

If that is, in fact, unfair competition, because it can provide a better product at a lower price, what kind of market share would a public option acquire?

Mr. HADLEY. That is difficult to say until we see the details of the plan, but if it is more attractive to consumers, then you would expect more consumers to choose that plan.

Mr. SCOTT. And if we had that option and people could get the benefits of the public plan, would it be necessary to eliminate private insurance?

Mr. HADLEY. No. You could have a public option in the context of a multi-payer system.

Mr. SCOTT. And you could essentially get most of the benefits of a Medicare for All, even allowing the existence of private plans, so long as we didn't let them underwrite and cherry pick. Is that right?

Mr. HADLEY. So you would keep some of the elements of a multi-payer plan, meaning you would still have to worry about things like selective enrollment and the competition among insurers and stability. But you could have a plan that provided benefits to more people and achieve closer to universal coverage that way.

Mr. SCOTT. And what would be the effect on Medicare for All on the ability to control costs?

Mr. HADLEY. So we haven't analyzed the specific plan that is in legislation now, but through a single-payer system you could have additional options that are very hard to pursue today under a multi-payer system. There would be some options that we discuss in the report that would become available. Utilization management and global budgets are two of them.

Mr. SCOTT. And you would be better able to control costs going forward?

Mr. HADLEY. Potentially, depending on the design of the system.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman YARMUTH. I thank you. The gentleman's time has expired.

I now recognize the gentleman from Oklahoma, Mr. Hern, for five minutes.

Mr. HERN. Mr. Chairman, Ranking Member Womack, thank you for being here today.

To the witnesses, Director Hadley, I really appreciate your time.

I am going to get right into some questions here. I have got like, I don't know, 60 or so.

The Democrats didn't ask for a price on this when they put it in the plan. I have read through your report, highlighted, and made tons of notes.

But going to the extreme of single-payer system, no private option, what is the anticipated cost? Do you argue with the $32 trillion, or could it be more? All in, all in. Sure, you are a budget office, sure you have looked at everything is all in, owned by the government, no private option.

Mr. HADLEY. But it still depends on the choices, the other design choices, such as cost-sharing and, critically, how the providers are paid, right? So if costs were controlled through payment rates to providers, it could bring down costs sort of in two ways, both the direct effect and also if there was a shortage of providers.

Mr. HERN. So the narrative would be is that we would continue paying the providers less until we got to a point where we could afford it? Because I think you say in your report also that doctors, the reimbursement rates would go down. Therefore, the demand would overtake the supply, and doctors would probably be less likely to want to stay in a business where they are making less.

Then you also go on to state in the report that the government could step in and educate more doctors. So this is a gift that keeps on giving, where the government is more and more engaged in the process of making this work.

Mr. HADLEY. So, yes, graduate medical education and how that is funded is one of the key issues that we highlight in the report.

Mr. HERN. And nobody has asked that question yet, by the way. Nobody has talked about how you are going to prop up the supply side.

Mr. HADLEY. And that is not the only way that could be done. It could also be done, there are some other methods that one could pursue, for example, allowing physicians assistants and nurses to carry out services that are currently done by doctors.

Mr. HERN. So have less doctors and just keep pushing down the requirements. So we would sort of devalue the expertise we have in the medical field, people who have gone a long time to school to give us what some would argue the greatest health care in the world.

And I know my friends across the aisle argue that, but we have people coming from these great countries like Canada and Europe, coming here to have specialized treatments done, because, as my colleague from Texas said, they can get it done in a timely manner, as opposed to possibly dying before those procedures could be done.

I have spoken to people in England who have the two-tier system. And when they have these immediate needs, because they can afford it, they go use the private insurance and not the national health insurance.

Mr. HADLEY. That is right. In England you can buy private insurance that helps have faster access to care.

Mr. HERN. And much of that is provided through these evil companies that are allowing their employees to actually buy that private health care. Is that correct?

Mr. HADLEY. Those are through public plan—or private plans, excuse me.

Mr. HERN. Also in there you state that, quote: Single-payer system could force compliance through an existing automatic payroll withholdings and taxes. Is that right?

Mr. HADLEY. That is correct.

Mr. HERN. Sounds like an individual mandate that we had in ObamaCare, that when was removed, people made the choice not to actually buy insurance. Nobody kicked them off, they just decided they didn't want to buy it anymore. Is that what you could see happen as well?

Mr. HADLEY. So in the context of the single-payer system, what we were envisioning was that there would be taxes that would be withdrawn from the economy, not—but I see your point about an individual mandate.

Mr. HERN. So I have got so many here, but you also said in there about rural hospitals and about taking over the hospitals. Is it true that one of the driving forces behind negative profit margins in many of the hospitals is due to reduced Medicare reimbursement rates?

Mr. HADLEY. Yes, that is correct, that when the Affordable Care Act put in place a change in the way that those providers' payments rates are set, that it now includes an increase for the cost that they face and a decrease for the total level of productivity within the economy as a whole.

Mr. HERN. I really appreciate your work in this. And, again, I read the report a couple times. It is safe to say that socialized medicine is and has always been the Democrats' end game since go all the way back to 2000 and—well, you can go a lot farther back than that.

A one-size-fits-all health care comes with an unbelievable price tag that we have seen through reports, $32 trillion on the low end cost estimates over 10 years. Even without expanding Medicare from its current role, the Medicare Hospital Insurance Trust Fund will be insolvent in 2026.

I support putting programs like Medicare and Medicaid on a fiscally sustainable path so it will be available for current and future generations.

If we cannot afford Medicare as is, why are the colleagues making empty promises to the American people we could afford Medicare for All. The problem with Medicare for All is the exact same problem with socialism. The system collapses on itself.

And I would ask my colleagues to be truthful to the American people and don't be, I guess, overtaken by the empty promises that big government—that this is not Medicare for All. This is Medicare for none.

Mr. Chairman, I yield back. Thank you.

Chairman YARMUTH. The gentleman's time has expired.

I now yield five minutes to the gentleman from California, Mr. Khanna.

Mr. KHANNA. Thank you, Mr. Chairman. Let me just commend your leadership for having this hearing and helping educate the Committee Members and the American public about Medicare for All.

Mr. Hadley, do you believe Medicare for All is socialism?

Mr. HADLEY. We haven't drawn a conclusion about socialism.

Mr. KHANNA. Do you think anyone would pass Economics 101 if they gave that answer in any major university in this country, MIT or University of Chicago? I mean, I studied economics at University of Chicago. Do you think if someone in first year Economics wrote a paper saying Medicare for All is socialism that the great free market economists then would give them a passing grade?

Mr. HADLEY. Well, CBO doesn't have a specific—its own definition of socialism.

Mr. KHANNA. Just given the economic definition, which is that you control the means of production, I mean, do you think that this is socialism under common economic definitions?

Mr. HADLEY. Well, so it would involve more government control over one aspect of the economy.

Mr. KHANNA. So you can't say that it is not socialism?

Mr. HADLEY. No. I—it is—we can't speak on it either way.

Mr. KHANNA. Okay. I mean, I think 99 percent of the people with a Ph.D., economists in this country, would say it is not socialism.

As you know, the employer average premium is $12,951 of cost to an employer under the current health care system. Most economic studies show that the stagnation of our wages for the last 40 years are directly tied to increasing health premium costs.

Can you speak to how much increase there would be on wages if employers weren't being burdened by the $12,951?

Mr. HADLEY. Well, as my colleague can explain further, you would expect a significant portion of that to be passed back to the employees.

Dr. BANTHIN. Yes. We would expect employers to pass back most of that in the form of other compensation or wages. However, employees would then face taxes related to the national health insurance.

Mr. KHANNA. Do you think that one of the biggest things our country can do to deal with wage stagnation of the bottom 50 percent of income earners is to reduce the burden that employers have in premiums?

Dr. BANTHIN. So the bottom 50 percent of earners do not always receive health insurance through their jobs.

Mr. KHANNA. The bottom 50 percent who have health insurance through their jobs. Do you think one of the biggest things we could do, in terms of wage stagnation, is to reduce employer costs on health care?

Dr. BANTHIN. I don't know what would happen to growth and wages over time. It would certainly cause a change during the transition from private to public health care.

Mr. KHANNA. It would be a massive raise for most Americans?

Dr. BANTHIN. We would expect to see an increase in wages. But if the scheme were financed through payroll tax, they may not take all of that home in their paycheck.

Mr. KHANNA. Sure. But even if it was funded through a payroll tax, it would be a net increase for most Americans, correct?

Dr. KLING. I am sorry. That would depend on the details of the tax system, sir.

Mr. KHANNA. I mean, there is no way that a tax would be $13,000 on any—I mean, any economic study—you have testified earlier to Mr. Doggett's questions that most Americans would actu-

ally—who are making under $75,000—would save money by having less costs of premiums than they would have to pay in the payroll tax. Isn't that correct?

Mr. HADLEY. Well, so I think what I said was that you could design a system that would be more progressive than the current system if you were considering what they are currently paying for health care as a tax.

But that is really a choice that policymakers have in front of them, not a conclusion that we can draw about the choices that you have already made.

Mr. KHANNA. But you could design a system, in your view, that the ordinary American who is watching this would pay less money in terms of the fees to the government than they currently are paying to health care, and they would get more money in their pockets in terms of increased wages? I mean, it is possible to design that system?

Mr. HADLEY. It is possible to design a system that would do that for some people, yes.

Mr. KHANNA. And most economists would not describe that as socialism, I mean, unless you believe that reducing people's costs and increasing their wages is socialism.

You get the last word.

Mr. HADLEY. No, they would not describe that as socialism.

Mr. KHANNA. Thank you.

Chairman YARMUTH. Thank you. The gentleman's time has expired.

I now yield five minutes to the gentleman from South Carolina, Mr. Norman.

Mr. NORMAN. Thank you, Mr. Chairman.

Mr. Hadley, thank you and your colleagues for coming.

You know, the way to predict the future is look to the past. I think we all remember during the Obama years, during ObamaCare, the statement: You can keep your own physician. How did that work out? Not too well.

I think we remember the statement that we are going to have reductions in our deductibles. How did that work out? Not too well.

In my state of South Carolina, we have got that single mom who is supporting two or three children, her premiums skyrocketed 62 percent, not 15 to 12 percent, as I have heard.

How did it work out when they promised lower deductibles? Not too good.

Let's look to the other countries that have—you can call it not socialism, but government-run systems in anything is pretty much socialism, if you really look at it and get down to the bottom line.

Let's look at Great Britain. Look at the shortages in physicians, 11,500 physicians short, 42,000 nurses short.

Let's look at Canada. As Mr. Roy said, he had his treatment for cancer in 10 days. How does the Canadian system work out? Well, it took patients 8.7 weeks to see a specialist, 4.3 weeks to get a CT scan, 10.6 weeks to get an MRI scan, and 3.9 weeks to get an ultrasound.

My son-in-law from Canada, when they had heart trouble, guess where he came. Not Canada. He came to the United States of America.

So, you know, the old system is not sustainable under ObamaCare. So I welcome this discussion to get into how are we going to improve it. It is not government-run health care.

Mr. Hern and I are in the private sector. He has restaurants. I am in the construction world. You think government can do it cheaper than we can? No. Competition is what makes a better product at cheaper prices.

I keep hearing this word "free." Okay, I am for free medical care, with the caveat, get the doctors to work for free. I am for free education, get the professors who are tenured to work for free. Get us as Congress to work for free.

So this is what we are talking about, and I am glad to have this discussion.

Incentives. Has there been any study on the incentives? Would you get more people in the medical profession if you cut their pay? Have you done any type work on that, Mr. Hadley?

Mr. HADLEY. I haven't, but my colleagues have looked at that issue and they have seen that in the context of a multi-payer system—I think we need to come back to that in a second—that if you cut the compensation of providers, they provide less care.

But the caveat is that was in a context of a relatively small change within the context of a multi-payer system. They had other places to go. It is hard to know exactly how that would play out in the context of moving to a single-payer system.

Mr. NORMAN. But you would agree, if you cut the incentives, you are not going to have the physicians getting into the field to practice their skill if you cut their pay. Does that make sense?

Mr. HADLEY. In general, we would expect that fewer people would enter the medical profession. And whether that would result in a shortage of services would depend on the incentives faced by the people who remain and also the extent to which we have foreign-trained doctors.

Mr. NORMAN. Do you agree, if there is a shortage of physicians, that would mean less doctors to see patients that need care? So the patient would ultimately suffer?

Mr. HADLEY. It could result in reduced levels of care, in part because of wait times.

Mr. NORMAN. Okay. And, finally, you know, our nation's debt is now $22 trillion. It has been estimated that the single-payer system would add $32 trillion. Bottom line, you can say that it adds to it. It is net. But bottom line, you are looking at a big number, and you are looking at a number that is unsustainable as we look forward, as we try to get a system and get this country back on a firm financial footing and not finance it with a credit card. Would you agree?

Mr. HADLEY. So, two things.

One, it would be a very large shift to move all of the private payments that are currently financing the health care system to become public payments, and that would require substantial additional government resources.

But more generally, the current level of debt and deficits are ultimately not sustainable.

Mr. NORMAN. Not sustainable, not going to be for the United States as it hasn't been for any of the socialistic countries who are basically going broke.

I would say that anybody that believes that a government-run health care system provides better health care at lower prices, I got some land that is underwater I need to sell you for high-rise condos.

Thank you so much.

Chairman YARMUTH. The gentleman's time has expired.

I now yield five minutes to the gentlelady from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. All this talk about socialism. That is exactly what we heard when Medicare was suggested. In fact, Ronald Reagan was the lobbyist who went around the country against Medicare because it was socialism.

I don't know about the VA. That sounds like a socialist system to me, too. That is a single-payer system provided for our veterans.

Social Security, oh my, that is definitely socialism, according to my Republican colleagues.

And a single-payer system would not be any more socialism than any of those current government-run programs that people like.

And, in fact, the idea of Medicare for All is really popular out there. It polls really well. Be careful of your slams against socialism. People want to have health care.

The United States of America currently pays more for health care than any other country. Is that right, Mr. Hadley?

Mr. HADLEY. Yes, that is correct, both on a per capita basis and as a percent of GDP.

Ms. SCHAKOWSKY. Thank you. And isn't it also true that in terms of outcomes, we are lower than most of the industrial countries in the world? Is that also true? Or longevity? Let's talk about maternal mortality. Is that true?

Mr. HADLEY. So for longevity, yes, among the OECD countries, the United States is below——

Ms. SCHAKOWSKY. We are the only industrialized country where actually our maternal mortality has gone up instead of down. Is that not true?

Mr. HADLEY. That is correct.

Ms. SCHAKOWSKY. That is true. So we need a bold plan here. And I am on every bill to improve health care. I have been for Medicare for All since many of you have been born. But I am also the cosponsor of Medicare for America. I helped write the Affordable Care Act. I am for improving it. I am for all the plans, because what we have now is not working.

My colleagues talk about wait lists. But your report, Mr. Hadley, showed that 29 million Americans don't have—are uninsured right now. They are not even in line. So there are people who never are going to get the kind of care that they need right now if they can't pay out of pocket. Isn't that true?

Mr. HADLEY. That is correct. Although, they do seek care through other sources, charity care and—so there can be some uncompensated care. But more generally, there are also people who have insurance that forego medical care because they can't afford the out-of-pocket.

Ms. SCHAKOWSKY. A lot of people. So people are waiting five weeks, five months, or whatever he said about Canada. How about your entire life waiting, because we see people die. And in fact, before the Affordable Care Act came in and Medicaid expansion came in, people were actually dying, and when we opened it up, we saw people who had stage four cancer, because they had avoided going to the doctor.

There was a really bad editorial yesterday, I thought, by Mr. Scalise, talking about how bad a Medicare for All system would be.

What effect would that have, if we had Medicare for All, on women's health care and the full range of reproductive services? Someone answer that.

Mr. HADLEY. So it depends critically on the design of the system and the services you choose to cover. So in the context of a single-payer system, we lay out those as design choices, but we haven't analyzed any of the specific proposals.

Ms. SCHAKOWSKY. Did you want to say anything?

Dr. BANTHIN. Yes. Well, the uninsured women would then get access to coverage and benefits. So that would be an improvement.

Ms. SCHAKOWSKY. I mean, we have, before the Affordable Care Act, being a woman was a preexisting condition.

I also just wanted to say to my colleagues, the idea of choice. You know what, Americans don't love picking an insurance company. They don't love insurance companies. Americans want a full, comprehensive package of benefits. You say they want to choose benefits. No, they want to know that those benefits are there.

What Americans want is a choice of doctor. And what I heard you say, Mr. Hadley, was that if there were Medicare for All, there actually might be more choices of providers. Is that right?

Mr. HADLEY. That is correct. As you could imagine, that all of the different networks that exist today would be sort of combined, so that all of the providers would participate and be potentially available.

Ms. SCHAKOWSKY. I yield back.

Chairman YARMUTH. The gentlelady's time has expired.

I now recognize the gentleman from South Carolina, Mr. Timmons, for five minutes.

Mr. TIMMONS. Thank you, Mr. Chairman.

I am going to begin by talking about Blockbuster. I went to Blockbuster all the time as a kid. I loved it. I got two or three movies. My parents were happy, I shut up, and I was downstairs watching television.

Blockbuster doesn't exist anymore because Netflix, Apple, Amazon have driven them out of business. They provide a better service, higher quality service, cheaper price. That is the free market. That is capitalism. That is what in many respects the American system of enterprise stands for.

So what we are talking about today is literally going to evaporate trillions of dollars of wealth.

I am going to start with insurance companies. So the largest insurance company in the country is United Health care. They have 300,000 employees. Last year, they had $226 billion in revenue.

Shockingly, it is actually headquartered in a member on this Committee's district. It is headquartered in Minnesota. And that

member is actually a cosponsor on this legislation. What would single-payer do to United Health care, to their employees, to their revenue?

So I guess I am just going to start, Deputy Director Hadley, is it safe to say that a transition to single-payer health care would be extremely disruptive to the hundreds of health insurance companies in this country?

Mr. HADLEY. Yes. I mean, depending on the role that was left to them by the system. And most of the single-payer systems that we have looked at in the world have a very limited role for private health insurance. And if there is a much more limited role, then you would expect a substantial reduction in share value and employment within the health insurance industry.

But by that same token, there would be the need to have more people administer the single-payer plan. And so some of the people who currently administer the health insurance plans could be employed by the government or its contractors as it administers the plan.

Mr. TIMMONS. I guess if we are going to legislate them out of work, they probably will be looking for a job. Might be able to find them one in the new system. But it would still evaporate hundreds of billions of dollars of investment from the private sector.

So I am going to go next to medical device sales. Fresenius is a German-headquartered company, but 70 percent of the revenue came from North America. That is $20.7 billion. They have 270,000 employees worldwide. But again, 70 percent of the revenue is from North America. You have to assume that many of them are here in the United States.

So the next question, Mr. Hadley, is, is it safe to say that the transition to single-payer would be extremely disruptive to the medical device sales industry?

Mr. HADLEY. Yeah. I mean, we would expect there would be substantial changes to all of the participants in the health care system. How the providers of medical devices were compensated would determine how affected they were, and that is a design choice for policymakers.

Mr. TIMMONS. So, again, billions of dollars legislated out of existence, billions of dollars of private investment legislated out of existence, and tens of thousands of employees free to pursue new opportunities. That doesn't seem American to me. We don't nationalize things here. That is what socialist countries do, and we have seen how that has gone.

I am going to go last to clinicians. So I spoke to the CFO of the largest health care provider in South Carolina this morning, and she told me that it was just virtually impossible that clinicians would not see a reduction in their compensation if we went to single-payer. Not to mention the fact that we would be conscripting them into federal service and likely result in fewer people being interested in becoming a doctor or a nurse. That doesn't seem to be a good outcome for the health care system in this country.

So, I guess, we have been talking about what is wrong with this, this proposal, and we don't really have a very good alternative. So the question is, what do we do?

And I would say that the answer lies in aligning the interests of the interested parties. So you have the individual who needs to have personal responsibility and make sure that they are as healthy as possible, diet and exercise. And you have the government, you have pharmaceutical companies, you have medical device sales, insurance, hospitals or health care providers, and clinicians.

So these are the seven interested parties, and we have to align their interests to reduce costs, maximize the output, and make our society healthier. We can do it at a lesser cost, but we have to work together.

And it seems that all we are doing is talking about Medicare for All, and some people think it is great, some people think it is terrible. But it is not a solution. It is not an American solution. It is not a viable solution. It will never pass Congress.

So we need to work together to find a real solution, and I look forward to working with everyone willing to align the interests of all the different parties and find a way to make our society as healthy as possible.

So thank you, Mr. Chairman. I yield back.

Chairman YARMUTH. The gentleman's time has expired.

I now yield five minutes to the gentlelady from Washington, Ms. Jayapal.

Ms. JAYAPAL. Thank you so much, Mr. Chairman, for driving this conversation forward on single-payer health care, and to the CBO for producing what I think is a very helpful document and guidance towards what that system should look like.

As Chairman Yarmuth said in his statement, it is not a question of if, it is a question of when our country has single-payer health care. And I, along with 109 cosponsors now—we just added 1, and we will continue to add a couple more over the next several weeks—have introduced a single-payer proposal called the Medicare for All Act of 2019.

It had its first historic congressional hearing ever in the House of Representatives in the Rules Committee. We look forward to doing that here. I understand I have bipartisan support for that hearing, because I actually think that this is exactly the kind of proposal that does address many of the things that have been laid out in the CBO report.

So, Mr. Hadley, according to the CBO report, how much did we spend on health care in 2017?

Mr. HADLEY. $3.5 trillion.

Ms. JAYAPAL. $3.5 trillion. And how does that $3.5 trillion—and that is annually, correct?

Mr. HADLEY. That was the 2017—that was the amount spent in 2017.

