



A not-for-profit health and tax policy research organization

Hearing before the
Committee on Ways and Means
U.S. House of Representatives

“Pathways to Universal Health Coverage”

June 12, 2019

Chairman Richard E. Neal
Ranking Member Kevin Brady

Testimony by Grace-Marie Turner
President
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Chairman Neal, Ranking Member Brady, and members of the committee, thank you for the opportunity to testify today.

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy. We focus on ways to ensure access to affordable health coverage and care for all Americans, especially the most vulnerable. I also have served as a member of the Advisory Board of the Agency for Healthcare Research and Quality, as an appointee to the Medicaid Commission, and as a congressional appointee to the Long Term Care Commission.

Mr. Chairman, in calling this hearing today, you acknowledge the growing interest in a bold proposal to achieve universal coverage in the United States.

During my recent testimony on Medicare for All before the House Rules Committee, I began by saying I believe there are important shared goals for health reform:

- Everyone should be able to get health coverage to access the health care they need
- Coverage and care should be affordable
- We must guard the quality of care
- People should be able to see the physicians and other providers of their choice
- We must work to protect the most vulnerable

There is no question that many millions of Americans are frustrated with our current health care system. Millions remain uninsured, and coverage and care cost too much. Many are simply priced out of the market for health insurance. The costs of premiums and deductibles can be prohibitive, especially for those who don't get subsidies. One dad in Virginia trying to provide coverage for his family faced premiums of \$4,000 a month for an Obamacare policy in Virginia.¹

¹ <https://www.forbes.com/sites/gracemarieturner/2018/06/22/health-care-choices-proposal-a-new-generation-of-health-reform/#1106ce6664f1>

Even those with insurance can face thousands of dollars in “surprise billings” and other have out-of-pocket costs so high they say they might as well be uninsured.

Those on public programs are often frustrated as well. Many Medicaid recipients struggle to find physicians who can afford to take the program’s low payment rates, and they can find it especially difficult to get appointments with specialists for more serious health problems.

People are hurting, and they feel powerless against this system.

Health care has become a very big and lucrative business. Many patients feel they are simply cogs in the \$3.6 trillion health sector with little power to impact choices of care or coverage—or even find out before they get care what it is going to cost them. Independent physicians are selling their practices to hospitals, and some hospital systems have become virtual oligopolies, setting prices and giving plans and purchasers little choice but to pay.

These and other frustrations, I believe, are generating interest in a bold plan that promises universal coverage for everyone, with no premiums, copayments, or deductibles, and the ability to choose any provider or hospital participating in the new system.

But it is hard to see how consumers would be more empowered when dealing with a single government payer. In a country that values diversity, will one program with one list of benefits and set of rules work for everyone?

TOO MUCH GOVERNMENT

The high costs of health care in the United States compared to other developed countries and the number of Americans who remain uninsured are real and serious concerns that deserve attention.

The United States does not have a properly functioning market in the health sector. It does not respond to the needs of consumers and their demands for lower costs and more choices, which they experience in other sectors of the economy.

The government is exerting greater and greater control over our health sector.

Wharton School Professor Mark Pauly has a new paper published by the American Enterprise Institute with important findings about the controlling role the federal government plays in our health sector today. In his paper,² Pauly details how the federal government shapes a much larger share of spending than the portion it finances directly. He finds the share of “government-affected” spending in 2016 totaled nearly 80%—“not leaving much in the unfettered, market-based category.”

² Mark Pauly, “Will Health Care’s Immediate Future Look a Lot like the Recent Past?” American Enterprise Institute, June 7, 2019. <https://www.aei.org/publication/health-cares-future-public-sector-funding-delivery-administration/>

The federal government finances nearly 55 percent of all “explicit and implicit” health spending, he reports—from Medicare, the federal share of Medicaid, and ACA subsidies to tax preferences for employer-sponsored health insurance. But the federal government controls even more through regulations and mandates on other allegedly private plans.

The more government gets involved, the more the providers throughout the health sector are forced to respond to legislative and regulatory demands rather than the needs and preferences of patients. Some now contend that the mess can only be solved by even more government involvement.

