Testimony Regarding:
"Proposals to Achieve Universal Health Care Coverage"

U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

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Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, thank you for the opportunity to testify today on the subject of proposals to expand insurance coverage. You have before you a number of legislative proposals aimed at expanding insurance coverage ranging from a single-payer "Medicare for All" system, to expanding access to Medicare and variations on the concept of a public option plan. While I will not go into each proposal in detail, I believe they can be organized into two general categories.

1. The first category is made up of proposals like H.R. 1384, the "Medicare for All Act of 2019." Medicare for All proposals would seek to achieve universal health insurance coverage by replacing the entire United States health care system with a single-payer, government-financed and managed health care system.

2. The second category—which includes the majority of the proposals before the committee today—encompasses proposals that can be described as short of Medicare for All. These proposals would not aim to achieve universal coverage directly but would instead attempt to make marginal gains in coverage rates through the establishment of new, or expansion of existing, federal insurance programs. These proposals appear mostly intended to serve as stepping stones to an eventual single-payer approach.

I believe both approaches are flawed. Medicare for All would be one of the most disruptive policy undertakings in our nation's history, both in terms of the health care system and the wider economic impacts. Further, I do not believe the tradeoffs in terms of access and quality of care, inherent in such a transition, have been adequately considered. Finally, the costs of financing such a system would be substantial, and the incentives could well exacerbate rising health care costs.

As for those proposals short of Medicare for All, they typically would spend a great deal of money to achieve minimal increases in coverage because they are not targeting the portion of the population that lacks coverage options.

Let me discuss each of these categories and their pitfalls further.

Medicare for All: Considering the Implications

First, Medicare for All would be incredibly disruptive. Disruption in and of itself is not always a bad thing, but it is an important factor to consider in setting policy. A key characteristic of our country and our health care system is phenomenal diversity. There are for-profit and not-for-profit providers, clinics and large hospitals, large multi-specialty practices and sole-practitioners, huge differences in population health across the country, and both state and federal regulations. As a result it would be extremely complicated to implement a one-size fits all approach, and such an approach would almost certainly have unforeseen ripple effects.

Second, coverage expansion under a Medicare for All system would come with tradeoffs. You will invariably sacrifice some quality and some access in exchange for government

control and universal coverage. Dr. Craig Garthwaite of Northwestern University's Kellogg School of Business has done some excellent work in this area. He argues that hospitals make investments in improving quality when they believe they will able to recoup that investment from private payers, even when such investments decrease their margin on care provided to Medicare recipients whose payment rates will not change to reflect the quality of care being provided.[1] One can extrapolate that a hospital with a disproportionate share of Medicare beneficiaries and fewer privately insured patients will be less inclined to make investments that they are unlikely to be able to recoup. While the exact payment rates under a Medicare for All proposal are unclear, if one objective is to control health care spending it would follow that rates would be set close to, or at, current Medicare reimbursement rates. Dr. Garthwaite argues that under a scenario where the government paid Medicare rates for all patients, hospitals would make fewer investments in quality, concluding "The decline in overall quality in exchange for expanded coverage and reduced prices might be an optimal decision from the view of society. This, however, is the ultimately the debate that we should be having."

More broadly, a federally run system will need to constrain costs, whether those cost reductions come from lower investment in improved quality, lower overall medical innovation (including the area of pharmaceuticals), fewer providers due to lower reimbursements, or all of the above. There will be trade-offs around quality of care and access to care of varying degrees, depending on the specifics of the proposal. Further, expansion of coverage will only exacerbate demands on the system, impacting access to care more.

Third, the cost of a Medicare for All, single-payer system would be high. Assuming rates close to Medicare reimbursement, the Urban Institute has estimated that the Medicare for All legislation from Senator Bernie Sanders would cost roughly $32 trillion.[2] AAF's Center for Health and Economy modeled the Sanders proposal in 2016 and showed a ten-year cost between $34.67 trillion and $47.55 trillion, depending on the generosity of the plan's benefits.[3] A Medicare for All system would almost certainly end up being a fee-for-service system because it's simply easier to pay providers for services. Any attempt to do otherwise could well cut into any anticipated administrative cost savings. Additionally, any increase in rates to mitigate the aforementioned tradeoffs would necessarily increase the cost of the program. Financing such a program would require substantial tax increases.