Ms. JAYAPAL. In 2017. So over 10 years, if we continue to spend $3.5 trillion, it would be $35 trillion. We are going to talk about that in a second.

How does that $3.5 trillion, which takes up 18 percent of our GDP, compare to other peer developed countries?

Mr. HADLEY. It is significantly higher.

Ms. JAYAPAL. Significantly higher than what other countries are paying for their health systems. So our current system costs $3.5

trillion. It is actually projected to cost $6 trillion by 2027, the most in the entire world by far.

And yet, we have 29 million people without insurance, which you pointed out in your report, and another 44 million who are underinsured. Almost one-quarter of our country, the richest country in the world, is unable to access health care.

Is a single-payer system capable of providing coverage for everyone and achieving universal health care?

Mr. HADLEY. Yes, a single-payer system could achieve universal health care.

Ms. JAYAPAL. That is a yes. I like your answer so much, I am going to repeat them. A single-payer system can achieve universal health care. Great.

So unlike our current system, if we move to a Medicare for All system, or a single-payer system, depending on its design, of course, we could achieve health care for everyone.

Let's talk about what it can do for costs. The CBO report provides a great list of design choices for single-payer that could bring savings for our system, such as administrative costs. In your testimony you describe the potential for considerable administrative savings because single-payer insurance, like Medicare, has significantly smaller administrative costs than for-profit insurance.

Our doctors and hospitals also have administrative costs of 25 to 30 percent, while hospitals in the single-payer countries spend less than half of that.

This is a huge drain of time and resources spent dealing with for-profit insurance and billing at the expense of the health of patients.

And another great benefit of a single-payer system is that when you bring everyone into one system, you gain significant market leverage.

So compared to a for-profit insurance company, would a single-payer system have more leverage to negotiate better prices for hospital costs?

Mr. HADLEY. Yes. Under the current system insurance companies' market power is fractured. If that were combined in a single-payer system, there would be more leverage, and it would depend on the design of the system to see how the government would act on that leverage.

Ms. JAYAPAL. So we could use the tremendous leverage of government power and a large marketplace, essentially, a large system of consumers, to negotiate the best prices for the American people, which I think is exactly what people want us to do.

And a single-payer system like Medicare for All would also bring us universal health care coverage, as well as market power, to generate even more savings from hospital costs. And we can use the same principle to reduce drug prices so that we are not paying twice what other countries are paying as we do now.

So there is a clear economic case for Medicare for All. And I wanted to read from a letter that came from over 200 economists yesterday. This is Economists in Support of a Medicare For All Health Care System, an open letter to the Congress and people of the United States. And I will just read, Mr. Chairman, from the first paragraph.

"As economists, we understand that a single-payer Medicare for All health insurance system for the United States can finance good quality care for all U.S. residents as a basic right while significantly reducing overall health care spending relative to the current exorbitant and wasteful system. Health care is not a service that follows standard market rules. It should, therefore, be provided as a public good. And evidence from around the world demonstrates that publicly financed health care systems result in improved health care outcomes, lower costs, and greater equity."

I ask unanimous consent to introduce this into the record.

Chairman YARMUTH. Without objection.

[The information follows:]

Economists in Support of a Medicare for All Health Care System

An Open Letter to the Congress and People of the United States

May 21, 2019

As economists, we understand that a single-payer "Medicare for All" health insurance system for the U.S. can finance good-quality care for all U.S. residents as a basic right while still significantly reducing overall health care spending relative to the current exorbitant and wasteful system. Health care is not a service that follows standard market rules. It should therefore be provided as a public good.

Evidence from around the world demonstrates that publicly financed health care systems result in improved health outcomes, lower costs, and greater equity. As of 2017, the U.S. spent $3.3 trillion annually on health care. This equaled 17 percent of U.S. GDP, with average spending at about $10,000 per person. By contrast, Germany, France, Japan, Canada, the U.K., Australia, Spain and Italy spent between 9 – 11 percent of GDP on health care, averaging $3,400 to $5,700 per person. Yet average health outcomes in all of these countries are superior to those in the United States. In all of these countries, the public sector is predominant in financing heath care.

For these reasons the time is now to create a universal, single-payer, Medicare for All health care system in the United States.

Public financing for health is not a matter of raising new money for healthcare, but of reducing total healthcare outlays and distributing payments more equitably and efficiently. Implementing a unified single-payer system would reduce administrative costs and eliminate individuals' and employers' insurance premiums and out-of-pocket costs. If combined with public control of drug prices and a dramatically simplified global budgeting system, a sensible Medicare financing system would reduce healthcare costs while guaranteeing access to comprehensive care and financial security to all.

As such, we support publicly and equitably financed health care through a Medicare for All system at the Federal level, as described in H.R. 1384 and S. 1129. We encourage Congress to move forward with implementing a public financed Medicare for All plan to achieve the equitable and affordable universal health care system that the American people need.

Signed,

1 Randy Albelda, Professor of Economics, University of Massachusetts Boston
2 Carolyn B. Aldana, Professor Emeritus, California State University, San Bernardino
3 Mona Ali, Associate Professor of Economics, SUNY New Paltz
4 Larry Allen, Professor of Economics, Lamar University
5 Jack Amariglio, Emeritus Professor of Economics, Merrimack College

6 Eileen Appelbaum, Co-Director and Senior Economist, Center for Economic and Policy Research
7 Peter Arno, Senior Fellow & Director Health Policy Research, Political Economy Research Institute, University of Massachusetts, Amherst
8 Michael Ash, Professor of Economics & Public Policy, University of Massachusetts Amherst
9 Glen Atkinson, Emeritus Professor of Economics, University of Nevada, Reno
10 M V Lee Badgett, Professor of Economics, University of Massachusetts Amherst
11 Ron Baiman, Assistant Professor of Economics, Benedictine University
12 Dean Baker, Senior Economist, Center for Economic and Policy Research
13 Erdogan Bakir, Associate Professor of Economics, Bucknell University
14 Radhika Balakrishnan, Professor, Rutgers University
15 Nina Banks, Associate Professor of Economics, Bucknell University
16 David Barkin, Distinguished Professor, Universidad Autonoma Metropolitana
17 Charles Barone, Professor Emeritus, Dickinson College
18 Deepankar Basu, Associate Professor, University of Massachusetts Amherst
19 Lourdes Beneria, Professor Emerita, Cornell University
20 Peter H. Bent, Assistant Professor, American University of Paris
21 Suzanne Bergeron, Professor, University of Michigan Dearborn
22 Cyrus Bina, Distinguished Research Professor of Economics, University of Minnesota (Morris Campus), and Fellow, Economists for Peace and Security
23 Josh Bivens, Research Director, Economic Policy Institute
24 Robert A. Blecker, Professor of Economics, American University
25 Peter Bohmer, Faculty in Economics and Political Economy, The Evergreen State College
26 Howard Botwinick, Associate Professor of Economics, SUNY Cortland
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29 Robert Brenner, Director, Center for Social Theory and Comparative History, UCLA
30 Michael Brün, Instructor, Heartland Community College
31 Antonio Callari, Professor, Franklin and Marshall College
32 Al Campbell, Emeritus Professor of Economics, University of Utah
33 Martha Campbell, Associate Professor of Economics, Emeritus, SUNY Potsdam
34 Jim Campen, Professor of Economics, Emeritus, University of Massachusetts Boston
35 José Caraballo, Professor, University of Puerto Rico
36 Scott Carter, Professor of Economics, The University of Tulsa
37 James F Casey, Associate Professor of Economics, Washington and Lee University

38 John Dennis Chasse, Professor Emeritus, SUNY College at Brockport

39 Ying Chen, Assistant Professor of Economics, The New School

40 Robert Chernomas, Professor of Economics, University of Manitoba

41 Kimberly Christensen, Economics Professor, Sarah Lawrence College

42 Douglas Cliggott, Lecturer, Economics, University of Massachusetts

43 Nathaniel Cline, Associate Professor, University of Redlands

44 Richard Cornwall, Professor Emeritus, Middlebury College

45 James Crotty, Emeritus Professor, University of Massachusetts

46 Dr. James Cypher, Professor of Economics, Universidad Autonoma de Zacatecas, Mexico, and Emeritus Professor, California State University

47 Omar Dahi, Hampshire College

48 Anita Dancs, Associate Professor of Economics, Western New England University

49 Flavia Dantas, Associate Professor of Economics, SUNY Cortland

50 Paul Davidson, Emeritus Professor Chair of Honor, University of Tennessee

51 Charles Davis, Professor of Labor Studies, Indiana University

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57 Geert Dhondt, Associate Professor, John Jay College, CUNY

58 Peter Dorman, Professor of Political Economy, Evergreen State College

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74 Barbara Garson, Author, *Money Makes the World Go Round*

75 Armagan Gezici, Associate Professor of Economics, Keene State College

76 Helen Lachs Ginsburg, Professor Emerita of Economics, Brooklyn College/CUNY

77 Mwangi Wa Githinji, Associate Professor, University of Massachusetts-Amherst

78 Art Goldsmith, Professor of Economics, Washington and Lee University

79 Neva Goodwin, Co-director, GDAE, Tufts University

80 Ulla Grapard, Professor of Economics and Women's Studies, Emerita, Colgate University

81 Robert Guttmann, Augustus B Weller Professor of Economics, Hofstra University

82 Robin E Hahnel, Professor Emeritus, American University

83 John Battaile Hall, Professor of Economics, Portland State University

84 Jay Hamilton, Assistant Professor, John Jay College

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86 John T. Harvey, Professor of Economics, Texas Christian University

87 Baban Hasnat, Professor of International Business, SUNY Brockport

88 Erin Hayde, Consultant, World Bank

89 F. Gregory Hayden, Professor, University of Nebraska-Lincoln

90 Carol E. Heim, Professor of Economics, University of Massachusetts Amherst

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116 Margaret Levenstein, Research Professor, Institute for Social Research and School of Information, University of Michigan

117 An Li, Assistant Professor, Sarah Lawrence College

118 Victor D. Lippit, Professor Emeritus of Economics, University of California, Riverside

119 James Luke, Professor of Economics, Lansing Community College

120 Daniel MacDonald, Assistant Professor, California State University San Bernardino

121 Arthur MacEwan, Professor Emeritus of Economics, University of Massachusetts Boston

122 Allan MacNeill, Professor, Webster University

123 Zagros Madjd-Sadjadi, Full Professor of Economics, Winston-Salem State University, and Former Chief Economist, City and County of San Francisco

124 Yahya M. Madra, Associate Professor of Economics, Drew University

125 Theresa Mannah-Blankson, Assistant Professor of Economics, Messiah College

126 Thomas Masterson, Director of Applied Micromodeling, Levy Economics Institute of Bard College

127 Gabriel Mathy, Assistant Professor, American University

128 Peter H Matthews, Dana Professor of Economics, Middlebury College

129 Scott McConnell, Associate Professor of Economics, Eastern Oregon University, and Owner/CEO, Side A Brewing

130 Elaine McCrate, Economics Professor Emerita, University of Vermont

131 Terrence McDonough, Professor Emeritus, National University Ireland Galway

132 Martin Melkonian, Adjunct Associate Professor, Economics, Hofstra University

133 Peter B. Meyer, Professor Emeritus of Urban Policy and Economics, University of Louisville

134 Thomas Michl, Professor of Economics, Colgate University

135 John Miller, Professor of Economics, Wheaton College

136 Katherine A. Moos, Assistant Professor of Economics, University of Massachusetts Amherst

137 Monique Morrissey, Economist, Economic Policy Institute

138 Tracy Mott, Professor, University of Denver

139 Michele Naples, Professor of Economics, The College of New Jersey

140 Daniel H. Neilson, Faculty in Economics, Bard College at Simon's Rock

141 Edward J. Nell, Emeritus Professor, New School for Social Research

142 Julie A. Nelson, Professor, University of Massachusetts Boston

143 Reynold F. Nesiba, Professor of Economics, Augustana University

144 John Casey Nicolarsen, Visiting Professor, Sarah Lawrence College

145 Eric Nilsson, Professor, California State University San Bernardino

146 Erik Olsen, Associate Professor, University of Missouri Kansas City

147 Paulette Olson, Professor Emerita, Wright State University

148 Lenore Palladino, Senior Economist, Roosevelt Institute

149 Christian Parenti, Associate Professor Department of Economics, John Jay College CUNY

150 Mark Paul, Assistant Professor of Economics, New College of Florida

151 Eva Paus, Professor of Economics, Mount Holyoke College

152 Karen A Pfeifer, Professor Emerita of Economics, Smith College

153 Lynda Pickbourn, Assistant Professor of Economics, Hampshire College

154 Bruce Pietrykowski, Professor of Economics, University of Michigan-Dearborn

155 Chiara Piovani, Associate Professor, University of Denver

156 Robert Pollin, Distinguished Professor of Economics, University of Massachusetts Amherst, and Co-Director, Political Economy Research Institute (PERI)

157 Devin T. Rafferty, Assistant Professor, Saint Peter's University, and Founding Director, MS Finance Program

158 Pratistha Joshi Rajkarnikar, Postdoc Scholar, Global Development and Environment Institute, Tufts University

159 Michael Robinson, Professor of Economics, Mount Holyoke College

160 John Roche, Associate Proferssor Emeritus, St John Fisher College

161 Leonard Rodberg, Emeritus Professor of Urban Studies, Queens College/CUNY

162 Leanne Roncolato, Assistant Professor of Economics, Franklin and Marshall College

163 Frank Roosevelt, Emeritus Professor of Economics, Sarah Lawrence College

164 Jaime Ros, Emeritus Professor, University of Notre Dame, and Professor of Economics, National Autonomous University of Mexico

165 Nancy E Rose, Professor Emeritus, California State University San Bernardino

166 Trevor R. Roycroft, Ph.D., Professor Emeritus, Ohio University

167 David F. Ruccio, Professor of Economics, University of Notre Dame

168 Jeffrey D. Sachs, Professor, Columbia University

169 Gregory M Saltzman, Professor of Economics and Management, Albion College

170 John Sarich, The Cooper Union for the Advancement of Science and Art

171 John Schmitt, Vice President, Economic Policy Institute

172 Jeremy Schwartz, Associate Professor, Loyola University Maryland

173 Elliott Sclar, Emeritus Professor, Columbia University

174 Stephanie Seguino, Professor of Economics, University of Vermont

175 Mark Setterfield, Professor of Economics, New School for Social Research

176 Anwar Shaikh, Professor, New School for Social Research

177 Barry G. Shelley, Senior Lecturer, Pardee School of Global Studies, Boston University

178 Zoe Sherman, Assistant Professor of Economics, Merrimack College

179 Heidi Shierholz, Senior Economist and Director of Policy, Economic Policy Institute

180 Hee-Young Shin, Assistant Professor, Wright State University

181 Nicholas Shunda, Associate Professor of Economics, University of Redlands

182 Kellin Stanfield, Assistant Professor of Economics, Hobart and William Smith Colleges

183 Howard Stein, Professor, University of Michigan, Ann Arbor

184 Jose A. Tapia, Associate Professor, Drexel University

185 Linwood Tauheed, Associate Professor, University of Missouri Kansas City

186 Daniele Tavani, Associate Professor, Colorado State University

187 Pavlina R. Tcherneva, Program Director and Associate Professor of Economics, Bard College, and Research Associate, Levy Economics Institute

188 Chris Tilly, Professor of Urban Planning, UCLA Luskin School of Public Affairs

189 E. Ahmet Tonak, Visiting Professor, Economics, University of Massachusetts Amherst

190 Mariano Torras, Professor, Adelphi University

191 Andres Torres, Distinguished Lecturer, Lehman College (retired)

192 Mayo Toruno, Professor Emeritus, California State University San Bernardino

193 Eric Tymoigne, Associate Professor of Economics, Lewis & Clark College

194 Vamsi Vakulabharanam, Associate Professor of Economics, University of Massachusetts Amherst

195 William Van Lear, Economics Professor, Belmont Abbey College

196 Ramaa Vasudevan, Associate Professor, Colorado State University

197 Tanadej Vechsuruck, Assistant Professor, University of Rhode Island

198 William Waller, Professor of Economics, Hobart and William Smith Colleges

199 John P. Watkins, Professor of Economics, Westminster College, and Adjunct Professor of Economics, University of Utah

200 David F. Weiman, Professor of Economics, Barnard College, Columbia University

201 Scott A. Weir, Ph.D. in Economics, Retired

202 Jeannette Wicks-Lim, Associate Research Professor, Political Economy Research Institute

203 Noé Wiener, Lecturer, University of Massachusetts Amherst

204 Robert B. Williams, Professor of Economics, Guilford College

205 John Willoughby, Professor, Department of Economics, American University

206 Benjamin Wilson, Assistant Professor, SUNY Cortland

207 Lucas Wilson, Professor, Mount Holyoke College

208 Valerie Wilson, Director, Program on Race, Ethnicity & the Economy, Economic Policy Institute

209 Andrew J Winnick, Professor Emeritus, California State University Los Angeles

210 Jon D. Wisman, Professor of Economics, American University

211 Richard D. Wolff, Professor of Economics Emeritus, University of Massachusetts Amherst

212 L. Randall Wray, Professor of Economics and Senior Scholar, Bard College and Levy Economics Institute

213 Brenda Wyss, Associate Professor, Wheaton College Massachusetts

214 Yavuz Yasar, Associate Professor, University of Denver

215 Tai Young-Taft, Assistant Professor of Economics, Bard College at Simon's Rock, and Research Scholar, Levy Economics Institute of Bard College

216 June Zaccone, Associate Professor of Economics, Emerita, Hofstra University

217 Ajit Zacharias, Senior Scholar, Levy Economics Institute

218 German A. Zarate-Hoyos, Associate Professor, SUNY Cortland

219 Gabriel Zucman, Assistant Professor of Economics, University of California, Berkeley

Ms. JAYAPAL. Thank you, Mr. Chairman.

I will just end by saying, here is what—people who are tuning in—here is what you get from a Medicare for All universal health care system.

First of all, you get comprehensive benefits, like medical, dental, vision, mental health, prescription drugs, long-term care, all of this with no copays, private insurance premiums, or deductibles, and you get more choice than you have now because there is no out-of-network hospital or doctor. Everyone is in network, and the same hospitals and doctors you see, you never have to cut pills again or be the one in five who skipped prescriptions because Medicare for All would actually negotiate those drug prices down.

So, Mr. Chairman, I can't wait to have the hearing on my bill. I can't wait to take on the Republican colleagues across the aisle who think that this is somehow a bad thing. The American people want this, and I am ready to work to deliver it.

Thank you so much.

Chairman YARMUTH. The gentlelady's time has expired.

I now recognize the gentleman from Tennessee, Mr. Burchett.

Mr. BURCHETT. Thank you, Mr. Chairman, Ranking Member, and members of this panel.

I would, knowing coming in here, I would probably rather take a beating than come in here. And I have taken a beating, you can ask some of my colleagues on my side of the aisle. And I appreciate you all, your all's willingness to be here.

And, Mr. Hadley, these are some questions I have for you.

I know that you have previously served as general counsel for the CBO. Is that correct?

Mr. HADLEY. That is correct, for eight years.

Mr. BURCHETT. Yes, sir. Okay.

The CBO report states: By owning and operating hospitals and pooling physicians, the government would have more control over the health care delivery system. They would also take on more responsibilities.

I am sure you are aware of the Takings Clause under the Fifth Amendment, I believe it is the last clause in the Fifth Amendment. Has the CBO mentioned or referenced those issues from a budget perspective in past records, scores, or studies?

Mr. HADLEY. So Fifth Amendment takings issues have arisen in previous cost estimates, and when we have looked at them it has typically been in the context where a government action was going to be clearly taking private property, and we estimated the cost that the government would pay.

So within the Treasury, there is what is called the Judgment Fund. It is a permanent, indefinite appropriation to pay claims against the United States. And one of the types of claims that that fund can pay are constitutional violations like a Fifth Amendment taking. And so we have, on occasion, estimated the cost of the federal government of paying that compensation.

Mr. BURCHETT. Okay. Would you be able to show those in a cost estimate of one of the specific proposals that are out there?

Mr. HADLEY. We would be happy to send you one of the—one of those cost estimates.

Mr. BURCHETT. Great. And what design considerations do you weigh relating to the federal government taking property and compensating private sector entities?

Mr. HADLEY. Well, so, if we are talking about a physical taking of property where they were actually taking over the property themselves, then the analysis is mostly on the side of trying to figure out how to value that property and what its value before the taking was. If it is a, as you know, if it is a regulatory taking, then it is a more complex analysis.

Mr. BURCHETT. Right. Of course, they would be taking a hospital. There would be physical property. And I assume there would be some formula for that?

Mr. HADLEY. We would try to figure out what the compensation was owed for the value of that asset.

Mr. BURCHETT. Okay.

How would you approach those issues if the government were to take these hospitals just for public use? Would there be a separate way of doing that or would there be something out there that you could rely on?

Mr. HADLEY. Well, in both cases we would be looking at the degree to which government control was being exercised.

So when we think about the boundaries of the budget and what is included within the federal budget, we look to the degree of federal control as one of the primary factors for when all of the activities of an entity are included within the budget.

So there are a few instances where there are private entities that are so thoroughly controlled by the federal government that all of their cash flows are considered to be federal cash flows.

Mr. BURCHETT. And what would you think of if they were to take one of these hospitals or private companies without compensation for the takings?

Mr. HADLEY. Well, we would look at the specifics of the legislation and of the action, and it may be difficult for us to gauge exactly what a current administration or a future administration would do with the authority that they are given.

But with those caveats aside, we would look to see what the legislation would do and how much it would cost. And one of the components of the cost that we would consider would be claims against the government.

Mr. BURCHETT. Okay. Thank you, Mr. Chairman. I yield back the remainder of my time.

Chairman YARMUTH. The gentleman yields back.