I would argue that the growing presence of government is a significant contributor to these problems. In the health sector, government officials, not consumers, increasingly determine what services can or must be covered, how much will be paid, and who is eligible to both deliver and receive these services. Third-party payment systems and the resulting lack of price and benefit transparency lead to significant disruptions in the market. Consumers are at the bottom of the health care totem pole.

TOO LITTLE COMPETITION

The Affordable Care Act significantly disrupted the individual health insurance market, with costs soaring and choices of plans shrinking. Average premiums more than doubled between 2013 and 2017 and increased another 27 percent in 2018, according to the Centers for Medicare and Medicaid Services. People in more than half of U.S. counties had a “choice” of only one insurer in 2018. These rising premium costs and limited choices led many people who were not eligible for subsidies to drop out of the market. Between 2016 and 2017, unsubsidized enrollment declined by 20 percent nationally and by more than 40 percent in six states.³

While the trends reversed slightly in 2019, costs are still too high. California spent \$100 million last fall trying to boost enrollment in its exchange, yet it saw the number of new enrollees shrink by nearly 24 percent.⁴

The major problem is cost. And while premium increases have leveled off, premiums and deductibles still can be prohibitive, especially for those who aren’t eligible for subsidies.

Rather than dramatically expanding the role of government through Medicare for All or other new taxpayer-supported programs, I believe we need to target appropriate solutions that empower consumers to get covered, provide incentives for more choices of affordable coverage and care, increase transparency, and build on what works.

³ <https://www.cms.gov/newsroom/fact-sheets/data-2019-individual-health-insurance-market-conditions>

⁴ “Covered California Plan Selections Remain Steady at 1.5 Million, but a Significant Drop in New Consumers Signals Need to Restore Penalty,” January 30, 2019. <https://www.coveredca.com/newsroom/news-releases/2019/01/30/covered-california-plan-selections-remain-steady-at-1-5-million-but-a-significant-drop-in-new-consumers-signals-need-to-restore-penalty/>

According to the Kaiser Family Foundation, most of the estimated 27.4 million people who were uninsured in 2017 had access to health insurance coverage.⁵ An estimated 15 million people, representing 55 percent of the uninsured, were eligible either for Medicaid or premium assistance under the ACA. Another 3.6 million declined offers of employer-sponsored coverage. Nearly 2 million had incomes greater than 400 percent of the federal poverty level. The great majority of the remaining uninsured are undocumented immigrants. That is a problem that is best addressed through immigration policy, not health reform.

STRUGGLING TO ACHIEVE PROMISED GOALS

I was in the gallery the night the House passed the Affordable Care Act in March of 2010 and heard member after member talk about the importance of passing the bill in order to “finally achieve universal coverage” and guarantee that everyone will be able to access quality, affordable care. Former President Obama promised repeatedly that people would be able to keep their doctors and their plans and that the typical American family’s premiums would drop by \$2,500 a year.

Many Americans are frustrated that, nine years later, our nation still is struggling to achieve these goals of access and affordability. They are understandably skeptical of new promises. When informed that Medicare for All would mean higher taxes and losing the coverage they have now, support plummets.⁶

IF YOU LIKE YOUR PLAN...

As members of Congress look toward increasing the role of government—either through Medicare for All or derivatives, such as Medicare buy-in or a federal “public option”—we would fall further down the slippery slope where government control of our health sector would make private coverage less and less viable.

Former President Obama’s promise that “If you like your plan, you can keep it” and “If you like your doctor, you can keep your doctor” was declared by PolitiFact to be The Lie of the Year in 2013.⁷

While the promises of Medicare for All sound utopian, what if 173 million people don’t want to give up their job-based insurance? What if 60 million seniors like their current Medicare and

⁵ Rachel Garfield, Kendall Orgera and Anthony Damico, “The Uninsured and the ACA: A Primer,” Kaiser Family Foundation, January 2019, p. 9. <http://files.kff.org/attachment/The-Uninsured-and-the-ACA-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-amidst-Changes-to-the-Affordable-Care-Act>