In fact, recently published research by the Heritage Foundation found that funding Medicare for All at a cost of $2.387 trillion in 2020 "would require additional payroll taxes equal to 21.2 percent of all wage and salary income." That rate is in addition to current taxes. They further determined that most American households would pay more in new taxes than they would save by no longer paying for their health care. According to the research, 65.5 percent of all households and 73.5 percent of the total population would pay more in taxes than they otherwise would have spent on health care services, making them worse off financially under a Medicare for All system.[4]

The irony is that most uninsured Americans already have access to federally subsidized insurance programs. According to the Kaiser Family Foundation, of the 27.4 million individuals who were without insurance coverage for some portion of 2017, 8.2 million were eligible for premium tax credits for coverage through the Affordable Care Act's (ACA) individual market exchange but did not elect to sign up. Another 4.4 million adults and 2.4 million children were eligible for Medicaid or other public insurance programs but not enrolled. Additionally, 3.8 million individuals declined an offer of employer-sponsored insurance, and 1.9 million individuals had incomes above 400 percent of the federal poverty level (FPL) making them ineligible for subsidies. There were also 4.1 million immigrants who did not qualify for public assistance because of their undocumented status. It is not clear that a single-payer system would necessarily cover these individuals either.

Finally, there are about 2.5 million individuals who are in the coverage gap as a result of states electing not to expand their Medicaid programs under the ACA and subsidies for individual market coverage only going down to 100 percent of FPL.[5] All told, 15 million of the 27.5 million uninsured in 2017 were eligible for existing federal insurance programs. Another 3.8 million had access to tax preferred employer-sponsored insurance, and only 4.4 million individuals legally residing in the United States were uninsured without access to federal assistance—almost 2 million of whom have household incomes higher the 400 percent FPL. Systemwide reform on the scale of Medicare for All seems disproportionate to the problem actually before us.

Incremental Steps to Single Payer: More Spending, Few Results

The rest of the proposals before the committee are efforts that do not attempt universal coverage; they are framed as more moderate approaches to expanding coverage and consist largely of new federal programs aimed at specific populations. While AAF has not undertaken a detailed review of every one of these proposals, we have recently undertaken modeling of one of the proposals before the committee, H.R. 1346, the "Medicare Buy-in and Health Care Stabilization Act of 2019." This legislation, similar to other proposals, would allow people from 50-64 years old to buy Medicare coverage for a premium based on the cost of their benefits. The premium charged will be the average of the amount per person "for benefits and administrative expenses that will be payable under parts A, B, and D." The legislation also makes a number of changes to the ACA. Our modeling found that the legislation would cost a bit more than $184 billion over the first 10 years. Despite this price tag, only 293,000 individuals are expected to sign up for the Medicare plan in the first year, and the number enrolled drops to 187,000 by 2029. According to our modeling, because of low uptake, most of the cost of H.R. 1346 comes not from the Medicare Buy-in portion but from spending on the ACA's individual markets—in particular a new reinsurance program. Those changes do result in lower individual-market premiums, but the overall rise in the number of covered individuals is still less 500,000.[6] This analysis is instructive of many of the proposals seeking to expand coverage short of single-payer. The proposals spend a

great deal of money to target narrow populations, who often already have coverage options, and make only incremental improvements in the total number of insured.

Conclusion

In summary, ensuring that all Americans have access to reasonably priced insurance coverage is a laudable goal. Many of the legislative efforts before you today, however, seem aimed at forcing people to take advantage of that coverage. I would advise a different approach. Policymakers would be well served to identify those populations that are truly without coverage options and target solutions directly to those individuals. Of primary concern are the 2.4 million people in the Medicaid coverage gap. Helping that population does not require a complete restructuring of the American health care system, a one-size-fits-all approach, or $30 trillion or more in increased federal spending.

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[1] https://economicstrategygroup.org/resource/the-economics-of-medicare-for-all/
[2] https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending
[3] https://healthandeconomy.org/medicare-for-all-leaving-no-one-behind/
[4] https://www.heritage.org/health-care-reform/report/how-medicare-all-harms-working-americans
[5] https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/
[6] https://www.americanactionforum.org/research/the_medicare_buy-in_and_health_care_stabilization_act_of_2019/