I now yield five minutes to the gentleman from California, Mr. Panetta.

Mr. PANETTA. Thank you, Mr. Chairman. I appreciate this opportunity.

And let me take this time to thank the witnesses for being here, as well as their preparation in order to be here. Thank you very much. I apologize for coming in late. I had another hearing, so bear with me if I ask questions that you have already heard.

Obviously, I would like to not only thank the witnesses, but again thank the Chairman for holding what many here in this room and many here across this country consider a very important hearing. Obviously, it is important to the families in my district on

the central coast of California who are very worried about their health care.

And we all understand that the Affordable Care Act was clearly an important step in the right direction. We also know that there is a lot more work to do.

Unlike 97 percent of California's residents, many of my constituents are unable to shop around on the individual market in order to choose the best insurance for themselves and their families. In two out of the four counties in my district, Monterey and San Benito Counties, there is only one insurer on the exchange marketplace. As you know well, that lack of choice sharply increases premiums, puts many of my constituents in high deductible plans, and it creates a lot of high out-of-pocket expenses.

To make matters worse, Congress reduced the individual mandate penalty to zero, and the Trump Administration proposed policy changes that would promote insurance plans that do not meet CBO's definition of health insurance.

These actions have left many, many of my constituents without health insurance and actually provided limited options for many of them who want to seek insurance on the marketplace.

Can any of you explain what role the Trump Administration's expansion of short-term limited duration, STLDs, as we know them, those types of plans and association health plans, what they have played on expanding coverage in the individual market, in the sense that have these actions increased access to quality health insurance, or have they helped people with preexisting conditions? If you can talk about that.

Dr. BANTHIN. So we believe that short-term limited duration plans will become more common starting this year because of the change in regulations.

Some of those plans will not provide coverage that meets what we consider to be coverage. Our definition includes a plan that provides some comprehensive major medical benefits, that is, would cover a serious illness. So some of these plans have limitations on what they pay, and so we don't consider them coverage.

However, we do think some of them will continue to provide major medical benefits, often with very high deductibles, even higher than those in the marketplace.

They are underwritten. They will sell them to everybody, but if they decide you have used that coverage for a preexisting condition they may not pay that bill retroactively.

Right now, those plans are small in number, we estimate fewer than 2 million.

Mr. PANETTA. Understood.

Now, in my area, there is, obviously, a good amount of rural area, and so we have a lot of rural hospitals as well. I was wondering if you could address what a single-payer system would do to help reduce costs for these types of hospitals in those rural areas.

Dr. BANTHIN. So many rural hospitals, I don't know about your district, are in—they are called critical access hospitals, and they receive higher payments than would be otherwise provided under Medicare because they are recognized as critical access.

They often treat a lot of public pay patients, as well as patients who are uninsured. It is possible under a single-payer that some of those rural hospitals would actually see—be better off and get more payment for their patients than they do today because some of them are uninsured.

Mr. PANETTA. Other countries that have single-payer systems, how have they dealt with the rural hospitals, and how has that contributed to the rural hospitals, if you know? Sorry to put you on the spot.

Dr. BANTHIN. I am sorry. I don't know about rural hospitals in other countries.

Mr. PANETTA. Okay.

Dr. BANTHIN. We can look that up and get back to you.

Mr. PANETTA. Okay. I would appreciate that.

Anybody else?

Voice. No.

Mr. PANETTA. Okay. Thank you.

Mr. Chairman, I yield back.

Chairman YARMUTH. The gentleman yields back.

I now yield five minutes to the gentleman from Texas, Mr. Crenshaw.

Mr. CRENSHAW. Thank you, Mr. Chairman. Thank you for this opportunity. I think it is time to put to rest the many false promises of Medicare for All and single-payer systems.

Mr. Hadley, I want to start with talking about supply. On page 22 of the report from the CBO, you say: Studies have found that increases in provider payments rates lead to a greater supply of medical care whereas decreases in payments rates lead to a lower supply.

Is this correct?

Mr. HADLEY. That is correct. That is what the report says.

Mr. CRENSHAW. So price controls, which are necessary when moving everyone under one payment rate, it affects supply, correct?

Mr. HADLEY. Yes, it can.

Mr. CRENSHAW. A single-payer system, using current Medicare reimburse rates, decreases the number of doctors. They simply don't get paid enough to keep up with expenses.

Second point, triage. Under single-payer systems, do providers typically bill for whatever they want, or is there an approved treatment list?

Mr. HADLEY. Typically, there would be an approved treatment list.

Mr. CRENSHAW. Thank you.

Generally in single-payer systems, is the government or a government body in charge of listing out national guidelines and standards for practice that doctors must follow?

Mr. HADLEY. So usually it is a set of standardized practices, but that can be done sometimes by an independent advisory board and sometimes——

Mr. CRENSHAW. Somebody has to do it.

Under these systems, what are common methodologies for deciding what is listed on the national guidelines or standards? Is it a cost-benefit analysis?

Mr. HADLEY. Yes. They look at cost effectiveness, but then for the prices for those sometimes it is through negotiations.

Mr. CRENSHAW. Sure. So what we get to—maybe it is a government bureaucrat, maybe it is a third party—but a bureaucrat is using a cost-benefit analysis formula that will decide what a patient is approved for.

The third thing I want to hit, innovation. So we have two issues here so far. We have lower payments to providers and a government-run list of approved care options. So we have to ask ourselves, why would anyone invest in new, cutting-edge medical technology or medications? You won't get paid as much. You are not even sure the government will allow doctors to use your new innovation. How do you think that changes the calculus of investors? It changes it enormously.

The fourth thing I want to hit, quality of care. In your report, you write: If the number of providers was not sufficient to meet demand, patients might face increased wait times and reduced access to care. Is this correct?

Mr. HADLEY. That is correct.

Mr. CRENSHAW. And later in your report you say: Public plans might not be as quick to meet patients' needs, such as covering new treatments. Correct?

Mr. HADLEY. Correct.

Mr. CRENSHAW. If we measure quality of care in wait times and innovative new care, wouldn't we agree that quality is decreasing? So there is less providers, there is less innovation, longer wait times, and overall less quality.

This isn't even the worst part. Let's move on to who this might actually hurt the most.

Director Hadley, in your testimony you write: The public plan would provide the same set of health care services to everyone eligible, so it might not address the needs of some people. For example, the public plan might not be as quick to cover new treatments and technologies as would a system with competing private insurers.

In your testimony, you are saying that a single-payer system might not address the needs of some people who need access to new treatments and technologies, correct?

Mr. HADLEY. That is correct, depending on the design of the program.

Mr. CRENSHAW. Would you say that some of these people who need new treatments, they could be patients with cancer, genetic disorders, patients who suffer from two diseases, like fatty liver disease or diabetes, all of them have very complicated, complex conditions?

Mr. HADLEY. It would really depend on how quickly and which technology or treatment was being provided and which group that affected.

Mr. CRENSHAW. Sure. But in your testimony you said some people, and it could easily include these people.

Could those people that I just listed also be described as people with preexisting conditions?

Mr. HADLEY. Yes.

Mr. CRENSHAW. So a single-payer system is worse for people with preexisting conditions. A private system is better for people with preexisting conditions than a public system.

Let's talk about what we have learned here. Let's summarize it.

A single-payer system has to set prices, and if set at current Medicare rates, which all plans call for, then this drastically cuts the money going to doctors and hospitals. They will have to cut resources. They will hire less. They will buy less equipment. It is simple economics.

Because there are less doctors, wait times will increase. With this newfound world of less doctors and more patients, the government will have to carefully screen or triage who gets care and who doesn't and what kind of care they get, all based on bureaucratic cost-benefit analysis.

Innovators will be less likely to invest in a system where the payoff is significantly less because they can't be sure whether the government bureaucrat will even allow doctors to use that new medical device, medication, or new procedure.

And, counterintuitively, the system ends up hurting the patients with the most unique conditions, also known as patients with preexisting conditions, because their care requires flexibility and innovation, both of which are drastically reduced in a single-payer system.

Thank you, Mr. Chairman.

Chairman YARMUTH. The gentleman's time has expired.

I now yield five minutes to the gentleman from Missouri, Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

Welcome to the Democrat House Budget Committee. We are 37 days past the statutory deadline for a budget, and CBO is here today to discuss an analysis of a bill that would overhaul our health care system so dramatically that they can't even estimate how much it would cost.

Without a budget and without talking in real numbers about how much this bill would cost the American public, we are wasting our time today. But since you want to talk about single-payer health care systems, let's look at the results of government-run health care.

Canada is celebrated by my liberal friends as a prime example. If a Canadian sees their primary care doctor for a checkup and their doctor recommends that they go see a specialist for a closer look, it could take nearly 20 weeks. Twenty weeks.

If a patient has knee problems and is struggling to walk, after their first doctor's visit it will take 39 weeks to have their knee surgery. If their knee problem gets worse while they are waiting, they might not be able to walk. That is when people miss work, when they miss their wages, and they can't attend family events like their kids' sporting events.

How about cancer? The median time for a patient with cancer to start treatment is nearly a month. Nearly a month. Imagine being diagnosed with cancer, having to wait four full weeks before getting treated in Canada.

In England, in England's single-payer health program, the British National Health Service cancelled 50,000 nonemergency oper-

ations, like cataract surgery and hip and knee surgeries, including replacements.

Bottom line, single-payer would impose long wait times and delays even for basic procedures and emergency medicine.

What about cost? CBO hasn't even attempted a cost estimate. Medicare for All by other projections will cost $32 trillion over 10 years. That would cost every household in America $25,000 a year. Every household in America $25,000 a year.

Our seniors who currently rely on Medicare would have their care disrupted, too. After a lifetime of work to earn their Medicare benefits, America's seniors would be forced into a one-size-fits-all government-run health care system no longer tailored to the needs of our older citizens, but one that rations care and limits their access.

CBO says it themselves, quote: "Patients might face longer wait times or a decrease in quality," close quotes, and could, quote, "worsen if provider payment rates were simultaneously lowered or more stringent cost containment methods were implemented," close quotes.

You thought IPAB was bad. We are talking about the real life death panels right here.

This is what Medicare for All gets you. Americans would have no choice but to pay more to wait longer for lower quality care.

Let's talk about access to care for rural Americans. Mr. Hadley, an alternative scenario reported—published earlier this year by the Medicare Trustees showed that looming physician cuts and cuts to hospitals due to ObamaCare's productivity cuts would put most providers out of business.

My question is, what happens in this scenario when we assume all providers get Medicare rates?

Mr. HADLEY. That is a complicated question for thinking about what it means for rural providers. So in general you would expect that the total amount of compensation going to hospitals would go down because right now commercial rates are, on average, higher than Medicare rates. So if you went to the lower level, compensation would go down, and so margins would go down.

But there is an important caveat for all hospitals, which is what is the degree of uncompensated care that they are currently providing, and if that became compensated care, then that would make up some of that difference.

In addition, in the context of rural hospitals, a greater proportion of them have lower margins than urban hospitals, and a greater proportion of them are running negative margins than the urban hospitals, but that is in part because they already serve a greater share of patients with public insurance plans. And because of that, they are already both receiving less, they would be somewhat less effective, but they also have less margin to work with.

Chairman YARMUTH. The gentleman's time has expired.

I now yield five minutes to the gentleman from Georgia, Mr. Woodall.

Mr. WOODALL. Thank you, Mr. Chairman.

I am a little embarrassed. I hadn't thought about what Mr. Smith said, that we are here talking about doubling the size of the

federal budget, and here on the Budget Committee we haven't passed a budget yet.

I know it is tough to find 218 votes on one side of the aisle or the other. But I have said it before and I will say it again, you are the right leader, colonel Womack is the right leader to bring a bipartisan group together around a budget.

It just seems silly that we are going to take over one-sixth of the American economy, and that takeover is going to be conducted by a government that can't even figure out how to pay its own bills year to year. We can do it; we just haven't done it.

Let me start, Mr. Hadley. I had the pleasure of being on the first Medicare for All hearing on the Rules Committee, and we learned there that Medicare for All abolishes all of the Medicare Advantage programs, which about half the seniors in my district take advantage of. So that Medicare for All means something for all, but you are going to lose access to Medicare Advantage.

What you say in your report, if I am reading it correctly, is thinking about utilization management as one of the cost containment procedures. You say it would impose new constraints on the choice of health care services for those who were previously enrolled in the Medicare Fee-for-Service program. Is that correct?

Mr. HADLEY. That is correct. You could have—I mean, using utilization management as a technique to control cost is an option for policymakers, and there are a variety of different strategies you could pursue, and we detail those in the report.

Mr. WOODALL. But our current Medicare beneficiaries, those who have been paying in through their entire life payroll tax, largest tax 85 percent of American families pay, folks today are not burdened by that constraint. Is that correct?

Mr. HADLEY. Correct. In general, most of Medicare's fee-for-service or voluntarily——

Mr. WOODALL. They either opted into a plan that is going to go away even though they chose it, or they have stayed in general Medicare, which is also going to go away because it is not subject to those utilization procedures.

You said something in response to a question earlier about improper payments. The question was whether or not improper payments would be higher under a Medicare for All system, and you said it would depend. Improper payments could be higher or lower than today depending on the investment in fraud prevention.

You all look at our numbers every year. Is it CBO's position that we have not yet reached the maximum utility of fraud prevention efforts in the Medicare system, that if we hired more fraud preventers we would get more than a dollar-for-dollar return on that in today's system?

Mr. HADLEY. Yes, that is correct.

Mr. WOODALL. About how much elasticity is there? Where are we? Are we 10 percent short in fraud preventers? Are we 20 percent short? It just seems like among the things that we could all agree on, nobody wants to see improper payments go out the door. It is wasted resources. How short are we?

Dr. Kling?

Dr. KLING. I don't have the exact numbers, but we are not that close to the threshold.

Mr. WOODALL. I would appreciate that. You don't have to create, reinvent the wheel for me, but if you could point me in the direction after the hearing, I would love to try to build some bipartisan consensus on fixing that issue. I think that we could.

The report says a single-payer system that collected comprehensive data on patients' use of health care services could potentially manage available resources more efficiently. That certainly makes sense, I don't think that was a radical conclusion. But what was surprising is you went on to say, in the United States public programs, those single-payer systems that we have today, have implemented few utilization management programs.

Why do you think that is, that you have identified an area where we could do better, and yet, in the programs where we have an opportunity to do better run at the federal level, we are not doing that?

Mr. HADLEY. Well, so one of the reasons is in general we are still operating under fee-for-service in many areas. But also, in order to have that degree of coordination, you need more providers talking with each other. And that means, you know, one way to get there would be having an IT system with medical records that are completely interoperable. But that is not the only way. You could do it in some other ways.

But I think kind of the two main reasons are that so far we have chosen to do things as a fee-for-service or we have struggled with our own systems.

Mr. WOODALL. Well, I would point that out, Mr. Chairman. I think Mr. Hadley is right. In our programs like Medicare, like Medicaid, that are single-payer systems, for whatever reason, the political folks who craft those programs, the policymakers, have chosen to keep them as fee-for-service systems, to not implement aggressive utilization management.

We would have to implement aggressive utilization management to bring down costs in a Medicare for All single-payer system. I would like to explore why it is that we have not done that in places that we could do that today to bring down costs. And if it is because the American people are averse to it, perhaps we should learn that lesson first with a smaller pool before we expand it to a larger pool.

I am not sure you all changed anybody's mind today, but I believe that CBO makes it a point not to try not to change anybody's mind and just provide good data. So thank you very much for doing that.

Chairman YARMUTH. Exactly. That was not their role, to try to change people's minds.

I thank the gentleman.

And now I yield 10 minutes to the Ranking Member, Mr. Womack.

Mr. WOMACK. Thank you, Mr. Chairman. And again, I appreciate the opportunity to have this conversation today, and perhaps there will be more to come on these types of programs.

I want to go to my last thought first, and that is, Deputy Director Hadley, let's assume for the sake of the argument that the United States of America did move to a Medicare for All type structure, universal health care. Is that something that can be done as

an experiment with the population at large, 329 million people? Or, if we went to that program and it didn't work, what then? So in that scenario, what would happen? In other words, we either have to be all in or not all in. Is that correct?

Mr. HADLEY. So you could have an extended period of transition. But if you go all in and then that results in insurance companies dropping in value and the disruptions to workers, all of that that we detail in the report, if that occurs, then how we would respond is very difficult to understand.

And I think this is one of the reasons why, looking at Taiwan, they thought about moving to their system for several years before they started to implement it.

Dr. KLING. So it would certainly be possible for a state or a group of states to implement a single-payer system and have the rest of the country observe how that was going and then make other decisions later. That is a choice that is up to you.

Mr. WOMACK. Kind of a pilot type project. All right.

Deputy Director Hadley, name me something that the federal government does really well, really efficiently, good cost efficiency.

Mr. HADLEY. It is very efficient at distributing Social Security payments.

Mr. WOMACK. Okay. So Social Security. That is a good topic. What is the health of Social Security right now?

Mr. HADLEY. It is going to—the trust fund is going to run out of resources early in the next decade.

Mr. WOMACK. Okay. Can you pick another? What else do we do well?

Mr. HADLEY. We defend the country.

Mr. WOMACK. We defend the country. But defending the country requires a lot more than just the federal government's share of it, i.e., there is a defense industrial base that has a certain role in it, correct? I mean, they build airplanes, they build ships, tanks, those kinds of things.

Mr. HADLEY. That is correct.

Mr. WOMACK. Would the government need to own that in order for it to be better?

Mr. HADLEY. No. And we talked about as one of the key features, the key choices for policymakers, you could have a single-payer system that operated, was administered by federal contractors, or it could be done by federal employees.

Mr. WOMACK. Let me ask this. How does the federal government do in the area of border security right now? There has been a lot of talk about that.

Mr. HADLEY. It is my impression that it is not meeting the goals of some policymakers.

Mr. WOMACK. Okay. What about in terms of infrastructure? There has been a lot of talk about infrastructure. How are we doing there?

Mr. HADLEY. It is my impression that it is not meeting the goals of some policymakers.

Mr. WOMACK. Okay. My friend Mr. Woodall talked briefly about budgets and appropriations. I mean, we are almost four months away from the beginning of a fiscal year, October 1, and we don't have a budget. We don't have agreed-upon numbers, yet the Appro-

priations Committee is marking up to numbers that have not been agreed to. So how are we doing in the area of budgets and appropriation?

Mr. HADLEY. So we have often missed the deadlines for providing appropriations on time.

Mr. WOMACK. Why is that?

Mr. HADLEY. So I think, in general, it is because of the—we haven't found the political will to find agreement.

Mr. WOMACK. So in the expansive world of policy, we do have the political piece of this thing with which to deal.

So explain to me why health care would be any different. If we are not doing very well at some of the other fundamental jobs that are in front of Congress, and I would argue that budgets and appropriations is the most fundamental, then how can we expect that government-run health care, as is being suggested by the other side, is going to be that one area where we do extremely well, very cost-efficient, without the political implications that go with some of the other policy issues? How, then, can we expect that government-run health care is going to be a good deal for Americans?

Mr. HADLEY. Well, we say in the report that there are a couple of areas where it is unclear what would happen in part because of political pressure. So, for example, we talk about in negotiating the prices of prescription drugs that it is not clear what would happen in terms of actually exercising that power with the threat of excluding drugs from the formulary.

Similarly, we talk about this idea that a single-payer system would have a greater incentive to invest in preventive services that are shown to reduce costs, but it is not clear whether the system would act on those incentives. But it is up to you and your colleagues to decide how to design the system to act and what discretion to give it and also what choices to make for it.

Mr. WOMACK. In my opening statement, you heard me talk about the expected cost of government-run health care and how would we pay for it, and so we talked about things like, well, we could raise taxes. That is one way we could pay for it. We could reduce the benefit structure. That is another way we could do it. We could introduce copays and this sort of thing. And then I said at the end of my comment, in those four areas that I talked about, that likely it would be all of the above. Would you agree or disagree with that?

Mr. HADLEY. That is again a choice for policymakers, but the more you spread the cost across different financing structures, the less disruptive any one of them would be.

Mr. WOMACK. I would also like to ask a question about what I call the suppression of ingenuity or the suppression of ideas. I think Mr. Crenshaw referred to it a little bit.

And that is, in a government-run area where we have a prescribed list of things that we, the government, would deem as acceptable or appropriate in treatment, that the impact it would have, government-run health care, on suppressing innovation, ideas—we talked a little bit about the provider network, we have a lot of young people today that are going off to school and incurring obscene numbers that I have seen on student debt in order to become professions—how would a government-sponsored, govern-

ment-run health care suppress innovation, ideas, and the ability for the—or the desire for people to want to get into the trade?

Mr. HADLEY. Well, this is largely dependent on the set of choices that policymakers make. But if, for example, they chose to constrain costs by lowering provider payment rates, that could drive some innovation to be more efficient to live within those rates.

But if we take, for example, the context of prescription drugs, on some level—prescription drugs are a global market. The United States is the largest market that companies turn to. If the prices paid in the United States are substantially lower, they might be less likely to enter the United States market.

Also, because the revenues have gone down, they might try to shift those costs to other countries by raising their costs there. But if they are unable to do that, then we might see a reduction in research and development as a result of the reduction in payment rates.

Mr. WOMACK. A couple of final questions.

Under a Medicare for All structure, who would own facilities? Who would own hospitals?

Mr. HADLEY. That is a choice for policymakers. In some countries, they are private not-for-profits. In some countries, they are owned by the national health service.

Mr. WOMACK. And we talked about the takings issue, that if the government chose to own those, then there would be a compensation factor for the present hospitals out there, I suppose.

And, Ms. Banthin, you talked about the fact that you thought that rural hospitals, critical access hospitals, and I have got a couple in my district, could benefit. Can you explain how they would benefit?