⁶ Robert E. Moffit, “No Choice, No Exit: The Truth About ‘Medicare for all’,” February 1, 2019. *The Sacramento Bee*. <https://www.heritage.org/medicare/commentary/no-choice-no-exit-the-truth-about-medicare-all-proposals>

⁷ <https://www.politifact.com/truth-o-meter/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/>

Medicare Advantage plans and don't want the program abolished? And what about union members who have made significant sacrifices in wages to earn their rich health benefit packages? Will they and others who like the coverage they have now be forced to pay significant new taxes to finance a government program that is inferior to the one they have now?

The Big Truth of Medicare for All would be that virtually everyone would lose the plan they have now and there would be no choice but the single, government-run health plan. Employer coverage would end. Medicare as seniors know it would end. Medicaid, the single-largest publicly-supported health program in the country, would end. Medicare Advantage, the Medicare Prescription Drug Program, and the Childrens' Health Insurance Program all would shut down.

“Free” health care would stimulate demand for health care, while threatening its supply. It could well lead to a shortage of doctors and hospital capacity, threatening both access to care and a diminution of quality.

Americans could soon find themselves waiting in line for care and their taxes sharply increased as federal indebtedness soars, putting at even greater risk future prosperity for our children and grandchildren.

THE MEDICARE MODEL

Today's Medicare is seen as a model for reform at least partly because it allows seniors in traditional fee-for-service Medicare to get care from the doctors of their choice. For example, the Medicare for All bill, H.R. 1384, which has more than 100 cosponsors in the House, would:

- allow patients to choose the doctors, hospitals, and other providers they wish to see.
- provide a much more comprehensive list of covered benefits than seniors have today. It would cover all primary care, hospital and outpatient services, 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, dietary therapies, transport, and more.
- guarantee that everyone would be able to access care without facing any private insurance premiums or deductibles. Upon receiving care, patients would not be charged any co-payments or other out-of-pocket costs.
- outlaw private health insurance, including employer-sponsored health insurance and Medicare Advantage or supplements, for any of the benefits covered under Medicare for All.

- eliminate Medicare, Medicaid, TriCare, the State Children’s Health Insurance Program, the Federal Employee Health Benefits Program, and ACA exchange coverage
- require the HHS secretary to determine policies and procedures to implement the new program, including determining benefit eligibility, enrollment, benefits provided, levels of funding, methods of determining payments to providers, appeal processes, planning for capital expenditures and health professional education, and set up a new system of “uniform reporting standards” to a national database.
- require the HHS secretary to “establish a national health budget, which specifies a budget for the total expenditures to be made for covered health care items and services” under the new program. Spending would be based upon “government negotiated prices.”
- require providers to provide information and allow examination of records that document items and services furnished to patients.
- begin the Medicare for All program two years after enactment of the bill.

Such unrestricted access to health benefits is virtually unprecedented, and it is difficult to anticipate the impact of this new system.

CONGRESSIONAL BUDGET OFFICE REPORT ON SINGLE-PAYER

The Congressional Budget Office recently was asked to evaluate key design elements of a single-payer system and came to sobering conclusions.⁸

CBO found that establishing such a system would be a “major undertaking” that would be “complicated, challenging, and potentially disruptive” and that the “changes could significantly affect the overall U.S. economy.” CBO says that “Setting payment rates equal to Medicare [fee-for-service] rates under a single-payer system would reduce the average payment rates most providers receive—often substantially.”

Further, this would likely “reduce the amount of care supplied and could also reduce the quality of care.” It says that “decreases in payment rates lead to a lower supply” and “fewer people might decide to enter the medical profession in the future. 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.”

According to CBO, the government’s low payment rates “could lead to a shortage of providers, longer wait times, and changes in the quality of care, especially if patient demand increased substantially.”