Dr. BANTHIN. Yes. Because they take care of so many Medicaid and Medicare and uninsured patients today, they treat a greater share of uninsured patients than some more urban suburban hospitals do. They could actually get more revenue under a single-payer if Medicare payment rates were provided for every patient.

Mr. WOMACK. And then, lastly, if I could just take a couple of more seconds. It was also stated earlier that under a universal coverage like this that the likelihood is is that private business out there would pass along the savings, as it were, to the employees in the form of higher wages.

How confident are any of you that there will be anything left over, that the cost associated with initiating universal coverage would, indeed, be a tax increase on these people? How confident are you that there would be any residual benefit that would be passed along to the everyday consumer?

Mr. HADLEY. It really depends on the design of the system. But I think what Dr. Banthin was referring to was the idea that if they didn't have to pay premiums to purchase health insurance, that that cost would be eliminated. But on the other hand, the tax increases or premiums paid to pay for the single-payer system would increase.

Mr. WOMACK. To me, that seems a bit problematic, but anyway.

Mr. Chairman, I again thank you for the opportunity to have this hearing, and hopefully, we will have more discussions.

Chairman YARMUTH. Absolutely. Thank you, Ranking Member.

I yield myself 10 minutes for my questions.

First of all, let me thank you all again, not just individually, for your responsiveness and your testimony, but also to CBO as a body. I think this report was extremely professional, was extremely thoughtful and comprehensive, and I think it will be very useful for all of us as we continue to discuss the delivery of health care in the country. So I applaud you for that.

You know, I have been now involved in health care legislation in the House of Representatives for 10 years. Some of my colleagues on the other side, as a matter of fact most of them, have not been involved in it for that long, at least not in this body.

And it has been fascinating to watch the discussions on health care with regard to my Republican colleagues, because when we spent all of 2009 and part of 2010 writing the Affordable Care Act, the Republicans in the House then gave us absolutely no input, no cooperation, and basically no interest, but lots of opposition.

And I don't know what their resistance to trying to find a better way to deliver health care in this country was, but it was very, very obvious.

Then we lost the majority in 2010. And then, for the next eight years with Republicans in the majority, we got 65 or so votes to repeal the Affordable Health Care, or aspects of it, and never an alternative proposal. I assume that they wanted to go back to pre-ACA days.

And I remember well in 2009 when premium rates on the commercial system across the country were rising at 38 percent, where 18,000 unnecessary deaths occurred because of lack of health care, where 800,000 bankruptcies occurred because of health care costs.

I suppose that is the glory days for Republicans in Congress. They are not for me. They are not for my colleagues on the Democratic side.

And I challenged them on many occasions. I remember sitting in the Rules Committee one day testifying. I said, you know, there is a reason you don't have an alternative to the Affordable Health Care. The only alternative is a single-payer system, and you don't want to go there.

That is still the case. And if there had been an alternative somewhere in those eight years, I suspect Heritage Foundation or Club for Growth or Cato or somebody would have come up with an alternative plan for delivering health care in this country.

Oh, by the way, part of the ACA came out of the Heritage Foundation. So I was amused a little bit when—I forget which member, I think it was Mr. Roy, talked about, oh, the ACA, all Democratic ideas. Actually, the insurance part of it was a Republican idea, that we embraced, that they opposed. It was a good idea when Mitt Romney introduced it in Massachusetts, but not when we tried to incorporate it in a plan for America.

So I find this discussion very interesting. And a lot of my colleagues today, because I think we would do it, too, if they got a big number, like $32 trillion, that they are going to make the most of it. They spent a lot of time talking about that, the Mercatus study, which is the cost of single-payer health care.

However, they neglected to mention the report's findings that I find most interesting. The authors of the Mercatus report said that

national health spending would be 4 percent lower in 2031 under a single-payer system compared to current law. So while that $32 trillion sounds like a lot of money, and it is a lot of money, it was significantly less than if we hadn't made a change to single-payer.

They have, I know, kind of tried to mock the fact that we didn't ask for a score on the Jayapal bill. Well, two reasons we didn't ask for a score.

One is we have several bills represented on this Committee. As we have seen through your report, there are thousands of ways you could construct a single-payer system and that a score on one combination of those, which is never going to be done exactly the way it was introduced, is not particularly useful.

But there have been analyses done of single-payer bills in addition to the Mercatus Center. The University of Massachusetts at Amherst at the end of last year issued a 200-page report which focused on the first Medicare for All bill, which was introduced by Senator Sanders in 2017.

Among the findings of that report, it would lower cost for people at lower and middle incomes and increase costs for those at higher incomes. Middle-income families would see their net costs for health care fall by 2.6 percent to 14 percent.

But it also said that overall cost of the system—again, this is Bernie Sanders' bill—would drop by 19 percent. That is a pretty substantial saving, a 19 percent saving.

Again, what we have seen from this hearing, and once again I applaud you, is that there are so many ways of doing this that there will be an enormous matrix with a lot of different numbers on it. And when we actually sit down and try to legislate in this area, we won't be doing it on this Committee, we will be considering all of those.

There are a number of things that have been said today that I absolutely have to comment on. It is one advantage of going last, I guess. And I am sorry most of the members have left, because I would love to ask them about it.

But Mr. Crenshaw came up with some of the most tortured logic I have ever heard to get to the point, to the claim, that, as I understood what he was saying, that people with preexisting conditions would be worse under a Medicare for All system.

Is that the way you understood what Mr. Crenshaw was saying? Did you get the same impression I did, Mr. Hadley?

Mr. HADLEY. So it was my impression that he thought that a Medicare—the single-payer system would be worse for people with preexisting conditions.

Chairman YARMUTH. Can you imagine how that would be possible?

Mr. HADLEY. It could be possible depending on the design of the system.

Chairman YARMUTH. Would any system that Republicans have devised be better off for people with preexisting conditions than a Medicare for All system would be?

Mr. HADLEY. I don't know. It is hard to make that comparison.

Chairman YARMUTH. So he also made the point that people under a Medicare for All system might not have access to the latest technologies and innovations. Do patients under today's system or

yesterday's system have access to the latest innovations and technologies?

Mr. HADLEY. Some do.

Chairman YARMUTH. Some do. Many are rejected. Many experimental procedures are not approved for many individuals. Isn't that correct?

Mr. HADLEY. That is correct.

Chairman YARMUTH. Correct.

I also thought it was interesting that Mr. Stewart said that citizens don't want to change their insurers. They don't want to choose—they want to choose their insurers. And I thought that was interesting because just a couple years ago Utah decided to-- the people of Utah voted to expand Medicaid, which would mean a lot more people would be out of the private insurance market and into expanded Medicaid.

So a substantial percentage of the population in his state, at least, thought a Medicaid system that expanded to cover more people was desirable, and those people probably don't care about choosing their insurers.

With two minutes left, I want to dive a little bit deeper into this issue of taxes. It is very convenient to divide $32 trillion by 300 million people and get a number and say this is what it is going to cost everybody. Is that a reasonable or thoughtful analysis of what the cost would be, Dr. Banthin, since you are shaking your head?

Dr. BANTHIN. Sorry. No, that is too simple. There are lots of details involved in devising a tax financing system.

Chairman YARMUTH. But when you consider financing the taxing system, you are looking at somebody who now is paying their share of the premium through their employer. They have copays. They have deductibles. And those things would net out of any additional tax increase if they weren't paying it as part of a single-payer system, correct?

Mr. HADLEY. That is correct. When we are looking at the total burden on people, we would be looking at how much they are paying net. But I also want to be clear that this would be an estimate that the Joint Committee on Taxation and CBO would do together. Remember, we look to them for their expertise in tax policy.

Chairman YARMUTH. Right. And also, presumably, we could construct and probably would construct this plan to pose an additional burden on employers since if we didn't, we would be ridding them of—it would be one of the greatest corporate bailouts ever if we took the responsibility for paying for 160 million people off of them and put it on the taxpayers. That would be a pretty good gift to corporate America, wouldn't it, if we didn't charge them more some way?

Dr. BANTHIN. I mean, economists believe that workers, not employers, bear the ultimate cost of their health insurance. But it would certainly save employers a lot of administrative costs, yeah.

Chairman YARMUTH. One final thing. Canada is mentioned a lot of times and in a very mocking way. I just want to share a story that I heard or read not too long ago. It is in a book called "The Healing of America" by T.R. Reid, which is a fantastic look at how

insurance is provided across the world. And if anyone reads it, I think they would be envious of a lot of other places.

But there was a poll done in Canada a few years ago as to who the most famous, most important Canadian in history was. And finishing by a wide margin in first place, beating out Wayne Gretzky and Celine Dion and many others, was the gentleman who invented the Canadian health care system.

So despite all these stories of gloom and doom about the Canadian system, the Canadians are very happy with their system. Not that we are trying to emulate that in any respect.

Ms. JACKSON LEE. Mr. Chairman?

Chairman YARMUTH. Ms. Jackson Lee.

Ms. JACKSON LEE. I don't want to interrupt you, but I did not want to miss the opportunity for a moment.

Chairman YARMUTH. All right. The gentlelady is recognized for five minutes.

Ms. JACKSON LEE. Mr. Chairman, did you finish getting your point.

Chairman YARMUTH. I was just going to conclude the hearing.

Mr. WOMACK. His time has expired.

Chairman YARMUTH. My time has expired.

Ms. JACKSON LEE. Then let me express my appreciation to you, Mr. Chairman. I was not dilatory. I was in a markup. I apologize to the Committee. But my passion for this work warranted a sprint over to this Committee.

So let me, first of all, indicate that I am sure you have heard from our members how committed and sincere we are on the basic question of health care for all Americans. And we do that on the basis of those that we see with preexisting conditions, for example.

But let me tell you what I base it upon. I base it upon having been here as a senior member for more than two decades and seeing the transition of what we had to offer. And then it looks like almost two years of hearings that I participated in on the issue of the Affordable Care Act.

I am reminded of a family that actually took their 8-year-old to a particular insurance company's office because she had leukemia, and she could not get coverage, or they could not get coverage, because there were no protections for individuals with preexisting conditions, and unfortunately and tragically, she died.

I had to listen to a mother whose son was a lawyer, but, unfortunately, he got hooked on drugs and got hepatitis and only wound up in medical care when he wound up in the emergency room in the Atlanta public hospital. He ultimately passed away. These were witnesses, of course, telling their stories.

So I want to see a situation where we do have health care. And so I am going to ask a question very quickly to Deputy Director Mark Hadley about your assessment of how many Americans are underinsured, meaning that they have health coverage, but they still face high health plan deductibles and high out-of-pocket medical expenses. They might even face having insurance policies, which I have heard of before, that does not cover hospitalization.

Mr. HADLEY. We don't have our own separate number, but if you look at some of the studies that are in the research literature, it is clear that there are many, many people in that category.

So, for example, there is a Commonwealth Fund study that shows that 27 percent of people who have health insurance decided to forego care because of its cost.

Ms. JACKSON LEE. And does that include also the high cost of prescription drugs plays a role in that?

Mr. HADLEY. I believe so, but we can get back you to about the specifics of the survey questionnaire that they used.

Ms. JACKSON LEE. If you would.

Dr. Banthin, why don't you comment?

Dr. BANTHIN. So, yes, the Commonwealth finds about 29 percent of people with coverage report having to delay or forego medical care, including prescriptions, due to the cost. The Peterson-Kaiser survey finds a lower number, but that includes people—all people under 65 also delay or forego medical care.

Ms. JACKSON LEE. And that creates a burden on the health care system.

Dr. Banthin, I am just going to continue.

That burdens the health care system, does it not, because they come sicker to the health care system?

Dr. BANTHIN. If they are foregoing prescribed treatment, yes, it can be a burden.

Ms. JACKSON LEE. Would you comment on the single-payer, single approach Medicare for All concept in terms of helping these both underinsured and expanding access to health care?

Dr. BANTHIN. So, of course, the answer depends critically on how the benefit package is designed and the choices made by the Congress, but a single-payer system would provide coverage, insurance coverage, for everyone. That is the key goal. And so certainly people would have coverage, and depending on the design of the benefit package, they could have fewer out-of-pocket costs that would be barriers to care.

Ms. JACKSON LEE. I am interested in saving lives, and so more lives could be saved if they had a package that worked for them.

Doctor?

Dr. BANTHIN. That is correct.

Ms. JACKSON LEE. Dr. Kling, you are on the economic side of it.

Would you care to see how that construct would work in terms of making sure that we had far-reaching health care for everyone in this nation?

Dr. KLING. It would certainly have a big effect on the economy. I wasn't sure what your question was.

Ms. JACKSON LEE. I am interested in the impact on people having health care.

Dr. KLING. So if people are healthier, they would be more productive, yes.

Ms. JACKSON LEE. And I will answer your question on the economy. If they are more productive, if there are more people in the system, if there are more people buying the product, the prescription, going to doctors—you know, I hear the issue about the economy. I would almost say that we could counter it by constructing something that would take into consideration the challenges that it might be to the economy.

We are ahead of this now, we are not behind it, and our idea would be to make sure that we had everyone in it. That means

healthy people would be in it, younger people would be in it. They would use it less and therefore maybe complement and/or contribute to the system not crunching, because they would provide sort of the extra wings to the system.

Would it not be that kind of construct?

Chairman YARMUTH. The gentlelady's time has expired.

Ms. JACKSON LEE. I thank you. I have answered my own question, Mr. Chairman. I think we can handle this Medicare for All single-payer and save lives.

And I yield back. Thank you.

Chairman YARMUTH. Thank you.

Again, I want to thank all our witnesses for being with us today. Please be advised members can submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record. Any members who wish to submit questions for the record may do so within seven days.

Chairman YARMUTH. Without objection, this hearing is adjourned.

[Whereupon, at 12:50 p.m., the Committee was adjourned.]

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STATEMENT
HEARING:
"KEY DESIGN COMPONENTS AND CONSIDERATIONS FOR ESTABLISHING SINGLE-PAYER HEALTH CARE SYSTEM"

COMMITTEE ON THE BUDGET
210 CANNON
MAY 22, 2019
10:00 A.M.

- Thank you Chairman Yarmuth and Ranking Member Womack for convening this hearing to discuss key design components and considerations for establishing a single-payer health care system.

- The purpose of today's hearing is to review the Congressional Budget Office's (CBO) recent report on those single-payer health care key design components and considerations prepared at the request of Chairman Yarmuth.

- Let me welcome our witnesses:

  Mark Hadley
  Deputy Director
  Congressional Budget Office

  Dr. Jessica Banthin
  Deputy Assistant Director for Health, Retirement, and Long-Term Analysis
  Congressional Budget Office

  Dr. Jeffrey Kling
  Associate Director for Economic Analysis
  Congressional Budget Office

- Thank you for being here and sharing your expertise with this Committee.

- Mr. Chairman, this is a timely topic because, like most of my colleagues, I hear from my constituents often that their greatest fear is that they or one of their loved ones might be stricken with a major illness or medical condition that could force them to choose between bankruptcy and foregoing or delaying the treatment that is needed.

- Today's health care system fails to provide quality, therapeutic health care as a right to all people living in the United States.

- Nearly 30 million Americans are uninsured, and at least 40 million more are underinsured, meaning that they cannot afford the costs of their copays and deductibles.

- The United States spends more money per capita on health care than any other major nation, yet the quality of our health care is much worse: life expectancy in the United States is lower, while our infant and maternal mortality rates are much higher.

- We waste hundreds of billions of dollars every year on unnecessary administrative costs, while health care industry executives measure success in profits, instead of patient care.

- The current health care system in the United States is inefficient and outrageously expensive.

- It is time to guarantee quality, therapeutic health care to every person living in the United States.

- This is a public conversation that is long over and that is why I am a sponsor of the H.R. 1384, the *"Medicare for All Act of 2019,"* introduced by Congresswoman Jayapal of Washington.

- H.R. 1384 improves and expands the overwhelmingly successful and popular Medicare program, so that every person living in the United States has guaranteed access to health care with comprehensive benefits.

- Congress must lead because this Administration has shown time and again that it cannot be trusted to look after health care interests of the American people.

- The President's FY2020 budget breaks his promise "to leave Medicaid and Medicare alone" by cutting Medicaid by $1.5 trillion, which represents approximately one out of every four dollars spent on the program.

- No part of the program would be safe: the budget entirely repeals the Affordable Care Act (ACA) Medicaid expansion, and it converts funding for everyone else into a block grant or per-capita cap.

- Under the reductions in funding that would result from block grants or per-capita caps, states will need to eliminate or drastically reduce services for low-income children, people with disabilities,

and seniors – or raise billions of dollars to cover the loss of federal resources.

- The budget requires all states to implement so-called work requirements, despite a complete lack of evidence that they help people find jobs.

- In Arkansas, which implemented the first work requirement in the country last year, more than 16,000 people already lost their health insurance with no evidence that they found new employment.

- Expanding this policy nationwide would undoubtedly result in hundreds of thousands, if not millions, of Americans losing their health care coverage.

- The budget also makes several changes to Medicare by shifting costs onto hospitals, post-acute care providers, and some beneficiaries, reducing federal spending by more than $500 billion.

- The President's FY2020 budget also breaks his promise that "everybody's going to be taken care of," by replacing the Affordable Care Act with block grants to states to use at their discretion, including for costs unrelated to health care coverage.

- Even if states used the block grant for coverage, there is no guarantee that current protections for people with pre-existing conditions will continue and services like maternity care and mental health treatment could be eliminated.

- And the size of the block grant would grow at the rate of inflation, meaning it would never keep place with the need for care.

- This proposed "replacement" leaves millions of Americans without meaningful health insurance and is nearly identical to the 2017 Graham-Cassidy proposal rejected by Congress and the American people.

- Mr. Chairman, it bears noting that despite spending more on health care per capita than any other country in the world, the United States has extreme health and health care disparities among racial and ethnic populations.

- These disparities typically impact African Americans, American Indians, and Alaskan Natives the hardest, with the Latino and immigrant communities also experiencing significant disparities.

- Currently, many low-income and minority communities face overcrowded hospitals and clinics, hospital closures, and shortages of nurses, doctors, and other health care professionals.

- So I am very interested to hear from our witnesses about the potential of a single-payer health care system to ensure that our safety-net and critical access hospitals, both rural and urban, are sufficiently resourced and that our communities are staffed with sufficient nurses, doctors, and other providers to promote good health where possible and provide therapeutic care where needed.

- Thank you, Mr. Chairman, I yield back my time.

U.S. House of Representatives
Washington, DC 20515
COMMITTEE ON THE BUDGET

"Key Design Components and Considerations for Establishing a Single-Payer Health Care System"

May 22, 2019

Questions for the Record

Ranking Member Steve Womack

Questions for Mark Hadley- Deputy Director, Congressional Budget Office (CBO)

Federal Health Spending Will Increase to Cover Single-Payer System. The CBO report states: "Government spending on health care would increase substantially under a single-payer system because the government (federal or state) would pay a large share of all national health care costs directly."

- How much of the spending on federal health programs is funded by:
  - Taxes collected through the Treasury?
  - Direct payments by beneficiaries in the form of premiums and out-of-pocket spending?
  - Tax deductions for employer-sponsored health insurance?
  - Other?
- What percentage of total health expenditures are NOT paid for by the federal government, which would likely be shifted to the federal government under a single-payer system?

Financing Single-Payer Health Care. The CBO report states: "In a federally administered single-payer system, the associated cash flows would be federal transactions, in CBO's view, and the spending and revenues for the system would appear in the federal budget."

- Please explain this statement further.
- How would CBO determine if this new spending would be considered mandatory or discretionary?

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- What are the potential trade-offs and risks if the federal spending was mandatory or discretionary?

Centralized IT System. The CBO report states: "A standardized IT system could help a single-payer system coordinate patient care by implementing portable electronic medical records and reducing duplicated services. … Establishing an interoperable IT system under a single-payer system would have many of the same challenges as establishing an interoperable IT system in the current health care system with its many different providers and vendors."

- What is the current status of the Affordable Care Act (ACA) website? What does it do? How many people use it to verify eligibility? What is the scale of the ACA website compared to a centralized IT system CBO describes in the report? The ACA website is a verification system and not a payment system, correct?
    - How much has been spent on the ACA website to date?
    - Did the ACA website ever have technical difficulties after its launch? What were some of these difficulties?
- What is the HITECH Act that was included in the stimulus package in 2009? How much was allocated to the project? What is the status of the project today? Is this an interoperable system, similar to what is described in the report?

Current Coverage Trends in the United States. The CBO report states: "Under the current system, CBO estimates, an average of 29 million people per month - 11 percent of the U.S. residents under the age of 65 - were uninsured in 2018."

- The report found that 243 million people under the age of 65 had health insurance. Where does this group of people get their insurance?
    - How many of these individuals obtain their insurance from companies or businesses? Unions? Self-employment?
- Would the individuals who currently have coverage, roughly 300 million Americans, be affected if we moved to a single-payer system? How many people who currently have coverage would be disrupted by the potential effects of such a massive overhaul?
- What is the breakdown of the uninsured population near retirement, 50-64 years old?
    - What is their general health status? What are their overall health conditions?

Reduced Quality of Care in a Single-Payer System. The CBO report states: "An expansion of insurance coverage under a single-payer system would increase the demand for care and put

pressure on the available supply of care. ...If the number of providers was not sufficient to meet demand, patients might face increased wait times and reduced access to care."

- What factors led CBO to state: "...patients might face increased wait times and reduced access to care"?

- In a single-payer system with little or no cost sharing relative to our current system, would demand for medical services increase? If provider payments decreased, would a single-payer system have the capacity to meet the demand? Please explain these trade-offs and risks.

- What does "reduced access to care" mean in CBO's view?

- What do wait times in other countries with single-payer health systems currently look like compared to the United States?

- What about systems within the United States that the government administers? The VA is primarily a government-run health care system. Were wait times ever a problem at the VA? What are recent examples?