⁸ Congressional Budget Office, “Key Design Components and Considerations for Establishing a Single-Payer Health Care System,” May 2019. <https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf>

While CBO was not asked to produce budget estimates of a single-payer system, H.R. 1384 sponsored by Rep. Pramila Jayapal and Rep. Debbie Dingell implies a recognition of the cost risk by imposing global budgets to cap Medicare for All spending for institutional providers. The relatively few providers who are expected to work in non-institutional settings would be paid on a federally-established fee schedule. In addition, the bill assigns to Washington the task of determining on an annual basis adjustments to the list of covered benefits. This would inevitably lead to significant restrictions on access to care, as CBO expects, including the long waiting lines and other barriers to timely care that we see in other countries with government-run health care systems and global budgets. The most vulnerable would be the most severely impacted.

THE HIGH PRICE OF FREE CARE

The experience of other countries shows that global budgets and associated centrally-determined benefit structures lead to rationing, waiting lines, and lower quality of care. While most offer universal coverage, these and other forms of rationing seriously compromise access to medical care.

While patients in countries with nationalized health systems say they value their access to “free” health coverage that makes care “free” (or virtually so) at the point of service, many pay a very high price in other ways. Tragically, it is often the most vulnerable who are left behind.

The Affordable Care Act’s expansion of Medicaid to non-disabled childless adults is one example. The federal government boosted its initial share of the costs for the expansion population to 100 percent, dropping to no less than 90 percent. States that expanded Medicaid worked hard to enroll these newly-eligible adults, often at the expense of many more vulnerable Medicaid patients who sometimes were put on waiting lists for support services.

The Fraser Institute in Canada devotes considerable time and resources to tracking waiting lists for Canadians seeking care.⁹ In “Waiting Your Turn: Wait Times for Health Care in Canada, 2018,” it finds that the median wait time for medically necessary treatment in Canada was 19.8 weeks. The wait is considerably longer for some specialty services.

We regularly see articles in UK papers about patients stuck in ambulances for hours in London waiting for an opening to a hospital emergency room.¹⁰ And once patients are admitted, they can be warehoused in hallways for days, with some dying before a hospital bed becomes available.¹¹

⁹ <https://www.fraserinstitute.org/categories/health-care-wait-times>

¹⁰ *The Guardian*, “16,900 people in a week kept in NHS ambulances waiting for hospital care,” January 4, 2018. <https://www.theguardian.com/society/2018/jan/04/16900-people-in-a-week-kept-in-nhs-ambulances-waiting-for-hospital-care>

¹¹ BBC, “Patients 'dying in hospital corridors,’” January 11, 2018. <https://www.bbc.com/news/health-42572116>

Sally Pipes of the Pacific Research Institute, who was born and raised in Canada, writes that Britain's version of Medicare For All is struggling with long waits for care.¹² "The [National Health Service] routinely denies patients access to treatment. More than half of NHS Clinical Commissioning Groups, which [plan and commission health services](#) within their local regions, are rationing cataract surgery. They call it a procedure of 'limited clinical value.' It's hard to see how a surgery that can prevent blindness is of limited clinical value," she writes.

Nearly a [quarter of a million British patients](#) have been waiting more than six months to receive planned medical treatment from the National Health Service, according to a recent report from the Royal College of Surgeons. More than [36,000 have been in treatment queues](#) for nine months or more.

WHAT SINGLE-PAYER AND GLOBAL BUDGETS WOULD MEAN TO PATIENTS

Disadvantaging the most vulnerable: Because just five percent of the population accounts for more than half of U.S. health care spending,¹³ those who are sickest with the greatest health needs are most disadvantaged when the health system is under government control. Political leaders inevitably work to make sure the great majority of their constituents are at least satisfied with the system, even if it means restricting access to services to the small minority with the greatest health needs.