Long-Term Services and Single-Payer System. The CBO report states: "Public spending would increase substantially relative to current spending if everyone received Long-term Services and Supports benefits."

- What are Long-term Services and Supports (LTSS) benefits and who receives them under the current system?

- How are these benefits covered now? What is the role of the states in funding the benefits?

- How would utilization change if these benefits were made free for patients?

- Please discuss the Community Living Assistance Services and Supports (CLASS) program. What was the program? What was the CBO cost estimate (both within the 10-year window and beyond)? Why did this program never go into effect? Was this program repealed?

Hospital Challenges Under a Single-Payer System. The CBO report highlights several issues hospitals might face if there was a shift to single-payer health care:

- "A single-payer system could retain current ownership structures, or the government could play a larger role in owning hospitals and employing providers. In one scenario, the government could own the hospitals and employ the physicians, as it currently does in most of the VHA system."

- What is the hospital ownership structure in the United States today?
- How would the quality of care change during a transition if the government takes more of a responsibility in the ownership of hospitals?
- What other changes could hospitals see if we change to a single-payer system?

Hospital Closures Due to a Single-Payer System. The CBO report states: "The number of hospitals and other health care facilities might also decline as a result of closures, and there might be less investment in new and existing facilities."

- CBO produced a report in 2016 entitled *Projecting Hospitals' Profit Margins Under Several Illustrative Scenarios.* In the report CBO found that "about 27 percent of [hospitals] had negative profit margins (in other words, they lost money) in that year."
  - According to the 2016 CBO report, what were the future projections of hospital margins in the U.S.?
  - What were the major factors that were driving more hospitals into financial distress?
  - What would happen if all hospitals received only the Medicare reimbursement rate?
  - Would the shift to universal Medicare reimbursement rates have a different impact on urban and rural hospitals?
  - How many hospitals are closing in the United States? Is there a differential rate between urban and rural hospital closures? What factors are hurting rural hospitals?
  - In other countries, has the government had to save hospitals by buying them?
  - If CBO were to score a single-payer proposal, could CBO provide a dynamic score?
    - What elements does CBO use to do a dynamic score?
    - Would CBO look at the effect of such a plan on jobs?
    - Would CBO look at hospital closures?
    - Would CBO look at the effect on the economy?

Private Insurance and a Single-Payer System. The CBO report states: "By contrast, proposals to establish single-payer systems often prohibit substitutive insurance because of concerns that it might interfere with the operation of the public plan."

- What is substitutive insurance?
- How would substitutive insurance interfere with the public plan?
    - What has happened in countries such as England?
- Today, how many Americans have private insurance plans? What are examples of such plans?
    - What are Medicare Advantage plans? Are they private insurance plans?
    - How many seniors are enrolled in Medicare Advantage plans today?
    - Why do seniors choose these plans?

How a Single-Payer System Chooses What to Cover. There are several sections of the report that mention "utilization management" and choices that would need to be made about what services and treatments would be covered in a single-payer system. For example, the CBO report states: "An independent board could recommend whether or not new treatments and drugs should be covered after their clinical and cost-effectiveness had been demonstrated—a role fulfilled in England by the National Institute for Health Care and Excellence."

- What does CBO mean by "utilization management"?
    - What trade-offs and risks would occur if there is no control compared to too much control?
    - How do we make these decisions now for federal programs such as Medicare or the ACA?
    - What is the United States' Preventive Services Task Force?
        - What are some examples of recommendations that have been made from them?
    - Under a single-payer system what types of decisions would be made regarding covered treatments and drugs? What are some examples?

Global/International Comparisons. The CBO report helpfully provides examples of other countries which have some elements of single-payer systems.

- What are examples of countries that have a more market-based system?
- What are examples of countries that have hybrid systems, some public and some private, and some which are shared?
- What are examples of controls used in other countries to contain the budgetary impacts of their single-payer systems?
    - Can the government decide which treatments to offer?
    - Can they approve use of certain medications?
    - What factors do these governments/systems use to determine which treatments to allow and which not to allow?
        - Does cost play a role in their decision making?
    - What is the process they use for rare but groundbreaking treatments?
    - Could a potential treatment, that doctors might say is reasonable, be denied due to decisions that were made by the government or a board?
    - In other countries can the government overrule what a patient or guardian would request?
- Which other countries use global budgets in their single-payer systems? Is it common or rare?
    - What would happen to patients in facilities that run out of money before the next budget cycle?

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"Key Design Components and Considerations for Establishing a Single-Payer Healthcare" System
May 22, 2019
Questions for the Record
Rep. Chip Roy

Questions for Mr. Mark Hadley, Deputy Director, CBO

CBO estimated in the report that an average of 29 million people per month - 11 percent of the U.S. residents under the age of 65 - were uninsured in 2018.

- Of the 29 million people who are under the age of 65 and uninsured, how many are eligible for health benefits but not enrolled?
- How many have access to insurance but choose not to purchase it?
- Who pays for their health care right now, the uninsured population under the age of 65, under the current system? For example, if someone receives medical care without coverage, who pays for their services? What is the net cost of this coverage?
- Would individuals who currently have coverage, roughly 300 million Americans, be affected if we moved to a single-payer system? How many individuals who currently have coverage would have their coverage disrupted by the potential effects of such an overhaul?

Spending:

- What percentage of total health expenditures are NOT paid for by the federal government, which would likely be shifted to the federal government under a single-payer system?

The report stated that roughly 29 million people do not have coverage, and 11 million of those individuals are not legally present in the United States.

- Has CBO done analyses on the federal spending impact of those 11 million people, including the net impact on healthcare spending? If so, please include the relevant responses.

Choice:

- The report states, "participants would not have a choice of insurer or health benefits… the benefits provided by the public plan might not address the needs of some people."
- Can you elaborate on what that means? The plan might not address the needs of some people?
- How many people in the US are covered by private insurance? How many are covered by a public program?

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Access:

- A recent Association of American Medical Colleges study found the U.S. will see a shortage of up to nearly 122,000 physicians by 2032 - this is under current law.
- Would a single payer system in the United States lead to an even greater shortage of physicians in the U.S?

Wait Times:

- Has CBO done a report on average wait times for care in the United States under current policy? If so, what do average wait times look like?
- What would average wait times look like for a patient under a single payer system?

Crowd out issue:

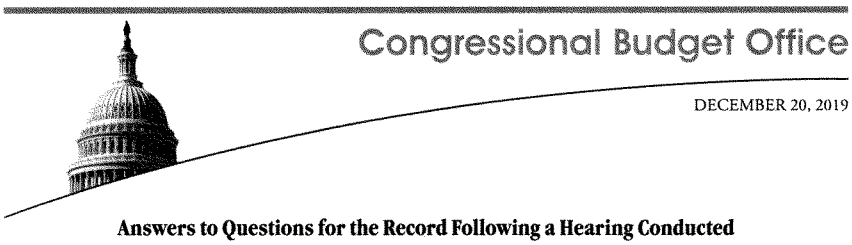
- With respect to Obamacare's Medicaid expansion, has CBO done any analysis of crowd out -- both the numbers of people dropping private coverage to enroll in expansion, and the Medicaid spending for those individuals?

- I've seen some reports suggesting significant numbers of people may be dropping private coverage to enroll in Medicaid, Louisiana specifically. Can CBO elaborate on this?

Cost Sharing Reduction payments:

- Finally, and with respect to the budgetary treatment of cost-sharing reductions, did CBO tell Budget Committee staff that CBO now assumes that all states will incorporate CSRs into their premium estimates *over time*? On June 8 last year, CBO wrote that it "generally expects the costs associated with CSRs to be covered by increases in premiums."
    - Is CBO required to assume payments will be made in all cases -- not some cases, or generally, or over time, but in all cases, and in all states?

- Some states, including North Dakota, Vermont, and South Dakota did not allow insurers to raise premiums for 2018 after CSR payments stopped. Yet CBO assumed that each of these states would do the exact opposite. Did CBO contact these states regarding their insurance markets when adjusting the treatment of CSRs in 2018, and when were they contacted? Director Hall had previously admitted that he provided incomplete, and inaccurate information to the Budget Committee Members when asked about this issue at a January 2018 hearing. I am greatly concerned about this issue and would appreciate CBO provide clarity on this subject in response to the above QFRs.



DECEMBER 20, 2019

Answers to Questions for the Record Following a Hearing Conducted by the House Committee on the Budget: Key Design Components and Considerations for Establishing a Single-Payer Health Care System

On May 22, 2019, the House Committee on the Budget convened a hearing at which Mark Hadley, the Congressional Budget Office's Deputy Director, Jeffrey Kling, CBO's Associate Director for Economic Analysis, and Jessica Banthin, CBO's former Deputy Assistant Director in the Health, Retirement, and Long-Term Analysis Division testified about the agency's report Key Design Components and Considerations for Establishing a Single-Payer Health Care System.[1] *After the hearing, Ranking Member Womack and Congressman Roy of the Committee submitted questions for the record. This document provides CBO's answers. It is available at www.cbo.gov/publication/55951.*

Ranking Member Womack

Question. The CBO report states: "Government spending on health care would increase substantially under a single-payer system because the government (federal or state) would pay a large share of all national health care costs directly."

- How much of the spending on federal health programs is funded by: Taxes collected through the Treasury? Direct payments by beneficiaries in the form of premiums and out-of-pocket spending? Tax deductions for employer-sponsored health insurance? Other?
- What percentage of total health expenditures is NOT paid for by the federal government, which would likely be shifted to the federal government under a single-payer system?

Answer. In fiscal year 2018, federal spending on major health care programs totaled $1.2 trillion, which consisted of spending on Medicare (excluding the effects of premiums and other offsetting receipts), Medicaid, and the Children's Health Insurance Program (CHIP), as well as subsidies for plans purchased thorough the marketplaces established by the Affordable Care Act (ACA).[2] Virtually all of the financing for the programs other than Medicare comes from the general fund of the Treasury. In 2018, combined funding for those programs amounted to $456 billion.

In 2018, transfers from the general fund of the Treasury accounted for $312 billion of the total funding for Medicare, revenues from payroll taxes accounted for $265 billion, and

1. See Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System* (May 2019), www.cbo.gov/publication/55150.

2. See Congressional Budget Office, "10-Year Budget Projections" (August 2019), Table 1-4, www.cbo.gov/about/products/budget-economic-data#3. That estimate does not include other federal spending for health care, such as health insurance costs for federal employees, veterans' health care, and the military health care system.

beneficiaries' premiums accounted for $99 billion. The remaining sources of financing for Medicare, which together account for less than 10 percent of the program's funding, include the following: revenues from a portion of the federal income taxes that Social Security recipients with income above a certain threshold pay on their benefits; interest credited to Treasury securities held in the Medicare trust funds (which in turn is financed by the Treasury's general fund); and payments from the states to help finance Medicare Part D.

The tax exclusion for employment-based health insurance reduces federal revenues and is therefore a federal subsidy for health insurance. The staff of the Joint Committee on Taxation (JCT) and CBO estimate that the tax exclusion cost the federal government about $300 billion in forgone revenues in 2018.[3] Altogether, that tax exclusion plus federal spending on major health care programs amounted to $1.5 trillion in 2018.

Currently, national health care spending—which totaled $3.5 trillion in 2017—is financed through a mix of public and private sources. Private sources paid more than half of that amount, and state or local governments paid about one-tenth. The federal government paid 37 percent of the total, or $1.3 trillion.[4] The percentage of national health expenditures that would be shifted to the federal government under a single-payer system would depend on the design of the system. Two key design features are the services that would be covered by the single-payer system and the amount of cost sharing that would be required. In a system covering a comprehensive set of benefits with little cost sharing, most national health expenditures would be made by the federal government. The total effect on the federal budget and the amounts individuals and organizations paid for health care coverage would depend on how the system was financed.

Question. The CBO report states: "In a federally administered single-payer system, the associated cash flows would be federal transactions, in CBO's view, and the spending and revenues for the system would appear in the federal budget."

- Please explain this statement further.
- How would CBO determine if this new spending would be considered mandatory or discretionary?
- What are the potential trade-offs and risks if the federal spending was mandatory or discretionary?

Answer. A single-payer system might be administered entirely by federal agencies, or private entities might play some role. CBO generally treats the transactions of nonfederal entities as federal if those entities act as agents of the federal government by using the sovereign power of the federal government, work to achieve a governmental purpose, or if they are subject to a significant degree of federal control. In CBO's view, the spending and revenues of the system would be governmental even if the private sector played some role in administering

3. See Congressional Budget Office, "Reduce Tax Subsidies for Employment-Based Health Insurance," *Options for Reducing the Deficit: 2019 to 2028* (December 2018), www.cbo.gov/budget-options/2018/54798.

4. The estimates of national health care spending by source of payment are from Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960–2018" (accessed February 15, 2019), https://go.usa.gov/xEUS6. The estimates of national and federal spending on health care include spending on investment in the medical sector, which accounts for 5 percent of national spending on health care and 3 percent of federal spending on health care. The estimates of federal spending for Medicare exclude the effects of premiums and other offsetting receipts. The estimates do not account for tax subsidies, such as the federal tax exclusion for employment-based health insurance.

it. For example, the federal government could contract with one or more private insurers to administer the program, and the responsibilities of those insurers could include collecting premiums and paying providers. Because those insurers would be acting as agents of the federal government, CBO would classify the cash flows as governmental in its cost estimates.[5]

For a system in which private insurers delivered the benefits, key design choices would be as follows: how policymakers would structure the competition among private insurers, how private insurance might supplement a standard benefit, and how such supplemental benefits would relate to previously existing benefits. Such a system could be more akin to a multi-payer system than a single-payer system if private insurers paid providers. However, some analysts would consider such a system to be a single-payer system if the government defined the eligible population, specified the covered services, collected the resources needed for the plan, required the eligible population to contribute toward financing the system, and showed the receipts and expenditures associated with the plan in the government's budget. That type of system could retain previously existing benefits.

Mandatory Versus Discretionary Funding. The spending for a single-payer system would be considered mandatory if the authorization act that established the new program also controlled its funding. The spending would be considered discretionary if the authorization act established the new program but did not control its funding. In the latter case, the amount of funding for the new program would be determined through the annual appropriation process. Those appropriations are subject to a set of budget enforcement rules and processes that differ from those that apply to mandatory spending.

Advantages and Disadvantages of Each Type of Funding. Specifying the spending for a single-payer system as mandatory rather than discretionary would provide greater certainty in funding for the program, which would be helpful to beneficiaries, providers, and manufacturers of drugs and medical devices. If spending for the program was discretionary, its funding would lapse if the appropriation bill for the program was not passed by the start of the fiscal year. In that case, temporary funding could be provided through a continuing resolution. Specifying the spending for a single-payer system as discretionary would give the Congress a formal mechanism to review the program on a yearly basis and make modifications that Members deemed appropriate. The Congress also could use other mechanisms to encourage reviews at less frequent intervals, such as a sunset provision whereby the program would end on a specified date unless it was reauthorized. Keeping total costs within the appropriated amount and minimizing disruptions as total spending neared that amount would be challenging if the government's role was to pay private-sector providers for all services rendered.

Question. The CBO report states, "A standardized IT system could help a single-payer system coordinate patient care by implementing portable electronic medical records and reducing duplicated services....Establishing an interoperable IT system under a single-payer system would have many of the same challenges as establishing an interoperable IT system in the current health care system with its many different providers and vendors."

- What is the current status of the Affordable Care Act website? What does it do? How many people use it to verify eligibility? What is the scale of the ACA website compared to a centralized IT system CBO describes in the report? The ACA website is a verification

5. See Congressional Budget Office, *How CBO Determines Whether to Classify an Activity as Governmental When Estimating Its Budgetary Effects* (June 2017), www.cbo.gov/publication/52803, and *The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System* (May 2009), www.cbo.gov/publication/41185.

system and not a payment system, correct? How much has been spent on the ACA website to date? Did the ACA website ever have technical difficulties after its launch? What were some of these difficulties?

- What is the HITECH Act that was included in the stimulus package in 2009? How much was allocated to the project? What is the status of the project today? Is this an interoperable system, similar to what is described in the report?

Answer. The Centers for Medicare & Medicaid Services (CMS) was responsible for developing a federally facilitated marketplace for states without their own marketplaces. The federally facilitated marketplace includes a website—HealthCare.gov—that is currently operational. It serves as a portal for consumers and several supporting information technology (IT) systems.

In 2019, 32 states use the federally facilitated marketplace, and 12 states and the District of Columbia operate their own state-based marketplaces. The remaining 6 states perform some administrative functions for their marketplaces, but all rely on the federal website and supporting IT systems.[6]

Utilization of Marketplace Websites. Consumers can compare health insurance plans and purchase a plan through the state marketplace websites or HealthCare.gov. The marketplaces verify that people are eligible for coverage before allowing them to enroll and provide people with an estimate of the cost of their coverage after accounting for any subsidies for which they are eligible. In some states, the marketplaces also can determine whether people are eligible for coverage through Medicaid or the Children's Health Insurance Program. In other states, the marketplaces make an initial assessment of eligibility for those programs and transfer applicants' information to state agencies for final determination. The marketplace websites are a verification and enrollment system, not a payment system. CMS uses supporting IT systems to review, approve, and generate financial assistance payments—such as premium tax credits and cost-sharing reductions—to insurers.

Over the course of the year, the average number of consumers who enrolled in the marketplaces and paid for their coverage across all states was about 5.5 million in 2014, 9.4 million in 2015, 10.0 million in 2016, 9.8 million in 2017, and 9.9 million in 2018. For 2019, that number is 9.5 million in CBO's projections. In addition, some people who apply for coverage through the marketplaces are determined to be eligible for Medicaid or CHIP and enroll in one of those programs. For example, that was the case for 5.2 million people in 2016.

The scale of the websites and supporting IT systems that serve the ACA marketplaces is much smaller than the scale of a centralized IT system that would be needed under a single-payer system. To put that in perspective, the total U.S. population was about 327 million in 2018.[7]

Cost of Implementing the Health Insurance Marketplaces. Through 2014, CMS spent $8.4 billion to set up the marketplaces. That figure includes about $5 billion in grants to states and an additional $3.4 billion in spending by CMS.[8] Those amounts include spending to establish all functions of the marketplaces, not just spending devoted to the websites and supporting IT systems. Based on information from CMS, about $2.1 billion was spent on

6. See Kaiser Family Foundation, "State Health Insurance Marketplace Types, 2020," https://tinyurl.com/yafjlgin.

7. See Census Bureau, "Quick Facts" (July 2018), www.census.gov/quickfacts/fact/table/US/PST045218.

8. Even states that run their own marketplaces rely on the federal IT infrastructure of HealthCare.gov and use the data hub built and maintained by the federal government. See Annie L. Mach and C. Stephen Redhead, *Federal Funding for Health Insurance Exchanges*, Report for Congress R43066 (Congressional Research Service, October 29, 2014), https://fas.org/sgp/crs/misc/R43066.pdf (479 KB).

IT infrastructure for the federally facilitated marketplaces from 2014 through 2018.[9] (CBO does not have information on the amount spent on IT infrastructure for the state-based marketplaces.)

Technical Difficulties. The website for the federally facilitated marketplace experienced technical difficulties after it was launched. According to a report issued by the Government Accountability Office (GAO) in 2015, there were several problems with the development and rollout of HealthCare.gov. People faced significant obstacles when they tried to create accounts and enroll in the system. Some of the issues that GAO highlighted included inadequate planning by CMS regarding the capacity needed for the system, software coding errors, and a failure to implement all planned functionality before the system was launched. Additionally, GAO concluded that CMS did not apply best practices for the system's development, which contributed to problems with the launch of HealthCare.gov. After the website was launched, CMS took steps to address those problems by increasing capacity, requiring additional software quality reviews, and awarding a new contract to complete the development of the systems.[10]

The marketplace's supporting IT systems, which perform functions such as linking consumers' information to other systems to facilitate the enrollment process and payments to insurers, also experienced difficulties. Prior to 2016, for example, CMS used an interim process to calculate and authorize financial assistance payments. The federal marketplace fully transitioned to an automated system in 2016 and nearly all of the state marketplaces have transitioned.[11]

The HITECH Act. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) encouraged health care providers to adopt health information technology. That act established a program that provided incentive payments early in the program and imposed penalties that came later. Eligible providers needed to demonstrate the ability to use a certified electronic health record (EHR) system in a meaningful way and meet other requirements. The legislation included a "certification" component that required EHRs to have certain common capabilities and a "meaningful use" component that required health care providers to meet certain criteria regarding their use of EHRs, such as using them for e-prescribing and reporting clinical quality measures.

According to CMS, the agency paid providers more than $30 billion from 2011 to 2018 through the Medicare and Medicaid EHR incentive programs.[12] As of 2017, 80 percent of

9. See Centers for Medicare & Medicaid Services, *Justification of Estimates for Appropriations Committees, Fiscal Year 2020* (2019), p. 167, https://go.usa.gov/xVJhs (PDF, 4.5 MB); *Justification of Estimates for Appropriations Committees, Fiscal Year 2019* (2018), p. 166, https://go.usa.gov/xVJhF (PDF, 4.5 MB); *Justification of Estimates for Appropriations Committees, Fiscal Year 2018* (2017), p. 171, https://go.usa.gov/xVJhJ (PDF, 3.6 MB); *Justification of Estimates for Appropriations Committees, Fiscal Year 2017* (2016), p. 307, https://go.usa.gov/xVSqq (PDF, 9.1 MB); and *Justification of Estimates for Appropriations Committees, Fiscal Year 2016* (2015), p. 88, https://go.usa.gov/xVSqa (PDF, 10.2 MB).

10. See Government Accountability Office, *CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices*, GAO-15-238 (March 2015), www.gao.gov/assets/670/668834.pdf (4.8 MB).