Provider shortages: Assigning Medicare rates to hospitals would entail payment rates that are roughly 40 percent lower than commercial rates, while physicians would be reimbursed at rates that are 30 percent lower than those paid by private insurers. These payment reductions would gradually grow larger over time for both. Medicare actuaries have warned that if Medicare payment rates contained in current law were put into place, many providers would face negative margins. That could mean that many physician practices and hospitals would be forced to close or significantly cut back on services. Some anticipate the new program would look more like mandatory Medicaid as a result.¹⁴

A new report from the Association of American Medical Colleges finds that, even under our current health system, the U.S. will see a shortage of up to nearly 120,000 physicians by 2030.¹⁵ The demand for physicians is expected to grow faster than the supply, and rural areas will be hit especially hard, according to the report.¹⁶ The payment cuts envisioned under Medicare for All

¹² Sally Pipes, "Britain's Version Of 'Medicare For All' Is Struggling With Long Waits For Care," *Forbes*, April 1, 2019. <https://www.forbes.com/sites/sallypipes/2019/04/01/britains-version-of-medicare-for-all-is-collapsing/#2c4418a536b8>

¹³ https://meps.ahrq.gov/data_files/publications/st497/stat497.pdf

¹⁴ Doug Badger, "Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage: Considerations for Policymakers," Galen Institute, December 2018. <https://galen.org/assets/Replacing-Empl-Spons-Insur-112618.pdf>

¹⁵ https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/

¹⁶ Association of American Medical Colleges, "The Complexities of Physician Supply and Demand: Projections from 2017-2032," April 2019. <https://aamc->

are likely to exacerbate this trend as more physicians close their practices or otherwise withdraw because of the payment reductions.

Disruption of current coverage: I began my testimony talking about the very real problems and frustrations with health care in America, but any policy solution must also take into account what people value about the system and assess the risks of such sweeping changes.

Medicare and Medicaid recipients, federal employees, kids on the Children’s Health Insurance Program, workers and retirees getting insurance through the workplace, and those receiving coverage through ACA exchanges all would lose their current coverage and be swept in to the new government-run program. Many would see this as severely disruptive.

Today, 60 million people, including 51 million older adults and 9 million younger adults with disabilities, rely on Medicare for their health insurance coverage.¹⁷ Seniors value Medicare, and many believe their access would be undermined if 265 million more Americans were competing with them for services from the same underpaid providers.

In 2018, two-thirds of Medicare beneficiaries were in traditional Medicare, and one-third had chosen to enroll in private Medicare Advantage plans.¹⁸ Medicare For All would take away the private coverage that 22 million seniors have voluntarily chosen under Medicare Advantage, and it would dramatically change the program for seniors in the traditional Medicare program as well, including outlawing private supplementary Medigap policies. Medicare Advantage deploys private insurers to provide better access and better-coordinated care to seniors. Government simply is unable to develop creative programs to personalize care to the needs of individual patients—as we see Medicare Advantage and in other private plans today.¹⁹

Dramatic federal spending increases: Using Medicare as a model for health reform risks incomprehensibly large deficit spending well into the future. Dr. Charles Blahous testified before the Rules Committee on April 30 that federal spending would increase by at least \$32 trillion over ten years if the United States were to adopt a single-payer health care system.²⁰ He found that even doubling individual and corporate taxes would be insufficient to finance this spending increase.

[black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update - the complexities of physician supply and demand - projections from 2017-2032.pdf](https://black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf)

¹⁷ <https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf>

¹⁸ <https://www.kff.org/medicare/issue-brief/sources-of-supplemental-coverage-among-medicare-beneficiaries-in-2016/>

¹⁹ Avik Roy, “Medicare Advantage: A Platform for Affordable Health Reform,” FREEOP, April 18, 2019. <https://freopp.org/medicare-advantage-a-platform-for-affordable-health-reform-fbe31bf444f3>

²⁰ Charles Blahous, Statement before the U.S. House of Representatives Committee on Rules, April 30, 2019. <https://docs.house.gov/meetings/RU/RU00/20190430/109356/HHRG-116-RU00-Wstate-BlahousC-20190430.pdf>

The Medicare Trustees' Report issued on April 22 presents warning signs about the financial sustainability of even the current Medicare program.²¹

It says Medicare is on track to bankruptcy in 2026. According to the report, Medicare had a cash shortfall in 2018 of \$363 billion. The program paid \$740 billion for medical goods and services for today's seniors but collected only \$377 billion in payroll taxes and seniors' monthly premiums.²² Medicare has accumulated a \$5.1 trillion cash shortfall since the program started in 1965, and covering this shortfall is responsible for one third of U.S. federal debt.