11. See Department of Health and Human Services, Office of Inspector General, *Initial Review of CMS's Automated System for Processing Financial Assistance Payments* (attachment to a letter to the Honorable Gus Bilirakis, May 8, 2017), https://oig.hhs.gov/oas/reports/region2/21702001.pdf (492 KB).

12. See Centers for Medicare & Medicaid Services, "Data and Program Reports" (May 2019), https://go.usa.gov/xVSqD. In 2018, CMS changed the name of its EHR incentive programs to the Medicare and Medicaid Promoting Interoperability Programs to focus on improving interoperability and patients' access to health information.

office-based physicians had adopted a certified EHR system, and 96 percent of all nonfederal acute care hospitals had a certified health IT system.[13]

Although interoperability of EHRs was an important goal of the HITECH Act, that goal has not been achieved.[14] (Interoperability is the ability of two or more systems to exchange information and the ability of those systems to use the information that has been exchanged without special effort.) The Office of the National Coordinator (ONC) at CMS has reported that electronic health information is often spread across multiple providers that use different systems that are not interoperable.[15] In 2017, just over 40 percent of hospitals engaged in all four domains of interoperability defined by the ONC: sending, receiving, finding, and integrating electronic patient records from external sources.[16]

Question. The CBO report states: "Under the current system, CBO estimates, an average of 29 million people per month—11 percent of U.S. residents under age 65—were uninsured in 2018."

- The report found that 243 million people under the age of 65 had health insurance. Where does this group of people get their insurance? How many of these individuals obtain their insurance from companies or businesses? Unions? Self-employment?
- Would the individuals who currently have coverage, roughly 300 million Americans, be affected if we moved to a single-payer system? How many people who currently have coverage would be disrupted by the potential effects of such a massive overhaul?
- What is the breakdown of the uninsured population near retirement, 50–64 years old? What is their general health status? What are their overall health conditions?

Answer. People under the age of 65 obtain health insurance coverage from various sources. A majority of those people have employment-based coverage—in 2019, an estimated 159 million people, or 58 percent of the total nonelderly population.[17] Of that total, roughly 6 million people are covered by multiemployer union plans.

On average, another 69 million people under the age of 65 obtain coverage through Medicaid or CHIP, 14 million obtain insurance through private nongroup plans, 1 million (who live in Minnesota and New York) are covered by the Basic Health Program, 8 million are covered by Medicare, and 3 million have coverage from other sources, such as student health plans or foreign sources.

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13. See Office of the National Coordinator for Health Information Technology, "Health IT Dashboard" (updated June 17, 2019), https://dashboard.healthit.gov/quickstats/quickstats.php.

14. See Julia Adler-Milstein, "Moving Past the EHR Interoperability Blame Game," *NEJM Catalyst* (July 2017), https://catalyst.nejm.org/ehr-interoperability-blame-game/.

15. See Government Accountability Office, *Health Information Technology: HHS Should Assess the Effectiveness of Its Efforts to Enhance Patient Access to and Use of Electronic Health Information*, GAO-17-305 (March 2017), www.gao.gov/assets/690/683388.pdf (6.6 MB).

16. See Office of the National Coordinator for Health Information Technology, *Variation in Interoperability Among U.S. Non-federal Acute Care Hospitals in 2017*, ONC Data Brief 42 (November 2018), https://go.usa.gov/xppxG (PDF, 647 KB).

17. The responses to this question are based on CBO's estimates for 2019. All of those estimates reflect average monthly enrollment over the course of the year. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085. That report was published shortly after the release of *Key Design Components and Considerations for Establishing a Single-Payer Health Care System.*

CBO and JCT estimate that in 2019 between 4 million and 5 million people are enrolled in health insurance that is subsidized by the income tax deduction for health insurance premiums that is available to people who are self-employed.[18] Many of those people purchase insurance on an individual basis instead of as part of a group; their coverage is categorized as nongroup rather than employment-based even though their subsidies are work-related.

Effects of a Single-Payer System on People Who Currently Have Coverage. In CBO's estimation, if private insurance was eliminated under a single-payer system, the following people under age 65 would need to switch their coverage to the single-payer plan: 159 million with employment-based insurance, 14 million with nongroup coverage, and 1 million with coverage through the Basic Health Program. Those estimates cannot be added to yield an estimate of the total number of people with private insurance because some people report more than one type of coverage. The role of private insurance under a single-payer system would depend on its design. For example, the system might eliminate private insurance, or it could retain a role for private insurance, such as offering benefits that supplement the public plan.

If current public programs were eliminated, people of all ages who participated in those programs would need to switch their coverage: an estimated 75 million enrolled in Medicaid, 7 million enrolled in CHIP, and 61 million enrolled in Medicare. (Those numbers count people with two sources of coverage, such as Medicare and Medicaid, in both categories.) Depending on the system's design, some people who now have public coverage could continue to have such coverage under a single-payer system, but their covered benefits and cost sharing might change.

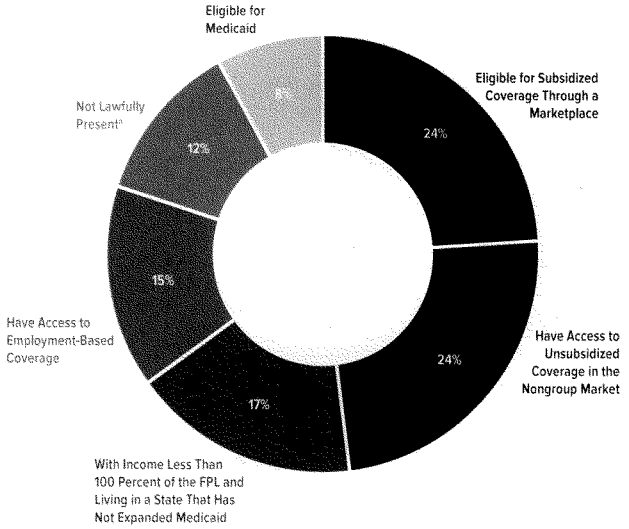
The Uninsured Population 50 to 64 Years Old. Among people ages 50 to 64 who are uninsured, CBO estimates, 24 percent are eligible for subsidized coverage through a marketplace, 24 percent have access to unsubsidized coverage in the nongroup market but choose not to purchase it, 17 percent have income less than 100 percent of the federal poverty guidelines (commonly referred to as the federal poverty level, or FPL) and live in a state that did not expand Medicaid, 15 percent have access to employment-based coverage, 12 percent are noncitizens who are not lawfully present in this country, and 8 percent are eligible for Medicaid but are not enrolled (see Figure 1).

According to CBO's analysis of data from the 2018 National Health Interview Survey, people between the ages of 50 and 64 who were uninsured had worse self-reported health status than people in the same age category who were insured. Among people ages 50 to 64 who were uninsured, 45.4 percent reported that they were in excellent or very good health, 34.0 percent were in good health, and 21.0 percent were in fair or poor health. By contrast, among people ages 50 to 64 who had health insurance, 54.4 percent reported that they were in excellent or very good health, 29.2 percent were in good health, and 16.3 percent were in fair or poor health. However, among people ages 50 to 64, the uninsured were less likely than those with insurance coverage to report having ever been told by a medical professional that they had certain medical conditions, such as diabetes (12.6 percent versus 14.1 percent), hypertension (35.7 percent versus 43.6 percent), or coronary heart disease (2.3 percent versus 4.9 percent). Those differences in reported health conditions might reflect differences between people with and without insurance coverage—specifically, differences in the nature and amount of their contact with the medical system—and thus differences in the opportunity for certain conditions to be diagnosed.

18. This estimate includes policyholders plus their dependents.

Figure 1.

Composition of the Uninsured Population Ages 50 to 64, 2019



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

FPL = federal poverty level.

a. Noncitizens who are not lawfully present in this country are ineligible for marketplace subsidies and for most Medicaid benefits.

Question. The CBO report states: "An expansion of insurance coverage under a single-payer system would increase the demand for care and put pressure on the available supply of care.... If the number of providers was not sufficient to meet demand, patients might face increased wait times and reduced access to care."

- What factors led CBO to state: "...patients might face increased wait times and reduced access to care"?
- In a single-payer system with little or no cost sharing relative to our current system, would demand for medical services increase? If provider payments decreased, would a single-payer system have the capacity to meet the demand? Please explain these trade-offs and risks.
- What does "reduced access to care" mean in CBO's view?
- What do wait times in other countries with single-payer health systems currently look like compared to the United States?

- What about systems within the United States that the government administers? The VA is primarily a government-run health care system. Were wait times ever a problem at the VA? What are recent examples?

Answer. A single-payer system with little cost sharing for medical services would lead to increased demand for care in the United States because more people would have health insurance and because those already covered would use more services. The extent to which the supply of care would be adequate to meet that increased demand would depend on various factors, such as the payment rates for providers and any measures taken to increase supply. If coverage was nearly universal, cost sharing was very limited, and the payment rates were reduced compared with current law, the demand for medical care would probably exceed the supply of care–with increased wait times for appointments or elective surgeries, greater wait times at doctors' offices and other facilities, or the need to travel greater distances to receive medical care. Some demand for care might be unmet.

Certain government policies could increase supply in the short run. For example, states could ease restrictions on the responsibilities that nurse practitioners and physicians' assistants are allowed to assume.

Over the longer term, the federal government could implement policies to encourage investment in the health care system. Examples include investing in both physical infrastructure (for instance, subsidizing the cost of additional hospital beds) and human capital (for instance, more heavily subsidizing medical education). Without sufficient investment over the long term, wait times could lengthen as providers' costs rise with other costs in the economy and the population grows.

Wait Times in the United States and Other Countries. In 2016, wait times in the United States were comparable to those in other countries for routine care, but wait times tended to be shorter for treatment by specialists or elective surgeries. A much larger share of the U.S. population reported barriers to obtaining care because of costs rather than wait times.[19] The reverse would be the case under a single-payer system in the United States that had little or no cost sharing.

Access to Care in Public Programs in the United States. The federal government administers health insurance for the elderly and the disabled through the Medicare program. It provides coverage for that population to receive care from private providers and contracts with private insurers to offer coverage. Medicare beneficiaries generally do not report issues with access to care.[20] Almost all providers accept Medicare patients.

Medicaid is a health insurance program for the low-income population that is administered jointly by the federal and state governments. Because of the relatively low payment rates set by state governments, Medicaid beneficiaries report more access issues—such as difficulty obtaining appointments—than privately insured patients do.[21]

Rather than administering an insurance plan, the Department of Veterans Affairs (VA) operates an integrated health care system in which most of the veteran beneficiaries receive

19. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), https://tinyurl.com/ybx6hj3v (PDF, 3.4 MB).

20. See Medicare Payment Advisory Commission, "Chapter 4: Physician and Other Health Professional Services," *Report to the Congress: Medicare Payment Policy* (March 2019), pp. 100–108, https://go.usa.gov/xVhWU (PDF, 367 KB).

21. See Medicaid and CHIP Payment and Access Commission, "Key Findings on Access to Care," https://go.usa.gov/xV4X7.

only a portion of their health care (with few or no out-of-pocket expenses). According to the March 2018 VA Inspector General Report, access to health care—including wait times, scheduling practices, and the distance to facilities—continues to be an issue for VA.[22] To address those issues, the VA MISSION Act of 2018 (which went into effect in June 2019) expanded VA's capacity to provide health care at non-VA facilities for eligible veterans.

Question. The CBO report states: "Public spending would increase substantially relative to current spending if everyone received long-term services and supports benefits."

- What are long-term services and supports (LTSS) benefits and who receives them under the current system?
- How are these benefits covered now? What is the role of the states in funding the benefits?
- How would utilization change if these benefits were made free for patients?
- Please discuss the Community Living Assistance Services and Supports (CLASS) program. What was the program? What was the CBO cost estimate (both within the 10-year window and beyond)? Why did this program never go into effect? Was this program repealed?

Answer. Long-term services and supports include a range of health services and other types of assistance to people who have difficulty completing self-care tasks because of disabling conditions or chronic illnesses. LTSS care is provided in nursing homes and other institutional settings, in people's homes, and in community-based settings. LTSS includes care furnished by paid providers and by unpaid family members and friends.[23]

Funding for LTSS. Public and private entities spent an estimated $366 billion on LTSS in 2016.[24] Public sources accounted for 70 percent of that total spending. Medicaid (including both federal and state payments) accounted for 42 percent, Medicare accounted for 22 percent, and other public sources (such as the Veterans Health Administration) accounted for 6 percent. Many of the people who receive Medicaid benefits for LTSS use their own funds to pay for such services before they qualify for Medicaid. Out-of-pocket payments accounted for 16 percent of spending on LTSS in 2016. Payments by private insurance and other private sources make up a small portion of LTSS spending.

Changes in Utilization of LTSS Care If It Was Free. Utilization of LTSS would increase if those benefits had little or no cost sharing. Demand for such care would increase among those who would otherwise use their own funds to pay for it. Much of LTSS is unpaid (or informal) care currently provided by family members and friends. If a single-payer system covered LTSS with little or no cost sharing, a substantial share of unpaid care might shift to paid care. That effect could be particularly large if the single-payer plan covered home- and community-based services, which many people prefer to care in an institution.

22. See Department of Veterans Affairs, Office of Inspector General, "Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15" (March 13, 2018), https://go.usa.gov/xV4kc.

23. See Erica L. Reeves and MaryBeth Musumeci, *Medicaid and Long-Term Services and Supports: A Primer* (Kaiser Family Foundation, December 2015), https://tinyurl.com/y45ybqnr.

24. See Congressional Research Service, *Who Pays for Long-Term Services and Supports?* (August 2018), https://fas.org/sgp/crs/misc/IF10343.pdf (340 KB). Experts disagree on whether skilled nursing facility care and home health care covered under Medicare should be classified as LTSS. In the estimates presented in this response, spending on those services under Medicare is included in the total estimated spending on LTSS.

The CLASS Program. The ACA authorized a national, voluntary insurance program—known as the Community Living Assistance Services and Supports program—that was intended to help people cover the cost of LTSS. The CLASS program, which was never implemented, would have allowed working adults to make premium contributions for five years before being eligible to claim benefits under the program. They would have been required to be actively employed or to have earned an income for at least three of the first five years of enrollment in the program. In addition, eligible workers could not have been excluded because of their health status or preexisting conditions. The program would have provided a daily cash benefit if a person had difficulty with at least two activities of daily living.[25]

CBO estimated that the difference between the premiums and costs in the initial years of the CLASS program would result in net federal savings of $70 billion over the first 10 years because no benefits would have been paid out in the first five years of the program. However, CBO also reported that the program would increase budget deficits in later years by far more than the savings in the first 10 years.[26]

Designing a program that would have been actuarially sound proved to be a challenge because it would have needed to attract enough relatively healthy enrollees to ensure that the program's premiums and the interest on those premiums were adequate to pay for future benefits. But the program would have been most appealing to people with the greatest likelihood of needing care, and people might have postponed enrolling in the program until they became at risk for being disabled. Because of those challenges, the Secretary of Health and Human Services announced in 2011 that she did not "see a viable path forward for CLASS implementation," and the program was later repealed in January 2013.[27]

Question. The CBO report highlights several issues hospitals might face if there was a shift to single-payer health care: "A single-payer system could retain current ownership structures, or the government could play a larger role in owning hospitals and employing providers. In one scenario, the government could own the hospitals and employ the physicians, as it currently does in most of the VHA system."

- What is the hospital ownership structure in the United States today?
- How would the quality of care change during a transition if the government takes more of a responsibility in the ownership of hospitals?
- What other changes could hospitals see if we change to a single-payer system?

25. See Joanne Kenen, "The CLASS Act (Updated)," *Health Affairs*, Health Policy Brief (November 2011), www.healthaffairs.org/do/10.1377/hpb20111117.188451/full/.

26. See Congressional Budget Office, *Measuring the Costs of Federal Insurance Programs: Cash or Accrual?* (December 2018), www.cbo.gov/publication/53921, and "Estimating the Budgetary Effects of the Affordable Care Act," *CBO Blog* (June 17, 2014), www.cbo.gov/publication/45447.

27. See Joanne Kenen, "The CLASS Act (Updated)," *Health Affairs*, Health Policy Brief (November 2011), https://www.healthaffairs.org/do/10.1377/hpb20111117.188451/full/.

Answer. Currently, there are 6,210 hospitals in the United States. Of that total, 5,262 (or 85 percent) are community hospitals, which are nonfederal, short-term general and specialty hospitals.[28] Both private and public entities own hospitals. Specifically:

- 48 percent are privately owned not-for-profit community hospitals;
- 21 percent are privately owned for-profit community hospitals;
- 16 percent are state and local government community hospitals;
- 3 percent are federal government hospitals;
- 10 percent are nonfederal psychiatric hospitals; and
- 2 percent include nonfederal long-term care hospitals and hospital units within an institution, such as prison hospitals or school infirmaries.[29]

Among community hospitals, 56 percent are private not-for-profit hospitals, 25 percent are for-profit hospitals, and 18 percent are owned by a state or local government.

The quality of care delivered in a hospital is not necessarily determined by its form of ownership. Depending on other features of a single-payer system, such as hospital payment rates, publicly owned hospitals under a single-payer system might provide better or worse care on average than privately owned hospitals under the current system. The transfer of ownership from private to public might be disruptive to the daily operation of hospitals, however. Such disruption might negatively impact the quality of care for patients.

The effects of a single-payer system on hospitals would depend on the system's design. A key design feature would be the method of determining payments to hospitals. Under one approach that has been discussed, hospital payment rates would be set to equal Medicare rates, which are much lower on average than the rates that private insurers pay hospitals for their commercial plans and much higher than the "base rates" paid by Medicaid. However, after accounting for additional payments from state Medicaid programs to hospitals that are not tied to particular admissions, Medicaid payment rates are similar to—and may even be greater than—Medicare rates.[30]

On balance, CBO expects that a single-payer system that paid hospitals using Medicare rates would result in a substantial decline in hospitals' average payment rates. Such a system would place considerable financial pressure on hospitals, particularly those that derive a substantial share of their business from commercially insured patients.

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28. According to the definition developed by the American Hospital Association, the specialty hospitals captured in the definition of community hospitals include those that focus on areas such as obstetrics and gynecology; eye, ear, nose, and throat; long-term acute care; rehabilitation; and orthopedics. Excluded are psychiatric hospitals and hospitals not accessible by the general public, such as prison hospitals and college infirmaries.

29. See American Hospital Association, "Fast Facts on U.S. Hospitals, 2019" (accessed June 13, 2019), https://tinyurl.com/y8nquhjs.

30. For analyses of how Medicaid hospital payment rates compare with Medicare rates, see Devin A. Stone, Bridget A. Dickensheets, and John A. Poisal, "Comparison of Medicaid Payments Relative to Medicare Using Inpatient Acute Care Claims From the Medicaid Program: Fiscal Year 2010–Fiscal Year 2011," *Health Services Research*, vol. 53, no. 1 (February 2018), pp. 326–340, http://doi.org/10.1111/1475-6773.12645; Medicaid Payment Advisory Commission, *Medicaid Hospital Payment: A Comparison Across States and to Medicare*, Issue Brief (April 2017), https://go.usa.gov/xp5sf (PDF, 250 KB); and Thomas M. Selden and others, "The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care," *Health Affairs*, vol. 34, no. 12 (December 2015), pp. 2147–2150, http://doi.org/10.1377/hlthaff.2015.0706.

A single-payer system could also yield some financial benefits for hospitals. They would not have the administrative costs associated with multiple insurers for billing and prior authorizations. If the single-payer system required no cost sharing, hospitals would no longer incur the administrative expense of billing patients for their portion of the bill. Hospitals would treat fewer uninsured patients and provide less uncompensated care, although the decline in the number of uninsured patients would depend on who was eligible for coverage under the single-payer system. The reduction in the amount of uncompensated care would be particularly beneficial for hospitals that currently provide a substantial amount of such care.

Question. The CBO report states: "The number of hospitals and other health care facilities might also decline as a result of closures, and there might be less investment in new and existing facilities." CBO produced a report in 2016 entitled *Projecting Hospitals' Profit Margins Under Several Illustrative Scenarios.*[31] In the report CBO found that "about 27 percent of [hospitals] had negative profit margins (in other words, they lost money) in that year."

- According to the 2016 CBO report, what were the future projections of hospital margins in the U.S.?
- What were the major factors that were driving more hospitals into financial distress?
- What would happen if all hospitals received only the Medicare reimbursement rate?
- Would the shift to universal Medicare reimbursement rates have a different impact on urban and rural hospitals?
- How many hospitals are closing in the United States? Is there a differential rate between urban and rural hospital closures? What factors are hurting rural hospitals?
- In other countries, has the government had to save hospitals by buying them?
- If CBO were to score a single-payer proposal, could CBO provide a dynamic score? What elements does CBO use to do a dynamic score? Would CBO look at the effect of such a plan on jobs? Would CBO look at hospital closures? Would CBO look at the effect on the economy?

Answer. CBO's 2016 analysis of hospital margins was intended to demonstrate the financial pressures that hospitals will face in the future as a result of various changes, including the provisions of the ACA that reduced Medicare payment updates and expanded insurance coverage. Hospitals' actual financial experience will depend on their responses to those financial pressures.

The Results of CBO's 2016 Analysis. To illustrate possible outcomes, CBO projected hospitals' profit margins under several scenarios.[32] Under one scenario, CBO assumed that hospitals would increase their productivity at the same rate as productivity growth in the economy as a whole and that they would use all of those productivity gains to reduce their costs. Under that scenario, CBO projected, 41 percent of hospitals would have a negative margin in 2025, and the average margin of hospitals in that year would be 3.3 percent. By comparison, in the base year for the analysis (2011), 27 percent of hospitals had a negative margin, and the

31. See Tamara Hayford, Lyle Nelson, and Alexia Diorio, *Projecting Hospitals' Profit Margins Under Several Illustrative Scenarios*, Working Paper 2016-04 (Congressional Budget Office, September 2016), www.cbo.gov/publication/51919.

32. A hospital's profit margin is equal to its revenues minus its costs, expressed as a percentage of its revenues.

average margin was 6.0 percent. Under the other scenarios CBO examined, the financial performance of hospitals was projected to be worse.

CBO found that the main factor contributing to smaller or negative margins for hospitals in the future was the ACA's reduction in Medicare payment updates. Under current law (as specified by the ACA), Medicare's annual update to hospital payment rates is equal to the percentage change in the average price of hospitals' inputs (such as labor and supplies) minus the estimated growth in productivity in the economy overall.

The analysis focused on about 3,000 hospitals that provide acute care and are subject to the cuts in Medicare's payment updates; thus, it excluded most rural hospitals. Most rural hospitals are designated as critical access hospitals, and Medicare pays 101 percent of their reasonable costs for inpatient and outpatient care.

The Effects of Paying All Hospitals Using Medicare Rates. On average, a shift to a single-payer system that paid all hospitals using Medicare rates would reduce payment rates to hospitals substantially compared with the rates that private insurers pay in their commercial plans. A working paper produced by CBO in 2017 found that the rates paid by private insurers for their commercial plans for hospital inpatient care were nearly 90 percent higher than Medicare rates on average.[33] The reduced payment rates would lower the total revenue of hospitals substantially and cause many to change their structure to lower costs. If all hospitals were paid 100 percent of Medicare fee-for-service rates, some would close unprofitable departments or close entirely, and fewer new hospitals would be built in the future, reducing access to care.

The effects of paying all hospitals using Medicare rates under a single-payer system would vary by hospital. For example, the effects would vary according to the percentage of patients that otherwise would have been commercially insured under current law (as opposed to uninsured or covered by Medicare or Medicaid). Hospitals that derive a large percentage of their revenue from commercially insured patients would suffer the greatest loss of revenue. The effects would also vary because the extent to which commercial payment rates for hospitals exceed Medicare rates varies by geographic market and by hospital within those markets.

The Impact of a Single-Payer System on Rural Hospitals. The financial viability of rural hospitals under a single-payer system would depend on the quantity of care they delivered and on the specific payment policies established for those hospitals. If a single-payer system required little or no cost sharing, the quantity of care delivered by rural hospitals would tend to increase. Compared with urban hospitals, rural hospitals have higher costs for uncompensated care as a share of their total expenses and a lower share of patients covered by private insurance (which generally has higher payment rates than Medicare). As a result, a shift to Medicare payment rates combined with increased quantity of care would have smaller effects on rural than urban hospitals in most cases and some rural hospitals would benefit. For rural hospitals overall, the effects on total revenue and people's access to care are unclear.

Under the current system, most rural hospitals receive higher payments from Medicare than they would receive under Medicare's standard payment methods. Under the most common program, Medicare pays hospitals that are designated as critical access hospitals 101 percent of their reasonable costs for inpatient and outpatient care. If the current Medicare payment method for rural hospitals was retained under a single-payer system, the payment rates to rural hospitals for current Medicare beneficiaries would stay the same. Alternatively, payment

33. See Jared Lane Maeda and Lyle Nelson, *An Analysis of Private-Sector Prices for Hospital Admissions*, Working Paper 2017-02 (April 2017), www.cbo.gov/publication/52567.

rates for current Medicare beneficiaries would be lower if rural hospitals were paid Medicare's standard payment rates under a single-payer system.

Several states also target supplemental payments, such as disproportionate share hospital (DSH) payments, to rural hospitals.[34] (DSH payments under Medicaid provide financial assistance to hospitals that serve a large proportion of Medicaid enrollees and other low-income patients.) Whether rural hospitals would receive similar or lower revenues for their current Medicaid beneficiaries would depend in part on whether such supplemental payments were provided under the single-payer system.

Factors Causing Financial Distress. A recent report by GAO found that 113 hospitals closed from 2013 through 2017. During that period, a slightly greater share of rural hospitals closed than urban hospitals. GAO estimated that 64 rural hospitals and 49 urban hospitals closed between 2013 and 2017—about 3 percent of all rural hospitals in 2013 and about 2 percent of all urban hospitals in 2013, respectively.[35] The report found that rural hospital closures were generally caused by financial difficulties, and it listed several factors that might explain the greater financial strains faced by rural hospitals. Those factors include lower demand stemming from increased competition from other providers and a decline in the rural population, as well as lower payments from Medicare as a result of sequestration (automatic spending cuts that occur through the withdrawal of funding for certain government programs) and lower Medicare payments for bad debt as a result of a change in law.[36] By contrast, increased Medicaid enrollment under the Affordable Care Act appears to have improved the financial status of rural hospitals as those enrollees have been provided with greater amounts of care than they would have otherwise received and hospitals have received payments for some care that would otherwise have been uncompensated.

CBO does not have information on whether the governments of other countries have taken over ownership of hospitals under financial distress.

Dynamic Analysis of a Single-Payer Proposal. In a dynamic analysis, CBO takes into account changes that would affect total output in the economy, such as changes in labor supply, household saving, investment, and aggregate demand for goods and services. Those broad macroeconomic changes resulting from legislation can themselves have additional budgetary consequences.

If provided enough time to undertake the complex modeling required to estimate the macroeconomic effects of a single-payer system, CBO could provide an assessment of those effects. To do so, the agency would analyze the effects of the proposed changes on labor markets, household saving, investment, aggregate demand, and output.

Establishing a single-payer health care system would affect the economy and the federal budget in various ways. Effects on people's disposable income and changes in the distribution of such income among households would alter overall demand for goods and services, thereby affecting output. In addition, depending on how the government financed the system—through higher taxes or borrowing—people's incentives to work and save and businesses' incentives to invest could change.

34. See Medicaid and CHIP Payment and Access Commission, "Rural Hospitals and Medicaid Payment Policy" (August 2018), https://go.usa.gov/xy6k5.

35. See Government Accountability Office, *Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors*, GAO-18-634 (September 2018), www.gao.gov/products/GAO-18-634.

36. The Middle Class Tax Relief and Job Creation Act of 2012 reduced the share of Medicare beneficiaries' bad debt for which Medicare reimbursed hospitals beginning in fiscal year 2013.

When deciding how much to work, for example, people consider not only the higher earnings from working more hours but also the resulting difference in after-tax income. Among people already working, if tax rates were increased to finance a single-payer system, such increases would have two opposing effects. One is the substitution effect, in which marginal tax rates increase: People tend to work fewer hours because other uses of their time become relatively more attractive.[37] Another is the income effect, in which after-tax income drops from what people would have otherwise earned: People tend to work more hours because having less after-tax income requires additional work to maintain the same standard of living. On balance, the first effect appears to be greater than the second, according to CBO's assessment of relevant research. Increases in marginal tax rates, on net, decrease the supply of labor by causing people already in the labor force to work less.[38]

Any dynamic analysis would include a quantitative assessment of the overall impact of the proposal on the economy and on employment but would not include a specific analysis of hospital closures. Other important issues of interest to policymakers—such as effects on the quality and availability of health care and the ways in which the economic circumstances and health of various groups of people would be affected differently—would be discussed qualitatively.

Question. The CBO report states: "By contrast, proposals to establish single-payer systems often prohibit substitutive insurance because of concerns that it might interfere with the operation of the public plan."

- What is substitutive insurance?
- How would substitutive insurance interfere with the public plan? What has happened in countries such as England?
- Today, how many Americans have private insurance plans? What are examples of such plans? What are Medicare Advantage plans? Are they private insurance plans? How many seniors are enrolled in Medicare Advantage plans today? Why do seniors choose these plans?

Answer. Substitutive insurance is a type of private insurance that duplicates the benefits of a single-payer health plan. It could be offered to people who are not eligible for the single-payer system, such as noncitizens who have recently entered the country or are temporary visitors. Substitutive insurance could also be an alternative source of coverage if people were allowed to opt out of the single-payer system.

Effects of Substitutive Insurance on a Single-Payer System. If substitutive insurance was allowed, some people, such as those with high income, might prefer to purchase substitutive insurance that offered more generous benefits or greater access to providers. If providers were allowed to participate in both the single-payer system and the substitutive insurance market and if providers' payment rates in the substitutive insurance plan were higher than in the single-payer system, they might prioritize the treatment of those enrollees. As a result, if many people enrolled in substitutive insurance, patients in the single-payer health care plan might experience longer wait times.

37. The marginal tax rate is the percentage of an additional dollar of income from labor or capital that is paid in taxes.

38. See Congressional Budget Office, *How the Supply of Labor Responds to Changes in Fiscal Policy* (October 2012), www.cbo.gov/publication/43674.

Allowing substitutive insurance could benefit some patients and providers. For example, some people might prefer to enroll in a substitutive insurance plan that suited their needs better than the public plan. Substitutive insurance might also improve the quality of care for people in both private and public plans. For example, private plans might introduce innovative design features to compete with the public plan, such as selectively contracting with higher-quality providers. That might encourage all providers to improve the quality of their care, which could also benefit publicly insured patients. Allowing private plans might also increase providers' income.

In the United Kingdom, for instance, about 11 percent of the population has some form of private insurance. Not all of those policies provide comprehensive major medical coverage that duplicates the benefits of the public plan. For example, few policies cover costs associated with pregnancy, childbirth, the care of newborns, or treatment for mental health, and none cover emergency care, accidents, or general practice visits. Additionally, those policies may have various restrictions, such as taking effect only if the wait times in the National Health Service (NHS) system are longer than a certain period, restricting which private hospitals patients can use without additional payment, or only covering certain conditions (for instance, cancer or cardiac care).[39] The private market shares the physician workforce with the NHS system. The vast majority of specialists are employed by the NHS (about 85 percent) and see private patients on their own time.[40]

Private Health Insurance in the United States. Some examples of private insurance plans include employment-based insurance, Medicare Advantage (MA), Medicare Part D (the prescription drug benefit), and nongroup plans that people purchase through the health insurance marketplaces or directly from insurers or brokers. CBO estimates that, among the population under age 65, 159 million people have employment-based insurance and 14 million people have nongroup coverage in 2019.[41] In addition, CBO estimates that 47 million people are enrolled in Part D for prescription drug benefits and 22 million people are enrolled in Medicare Advantage for health care benefits (about 38 percent of Medicare enrollees).[42] All of those estimates reflect average monthly enrollment over the course of the year.

Medicare Advantage plans are private plans that deliver the benefits of the Medicare program. Beneficiaries have a choice of enrolling in traditional Medicare or MA. MA plans must offer benefits that are at least as comprehensive as traditional Medicare and cover all Part A (Hospital Insurance) and Part B (Medical Insurance) services. In addition, MA plans must include a limit on out-of-pocket expenses, which is not required in traditional Medicare. The benefit design of MA plans can vary widely in terms of the extent of extra benefits, cost sharing, premiums, and provider networks. MA plans also can offer supplemental benefits, such as dental and vision coverage or reduced premiums for prescription drug coverage.[43]

39. See Commission on the Future of Health and Social Care in England, *The UK Private Health Care Market* (2014), https://tinyurl.com/y37zg72s.

40. Ibid.

41. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085.

42. See Congressional Budget Office, "Medicare—CBO's May 2019 Baseline" (May 2019), www.cbo.gov/system/files/2019-05/51302-2019-05-medicare_0.pdf (203 KB).

43. See John Bertko and others, *Medicare Advantage: Better Information Tools, Better Beneficiary Choices, Better Competition* (November 2017), https://tinyurl.com/y5uehdrr (PDF, 674 KB).

Some people choose to enroll in MA plans because they typically offer extra benefits—such as reduced cost sharing on Medicare benefits and, in some cases, coverage for dental, vision, or hearing services—and because of MA's out-of-pocket limit on medical expenses. MA patients face a more restricted network of providers, and they may need to receive prior approval before seeing a specialist or before receiving certain treatments.

Question. There are several sections of the report that mention "utilization management" and choices that would need to be made about what services and treatments would be covered in a single-payer system. For example, the CBO report states: "An independent board could recommend whether or not new treatments and drugs should be covered after their clinical and cost-effectiveness had been demonstrated—a role fulfilled in England by the National Institute for Health Care and Excellence."

- What does CBO mean by "utilization management"?
- What trade-offs and risks would occur if there is no control compared to too much control?
- How do we make these decisions now for federal programs such as Medicare or the ACA?
- What is the United States Preventive Services Task Force? What are some examples of recommendations that have been made from them?
- Under a single-payer system what types of decisions would be made regarding covered treatments and drugs? What are some examples?

Answer. Utilization management refers to methods used by or on behalf of payers to manage health care costs by influencing decisions about patient care.[44] Utilization management includes review of care prior to its provision and more intensive management of high-cost patients. Prior review involves the payers' assessment of the appropriateness of proposed procedures or services. High-cost case management focuses on patients with past or expected large medical expenditures. Through an assessment of individual needs, alternative treatment options with lower costs might be identified. Retrospective review (that is, review of claims after the provision of care) is not typically considered utilization management. Payers could use the information from retrospective review for provider education programs and to select providers for their networks.

Trade-offs and Risks of Utilization Management. On the one hand, the use of cost-containment techniques through utilization management could reduce waste in the system and lower the growth of total health care spending. In a system in which the provision of care was limited by its supply, the reduction or elimination of unnecessary care would free up providers' time, thus improving access to care for those who need it compared with allocation of care in some other way, such as by using a waiting list. On the other hand, a payer's assessment of the appropriateness of care might differ from that of the patient or the provider. Greater control by a payer over a patient's choices of services could also adversely affect access to and quality of care for that patient. Less spending on medical services could also alter manufacturers' incentive to develop new technologies or providers' incentive to invest in capital, which could affect patients' choices over the longer term.

44. See Institute of Medicine (U.S.) and Committee on Utilization Management by Third Parties, Marilyn Jane Field and Bradford H. Gray, eds., *Controlling Costs and Changing Patient Care? The Role of Utilization Management* (National Academies Press, 1989), https://tinyurl.com/yxmkl2lf.

How Federal Programs Make These Decisions Now. In the United States, public programs have implemented few utilization management programs directly. Private insurers participating in public programs—such as Medicare Advantage, Medicare Part D prescription drug insurance, and subsidized insurance purchased through the ACA's marketplaces—have increasingly used them to lower costs. For example, some private insurers require prior authorization for patients seeking certain care, such as expensive therapies.

The U.S. Preventive Services Task Force (USPSTF). The USPSTF was formed in 1984 to make independent, evidence-based recommendations about preventive health care services, including medications and screening. The USPSTF is made up of 16 volunteer members who are nationally recognized experts in prevention, evidence-based medicine, and primary care. Their fields of practice and expertise include behavioral health, family medicine, geriatrics, internal medicine, pediatrics, obstetrics and gynecology, and nursing. Task force members are appointed by the Director of the Agency for Healthcare Research and Quality (AHRQ) to serve four-year terms. Members are screened to ensure that they have no substantial conflicts of interest that could impair the scientific integrity of the task force's work. AHRQ has been authorized by the Congress to convene the task force and to provide ongoing scientific, administrative, and dissemination support to the task force.

The USPSTF's recommendations are based on a systematic review and synthesis of peer-reviewed literature. The services graded are those that would be provided in a primary care setting or that would be received following referral from a primary care provider. The recommendations apply to asymptomatic patients.

The USPSTF assigns grades of "A," "B," "C," "D," and "I" to health care services and procedures. The task force recommends that clinicians offer or provide services with a grade of "A" or "B." Services with a grade of "C" can be recommended to select patients on the basis of the provider's judgment and the patient's preferences. The task force discourages the use of services with a grade of "D." When there is insufficient evidence about a given set of services, those services receive a grade of "I." The task force does not take costs into account when deciding the grade given to a preventive health care service.

In many cases, the USPSTF's recommendations are tailored to specific populations. For example, the grade for abdominal aortic aneurysm screening depends on patients' sex, age, and smoking history. The task force's recommendations are made available on its website (www.uspreventiveservicestaskforce.org/BrowseRec/Index) and in peer-reviewed publications.

Some examples of recommendations from the USPSTF include:

- Screening for colorectal cancer starting at age 50 and continuing until age 75 (grade A).
- Screening for depression in the general adult population, including pregnant and postpartum women (grade B).
- Recommending that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 milligrams of folic acid (grade A).
- Referring adults who are overweight or obese and have additional risk factors for cardiovascular disease (CVD) to intensive behavioral counseling—or offering such services—to promote a healthful diet and physical activity for CVD prevention (grade B).
- Screening for osteoporosis with bone-measurement testing to prevent osteoporotic fractures in women age 65 or older (grade B).

Decisions About Coverage Under a Single-Payer System. To specify the benefit package for a single-payer system, policymakers would first need to decide the set of services to include,

which might encompass the essential health benefits provided by the Affordable Care Act, the benefits covered by Medicare or Medicaid, or some other set, perhaps based on a cost-effectiveness criterion or the federal government's willingness to pay to cover certain services. Decisions would also need to be made about which new treatments and technologies would be covered. One approach would be to limit coverage to items or services that are judged to be reasonable and necessary for the diagnosis or treatment of illness and injury, similar to Medicare's existing national coverage determination process.

Alternatively, an independent board could recommend whether or not new treatments and drugs should be covered after their clinical efficacy and cost-effectiveness had been demonstrated. For example, policymakers would need to decide whether a single-payer system would cover gene therapy treatments that might be very costly, such as those that treat spinal muscular dystrophy. Another example is whether the single-payer system would cover specialty drugs that treat rare conditions but might be costly to develop, or whether experimental treatments would be covered. If experimental treatments were covered, policymakers would need to decide how much evidence would be required before coverage of a new treatment was authorized. Policymakers would also need to decide how much to pay for DNA tests and new diagnostic tests, and the ways in which medical care could be individualized for patients.

Question. The CBO report helpfully provides examples of other countries which have some elements of single-payer systems.

- What are examples of countries that have a more market-based system?
- What are examples of countries that have hybrid systems, some public and some private, and some which are shared?
- What are examples of controls used in other countries to contain the budgetary impacts of their single-payer systems? Can the government decide which treatments to offer? Can they approve use of certain medications? What factors do these governments/systems use to determine which treatments to allow and which not to allow? Does cost play a role in their decision making? What is the process they use for rare but groundbreaking treatments? Could a potential treatment, that doctors might say is reasonable, be denied due to decisions that were made by the government or a board? In other countries can the government overrule what a patient or guardian would request?
- Which other countries use global budgets in their single-payer systems? Is it common or rare? What would happen to patients in facilities that run out of money before the next budget cycle?

Answer. Germany and Switzerland are examples of countries that have achieved universal coverage through a more market-based health care system rather than a single-payer system. Those two countries have a multipayer system, in which people can choose from a number of competing private, nonprofit insurance plans.[45] In Germany, about 90 percent of the population chooses from the more than 100 private, nonprofit "sickness funds" that participate in the statutory health insurance system. The rest of the population chooses from private insurance plans operating under a separate system. In both Germany and Switzerland, all citizens and legal residents are required to have health insurance.

45. Unless noted otherwise, all of the information on the health care systems of other countries included in this response comes from Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), https://tinyurl.com/ybx6hj3v (PDF, 3.4 MB).

Hybrid Health Care Systems. Germany and Switzerland could also be regarded as having hybrid systems because each country relies primarily on public financing for health care, and government bodies in each country regulate the benefit packages that private insurers offer. In Germany, a federal government agency specifies broad requirements concerning the benefit package, and a committee consisting largely of representatives of providers and the sickness funds has the authority to decide whether specific services and drugs are included in the benefit package. To the extent possible, the committee takes into account studies of the comparative effectiveness of different treatments. In Switzerland, a federal agency specifies the services that must be included in the benefit package by evaluating whether services are effective, appropriate, and cost-effective. CBO did not find any specific information on the process for approving coverage for new treatments for rare conditions in those countries.

Cost-Containment Methods in Countries With Single-Payer Systems. Global budgets, which are discussed in greater detail below, are commonly used in countries with single-payer systems to contain costs. Such countries also contain costs through the prices they pay for medical care. Countries with single-payer systems also use various forms of utilization management to contain health care spending. In Canada's single-payer system, some provinces make lower payments to specialists when a patient has not been referred by a primary care physician. In England, access to specialists generally requires a referral from a primary care physician. Taiwan monitors the use of services and costs in near real-time through its information technology system to identify wasteful spending and inappropriate care.

In countries with a single-payer system, the government determines which health care services and drugs are covered. The benefit package typically provides comprehensive major medical coverage, including hospital and physician care, mental health services, and diagnostic tests. Prescription drugs are covered by most single-payer systems, but not by the Canadian system. For new treatments and technologies, a group of experts generally provides evidence on their cost-effectiveness to agencies that make decisions about their coverage or payments. Examples include the National Institute for Health Care and Excellence (NICE) in England, the Health Technology Assessment division of the Center for Drug Evaluation in Taiwan, and the Canadian Agency for Drugs and Technologies in Health in Canada.[46] For treatments of rare conditions, other countries with single-payer systems generally have a separate process for their appraisals, such as the Highly Specialised Technology evaluations by NICE in England.[47] Canada is establishing a new federal agency, the Canadian Drug Agency, to assess the cost-effectiveness of drugs and negotiate prices, and the new agency is tasked with developing a national strategy for drugs that treat rare diseases.[48] Currently in Canada, the cost-effectiveness of cancer drugs is assessed through the pan–Canadian Oncology Drug Review, which is a separate review process from other drugs (or the Common Drug Review).[49]

A potential treatment that a doctor deems reasonable might not be covered by a single-payer system. CBO determined that information on whether and under what circumstances

46. See Center for Drug Evaluation, Taiwan, "Health Technology Assessment" (accessed on October 24, 2019), http://www.cde.org.tw/eng/HTA/; and Canadian Agency for Drugs and Technologies in Health (accessed on October 24, 2019), https://cadth.ca/about-cadth.

47. See National Institute for Health Care and Excellence, "NICE Highly Specialised Technologies Guidance" (accessed on October 24, 2019), https://tinyurl.com/yybengso.

48. See Government of Canada, "Moving Forward on Implementing National Pharmacare" (accessed on October 24, 2019), https://tinyurl.com/y2gl6o5b.

49. See Maureen E. Trudeau and others, "Pan-Canadian Oncology Drug Review (pCODR): A Unique Model to Support Harmonization of Cancer Drug Funding Decisions in Canada," *Journal of Clinical Oncology*, vol. 36, supplement 30 (October 2018), pp. 41–41.

physicians or patients can appeal coverage decisions in countries with single-payer systems was not readily available. Some patients in such situations obtain care in other countries.

Global Budgets. Global budgets (which establish a prospective budget for health care spending during a specified period) are commonly used in other countries with single-payer systems. England and Taiwan both set national global budgets for their single-payer systems. In Canada, most hospitals operate under annual global budgets. In Australia, Denmark, and Sweden, hospitals receive part of their funding through global budgets and part through other methods, such as predetermined payments per admission based on the patient's diagnosis.

One limitation of a global budget is that health care providers might reduce the number of services they deliver if it appears their total costs will exceed their budget. The likelihood of this occurring depends partly on how the global budget is determined and updated over time. In England, the global budget is allocated to approximately 200 local organizations that are responsible for paying for health care. Since 2010, the global budget in England has grown by about 1 percent annually in real (inflation-adjusted) terms, compared with average real growth of about 4 percent previously. The relatively slow growth in the global budget since 2010 has created severe financial strains in the health care system. Providers' payment rates have been reduced, many providers have incurred financial deficits, and wait times for receiving care have increased.

Congressman Roy

Question. CBO estimated in the report that an average of 29 million people per month—11 percent of the U.S. residents under the age of 65—were uninsured in 2018.

- Of the 29 million people who are under the age of 65 and uninsured, how many are eligible for health benefits but not enrolled?
- How many have access to insurance but choose not to purchase it?
- Who pays for their health care right now, the uninsured population under the age of 65, under the current system? For example, if someone receives medical care without coverage, who pays for their services? What is the net cost of this coverage?

Answer. CBO estimates that 30 million people who are under the age of 65 are uninsured in 2019. Of those people, CBO estimates that 23 percent are eligible for subsidized coverage through a marketplace; 20 percent are noncitizens who are not lawfully present in this country; 15 percent are eligible for Medicaid or CHIP but are not enrolled; 12 percent have income that is less than 100 percent of the federal poverty level and live in a state that did not expand Medicaid; and 30 percent have access to coverage through an employer or directly from an insurer but have chosen not to purchase it.[50]

The uninsured seek care in various settings, including physicians' offices, community health centers, and hospitals. Some uninsured patients pay for their care out of pocket. In some cases, they pay a provider's full charges, which are typically higher than the payments providers receive from insured patients. In other cases, low-income uninsured patients receive

50. The responses to this question are based on CBO's estimates for 2019. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085. That report was published shortly after the release of *Key Design Components and Considerations for Establishing a Single-Payer Health Care System.*

charity care—that is, services are furnished by the provider at no cost or at a reduced price. Providers can also incur bad debt as a result of treating uninsured patients—that is, the provider bills the patient but receives no payment or only a partial payment.

People who are eligible for Medicaid or CHIP but not enrolled are identified in most states when they go to a hospital. Those people are regarded as presumptively eligible for a limited period. In such cases, Medicaid pays the hospital for the person's care. The person must file a complete Medicaid application after leaving the hospital in order to obtain Medicaid eligibility for a longer period. In addition, in most states, when people apply for Medicaid they can receive retroactive coverage for up to three months before the date of application. If, during that period, applicants met Medicaid eligibility criteria and incurred medical expenses, Medicaid pays providers for any covered health care services they used. Data are not available on the amount that Medicaid spends on hospital care for people determined to be presumptively eligible or the amount that Medicaid pays providers under the retroactive coverage option.

CBO is not aware of any recent studies focusing on the amount of health care used by the uninsured or the sources of payment for that care. The most recent such study is of limited relevance because it relied on data for 2013 and thus does not capture the effects of the insurance coverage expansions under the Affordable Care Act.[51]

The federal, state, and local governments provide financial support to providers to help offset the costs of caring for the uninsured. Examples of such support include Medicare and Medicaid disproportionate share hospital payments and funding for the Veterans Health Administration, community health centers, state and local health departments, and the Indian Health Service.

Question. Would individuals who currently have coverage, roughly 300 million Americans, be affected if we moved to a single-payer system? How many individuals who currently have coverage would have their coverage disrupted by the potential effects of such an overhaul?

Answer. If private insurance was eliminated under a single-payer system, people who currently have it would enroll in the public plan. Among people under age 65, CBO estimates that 159 million have employment-based insurance in 2019, 14 million have private nongroup coverage, and 1 million have coverage through the Basic Health Program.[52] Those estimates cannot be added to yield an estimate of the total number of people with private insurance because some people report more than one type of coverage. People who currently have private insurance would probably need to switch their coverage. The role of private insurance under a single-payer system would depend on its design. For instance, the system might eliminate private insurance, or it could retain a role for private insurance, such as by offering benefits that supplement the public plan.

If current public programs were eliminated, people who currently have public coverage would enroll in a new public plan under a single-payer system. Their covered benefits and cost sharing might change, depending on the system's design. Taking into account people of

51. See Teresa A. Coughlin and others, *Uncompensated Care for the Uninsured in 2013: A Detailed Examination* (Kaiser Commission on Medicaid and the Uninsured, May 2014), https://tinyurl.com/y45a95aq.

52. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085.

all ages, CBO estimates that there are 75 million enrolled in Medicaid in 2019, 61 million enrolled in Medicare, and 7 million enrolled in CHIP.[53]

Question. What percentage of total health expenditures is NOT paid for by the federal government, which would likely be shifted to the federal government under a single-payer system?

Answer. Currently, national health care spending—which totaled $3.5 trillion in 2017—is financed through a mix of public and private sources. Private sources paid more than half of that amount, and state or local governments paid about one-tenth. The federal government paid 37 percent of the total, or $1.3 trillion.[54] The amount of total health care spending that would be shifted to the federal government under a single-payer system would depend on the design of the system. Two key design features are the services that would be covered by the single-payer system and the amount of cost sharing that would be required. In a system covering a comprehensive set of benefits with little cost sharing, the shift of national health care spending from other payers to the federal government would be substantial.

Question. The report stated that roughly 29 million people do not have coverage, and 11 million of those individuals are not legally present in the United States. Has CBO done analyses on the federal spending impact of those 11 million people, including the net impact on healthcare spending? If so, please include the relevant responses.

Answer. An average of 11 million people per month in 2018 were estimated to be noncitizens who were not lawfully present, and about half of the 11 million people had health insurance that year (mainly through private insurers).[55] Noncitizens who are not lawfully present are ineligible for most federal programs, including Medicare, Social Security, Supplemental Security Income, the Supplemental Nutrition Assistance Program, subsidies for nongroup health insurance, Pell grants and federal student loans, and unemployment insurance.[56] Noncitizens who are not lawfully present are not eligible to enroll in Medicaid. However, Medicaid pays hospitals for emergency services provided to noncitizens who are not lawfully present if they would have qualified for Medicaid if not for their immigration

53. See Congressional Budget Office, "Medicaid—CBO's May 2019 Baseline" (May 2019), www.cbo.gov/system/files/2019-05/51301-2019-05-medicaid.pdf (139 KB); "Medicare—CBO's May 2019 Baseline" (May 2019), www.cbo.gov/system/files/2019-05/51302-2019-05-medicare_0.pdf (203 KB); and "Children's Health Insurance Program—CBO's May 2019 Baseline" (May 2019), www.cbo.gov/system/files/2019-05/51296-2019-05-chip.pdf (171 KB).

54. The estimates of national health care spending by source of payment are from Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960–2018" (accessed February 15, 2019), https://go.usa.gov/xEUS6. The estimates of national and federal spending on health care include spending on investment in the medical sector, which accounts for 5 percent of national spending on health care and 3 percent of federal spending on health care. The estimates of federal spending for Medicare exclude the effects of premiums and other offsetting receipts. The estimates do not account for tax subsidies, such as the federal tax exclusion for employment-based health insurance.

55. See Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System* (May 2019), www.cbo.gov/publication/55150.

56. See Congressional Budget Office, *How Changes in Immigration Policy Might Affect the Federal Budget* (January 2015), www.cbo.gov/publication/49868.

status.[57] In fiscal year 2018, federal Medicaid spending on emergency services provided to such people was $1.6 billion, or 0.4 percent of total federal spending on Medicaid.[58]

Noncitizens who are not lawfully present are generally not eligible to enroll in CHIP. However, since 2002, states have had the option to cover prenatal care to women regardless of their immigration status by extending CHIP eligibility to the unborn child. As of January 2019, 16 states had exercised that option.[59] No data are available on the number of noncitizens who are not lawfully present who have received such services under CHIP.

Question. The report states, "participants would not have a choice of insurer or health benefits... the benefits provided by the public plan might not address the needs of some people."

- Can you elaborate on what that means? The plan might not address the needs of some people?
- How many people in the US are covered by private insurance? How many are covered by a public program?

Answer. Under a single-payer system that eliminated private insurance entirely, there would be only one insurer with a standardized set of benefits. Thus, patients would not have a choice of insurer or benefits, and those standardized benefits might not meet the needs of some people. For example, certain specialty drugs or expensive new treatments, such as gene therapy, might not be covered under a single-payer system.

CBO estimates that, among the population under age 65 in 2019, average monthly enrollment for people with employment-based insurance is 159 million, and the number of people with nongroup coverage is 14 million.[60]

Among the entire population, the agency estimates, an average of 61 million people are enrolled in Medicare on a monthly basis in 2019: 47 million are enrolled through a private insurer in Medicare Part D (for prescription drug benefits) and 22 million are enrolled through a private insurer in Medicare Advantage (for health care benefits).[61] Average monthly enrollment in Medicaid and CHIP is 75 million and 7 million, respectively, in 2019. (Those numbers count people with two sources of coverage, such as Medicare and Medicaid, in both categories.) Most Medicaid beneficiaries are enrolled in one or more private managed care plans.[62]

57. See Samantha Artiga and Maria Diaz, *Health Coverage and Care of Undocumented Immigrants*, Issue Brief (Kaiser Family Foundation, July 2019), pp. 3–4, https://tinyurl.com/y48owh5b (PDF, 270 KB).

58. Those estimates are from the Medicaid Financial Management Report for Fiscal Year 2018 produced by the Centers for Medicare & Medicaid Services. That report is not yet publicly available.

59. See Tricia Brooks, Lauren Roygardner, and Samantha Artiga, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings From a 50-State Survey* (Kaiser Family Foundation, March 2019), pp. 10–11, https://tinyurl.com/y4c8n7ye (PDF, 2 MB).

60. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085.

61. See Congressional Budget Office, "Medicare—CBO's May 2019 Baseline" (May 2019), www.cbo.gov/system/files/2019-05/51302-2019-05-medicare_0.pdf (203 KB).

62. See Congressional Budget Office, *Exploring the Growth of Medicaid Managed Care* (August 2018), www.cbo.gov/publication/54235.

Question. A recent Association of American Medical Colleges study found the U.S. will see a shortage of up to nearly 122,000 physicians by 2032—this is under current law. Would a single payer system in the United States lead to an even greater shortage of physicians in the U.S.?

Answer. CBO has not reviewed the methods and assumptions used in the study by the Association of American Medical Colleges. That study concluded that the United States will face a shortage of physicians, but experts disagree about that. A report by the Institute of Medicine reviewed the available studies and concluded that the evidence does not indicate that the United States faces such a shortage.[63]

If a single-payer system had little or no cost sharing, the demand for physicians' services would tend to rise. If payment rates were reduced, on average, the supply of care from physicians would tend to fall. Both of those factors would contribute to a shortage of physicians in the United States. By contrast, the time that was previously spent on administrative tasks associated with multiple insurers and utilization management could be used instead to increase the supply of care. On net, whether a single-payer system would lead to a shortage of physicians would depend on the system's design. The government could also implement some policies that would increase the supply of physicians, such as increasing subsidies for medical education. Lower payments to providers would cause changes in the nature of the health care system in the long term, such as leading different people to become physicians, and could result in greater use of nurse practitioners and physician assistants. Some of the decisions involved, such as the scope of practice for health professionals, would be made at the state level.

Question. Has CBO done a report on average wait times for care in the United States under current policy? If so, what do average wait times look like? What would average wait times look like for a patient under a single-payer system?

Answer. CBO has not conducted an analysis of average wait times for care under the current system or under a single-payer system. Average wait times under a single-payer system would depend on the system's design features, such as the covered services, cost-sharing requirements, and providers' payment rates. For example, if there was little or no cost sharing and payment rates were substantially lower than what providers would receive under current law, CBO expects that average wait times would increase.

Question. With respect to Obamacare's Medicaid expansion, has CBO done any analysis of crowd out—both the numbers of people dropping private coverage to enroll in expansion, and the Medicaid spending for those individuals? I've seen some reports suggesting significant numbers of people may be dropping private coverage to enroll in Medicaid, Louisiana specifically. Can CBO elaborate on this?

Answer. CBO has not conducted its own analysis of the extent to which people drop private coverage to enroll in Medicaid as a result of the ACA. However, recent peer-reviewed studies found mixed results, with some showing little or no evidence of crowding out from Medicaid

63. See Institute of Medicine, "Chapter 2: Background on the Pipeline to the Physician Workforce," in Jill Eden, Donald Berwick, and Gail Wilensky, eds., *Graduate Medical Education That Meets the Nation's Health Needs* (National Academies Press, 2014), www.nap.edu/read/18754/chapter/4.

and others showing some evidence of that phenomenon in certain populations.[64] Decker, Lipton, and Sommers (2017), Frean, Gruber, and Sommers (2017), and Courtemanche and others (2017) found little or no evidence of such crowding out.[65] Wehby and Lyu (2018) found some evidence of crowding out of private coverage, including both individually purchased and employment-based coverage, among certain groups of people, particularly among adults ages 19 to 26 and women.[66] Sommers, Kenney, and Epstein (2014) examined the phenomenon in Connecticut and the District of Columbia, which implemented the ACA Medicaid expansion before 2014. They found evidence of some crowding out of private coverage in Connecticut (accounting for 30 percent to 40 percent of the increase in Medicaid coverage), particularly for healthier and younger adults ages 19 to 25, but found no evidence of crowding out in the District of Columbia.[67]

The data from Louisiana contribute to the literature that shows some evidence of crowding out. Louisiana expanded Medicaid to nonelderly adults with income up to 138 percent of the federal poverty level on July 1, 2016. The data about that experience have not been analyzed using methods as rigorous as those applied in many of the peer-reviewed studies, which used statistical methods to control for other factors that could cause insurance coverage rates to change. One study used two types of analysis and concluded that the Medicaid expansion in Louisiana resulted in a substantial crowding out of private coverage.[68]

The first analysis relied on estimates from a survey of Louisiana residents that found that, among other things, the number of nonelderly adults with income up to 138 percent of the FPL who had private insurance coverage declined from 2015 to 2017.[69] The biggest decline among people in that segment of the population was for employment-based insurance; the number of people with such coverage fell from about 181,000 in 2015 to about 140,000 in 2017. The crowding-out study characterized the difference between those two numbers (about 40,000) as the number of nonelderly adults with income up to 138 percent of the FPL who dropped employment-based insurance to enroll in Medicaid. However, the decline of 40,000 nonelderly adults with employment-based insurance and income up to 138 percent of the FPL was mostly due to the fact that the survey estimated a substantial decline in the total number of nonelderly adults in that income range in Louisiana (from

64. See Kaiser Family Foundation, *The Effects of Medicaid Expansion Under the ACA: Updated Findings From a Literature Review* (August 2019), p. 4, https://tinyurl.com/yxp66v2v (PDF, 1.5 MB).

65. See Sandra L. Decker, Brandy J. Lipton, and Benjamin D. Sommers, "Medicaid Expansion Coverage Effects Grew in 2015 With Continued Improvements in Coverage Quality," *Health Affairs*, vol. 36, no. 5 (May 2017), pp. 819–825, https://doi.org/10.1377/hlthaff.2016.1462; Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act," *Journal of Health Economics*, vol. 53 (May 2017), pp. 72–86, https://doi.org/10.1016/j.jhealeco.2017.02.004; and Charles Courtemanche and others, "Early Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States" *Journal of Policy Analysis and Management*, vol. 36, no. 1 (Winter 2017), pp. 178–210, https://doi.org/10.1002/pam.21961.

66. See George L. Wehby and Wei Lyu, "The Impact of the ACA Medicaid Expansions on Health Insurance Coverage Through 2015 and Coverage Disparities by Age, Race/Ethnicity, and Gender," *Health Services Research*, vol. 53, no. 2 (April 2018), pp. 1248–1271, https://doi.org/10.1111/1475-6773.12711.

67. See Benjamin D. Sommers, Genevieve M. Kenney, and Arnold M. Epstein, "New Evidence on the Affordable Care Act: Coverage Impacts of Early Medicaid Expansions," *Health Affairs*, vol. 33, no. 1 (January 2014), pp. 78–87, https://doi.org/10.1377/hlthaff.2013.1087.

68. See Chris Jacobs, *What You Need to Know About Medicaid Crowd Out* (Pelican Institute for Public Policy, 2019), https://tinyurl.com/vero52f (PDF, 434 KB).

69. See Stephen R. Barnes and others, "Louisiana Health Insurance Survey, 2017" (sponsored by the Louisiana Department of Health), Table 2.5, https://tinyurl.com/y58neud8 (PDF, 1.2 MB).

about 900,000 in 2015 to about 715,000 in 2017). When measured on a percentage basis, the decline in employment-based coverage among that segment of the population was much smaller (from 20.1 percent in 2015 to 19.6 percent in 2017). Moreover, that percentage change in employment-based coverage might have been due to changing economic conditions or other factors and cannot be attributed entirely to people choosing to drop their coverage.

In the second analysis, the study focused on people who enrolled in Medicaid in Louisiana under the expanded eligibility criteria in August 2017. The study reported that 36 percent of those people had dropped private coverage within 30 days of enrolling in Medicaid. The 36 percent figure appears not to be limited to people who voluntarily dropped their coverage before enrolling in Medicaid but also includes people who lost their coverage (for example, because of the loss of employment or a change from full- to part-time employment). A challenge is to distinguish between people who lost their insurance coverage because of the Medicaid expansion (for example, if employers of low-wage workers stopped offering health insurance as a result of the Medicaid expansion) and people who lost private coverage for other reasons (such as losing their jobs). The former represent crowding out and the latter do not.

Question. Finally, and with respect to the budgetary treatment of cost-sharing reductions, did CBO tell Budget Committee staff that CBO now assumes that all states will incorporate CSRs into their premium estimates over time? On June 8 last year, CBO wrote that it "generally expects the costs associated with CSRs to be covered by increases in premiums."[70] Is CBO required to assume payments will be made in all cases—not some cases, or generally, or over time, but in all cases, and in all states?

Some states, including North Dakota, Vermont, and South Dakota did not allow insurers to raise premiums for 2018 after CSR payments stopped. Yet CBO assumed that each of these states would do the exact opposite. Did CBO contact these states regarding their insurance markets when adjusting the treatment of CSRs in 2018, and when were they contacted? Director Hall had previously admitted that he provided incomplete and inaccurate information to the Budget Committee Members when asked about this issue at a January 2018 hearing. I am greatly concerned about this issue and would appreciate it if CBO could provide clarity on this subject in response to the above QFRs.

Answer. Starting in the spring of 2018, CBO anticipated in its baseline projections that the expenses associated with cost-sharing reductions (CSRs) would be covered in all states by the government's premium tax credits. In most cases, insurers promptly increased premiums to accomplish that result.[71] However, in the few cases in which states barred such increases in 2018, the agency projected that premiums were sufficient to cover the cost of CSRs without increases for that purpose. In 2019, insurance regulators in all states (but not the District of Columbia) have allowed insurers to explicitly increase premiums for silver plans in the marketplaces to account for CSRs.

In preparing its projections, CBO discussed this matter with some insurers and state regulators. For many states—including North Dakota, Vermont, and South Dakota—CBO relied

70. See Congressional Budget Office, letter to the Honorable Mark Meadows providing information about the budgetary treatment of cost-sharing reductions (June 8, 2018), www.cbo.gov/publication/53961.

71. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085, and *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), www.cbo.gov/publication/53826.

on information provided by the National Association of Insurance Commissioners and the Commonwealth Fund and on information in insurers' public rate filings for the 2018 plan year.[72]

Regarding the budgetary treatment of CSRs, if legislation was enacted that appropriated funds for direct payments for CSRs, CBO would update its baseline projections to incorporate those appropriations and to reflect lower premium tax credits and other effects because insurers would no longer increase gross premiums for silver plans offered through the marketplaces to cover the costs of providing CSRs. For such legislation—which would change the means of funding the CSR entitlement—CBO would estimate that enactment would not affect the federal deficit because the obligations stemming from the entitlement to CSRs could be fully satisfied through either a direct payment or higher premiums and larger premium tax credits. Those procedures reflect consultation with the budget committees about the baseline and about cost estimates relative to that baseline.

72. See National Association of Insurance Commissioners, "System for Electronic Rates & Forms Filing" (accessed most recently on February 25, 2019), www.serff.com; Sabrina Corlette, Kevin Lucia, and Maanasa Kona, "States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments," *To the Point* (blog entry, October 27, 2017), http://tinyurl.com/y728ro2y; and Centers for Medicare & Medicaid Services, "Rate Review" (accessed most recently on February 25, 2019), https://ratereview.healthcare.gov.