Just balancing the books for the program for today's seniors would mean increasing payroll taxes for working Americans by 15 percent and increasing Medicare premiums for seniors by 261 percent.²³

Restricted access to new medicines and other medical technologies also is limited in countries with government-centric health systems. In just one example, my colleague Doug Badger recently surveyed access to new drugs in a number of countries with government-dominated health systems.²⁴ He found the French have access to only 48% of new drugs introduced between 2011 and 2018. Americans, by contrast, have access to 89% of those innovative medications. Nor is France an exception. The Swiss have access to only 48% of newly-developed drugs, the Belgians 43%, and the Dutch 56%.

Thwarting innovation: The United States is a recognized leader in medical innovation. Over the past half century, the United States has been the birthplace of the majority of the world's biomedical innovations.²⁵ Our hospitals and physicians offer top quality care where Americans have access to the latest medical diagnostics. Generations of people in the UK have grown up knowing no system other than the National Health Service, but Americans are accustomed to better quality and access and are unlikely to be satisfied with restrictions and rationing and to stalling the innovation that continues to produce new and better treatments and medicines.

Turning the clock backward: In our increasingly complex health care system, many patients are bewildered when faced with a health challenge. Significant progress has been made in developing coordinated care to provide patients with an integrated network of physicians, from

²¹ 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, April 22, 2019. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf>

²² Tara O'Neill Hayes and Gordon Gray, "The Future of America's Entitlements: What you need to know about the Medicare and Social Security Trustees Reports," American Action Forum, April 22, 2019. <https://www.americanactionforum.org/research/the-future-of-americas-entitlements-what-you-need-to-know-about-the-medicare-and-social-security-trustees-reports-2/>

²³ *Ibid*

²⁴ Doug Badger, "Examination of International Drug Pricing Policies in Selected Countries Shows Prevalent Government Control over Pricing and Restrictions on Access," Galen Institute, March 5, 2019. <https://galen.org/2019/examination-of-international-drug-pricing-policies-in-selected-countries-shows-prevalent-government-control-over-pricing-and-restrictions-on-access/>

²⁵ <https://www.americanactionforum.org/weekly-checkup/new-drug-patents-country/>

primary and specialty care, to lab services, pharmaceutical benefits, and hospital services. Many health systems have sophisticated information systems to better track and manage patient care.

In addition to improving the quality and effectiveness of health care, providing personalized care is more cost effective than throwing patients into a free-for-all in the health sector. Putting government in charge of our health sector would turn back the clock on the progress we are making to move away from Medicare's 1965-model fee-for-service system. Government rules and payment policies would stifle the movement toward personalized care.

Administrative costs: Medicare for All advocates say the administrative savings would help fill the funding gap. But the new single-payer system still would require many of the same administrative functions in any insurance system. Physicians, hospitals, labs and other service providers would have to be approved and payment rates set. The government would need verification that approved services were actually provided, providers would have to be paid, and there would be an even greater need for safeguards against fraud and abuse.

Merrill Matthews, now with the Institute for Policy Innovation, and colleagues analyzed Medicare administrative costs vs those of private insurers.²⁶ He found that an apples to apples comparison showed little administrative savings between Medicare and private payers when, for example, services such as the costs that government agencies perform in collecting premium revenue are considered.

EMPLOYER-SPONSORED HEALTH INSURANCE: A CENTRAL PILLAR IN OUR HEALTH SECTOR

In our multi-payer health sector, employer-sponsored health insurance (ESI) is the single-largest conveyer of health coverage in America. As such, it is worth taking a deeper dive into this program and its central role in our health sector—including supporting the current Medicare program.

In 2016, an estimated 173 million Americans received health coverage through the workplace, either as an employee, retiree, or dependent. The great majority highly value their coverage that would be eliminated under Medicare for All.

A survey by Luntz Global Partners shows the critical importance of employer-sponsored health coverage to American workers.²⁷ It found 71 percent of Americans are satisfied with their current employer health coverage. Further, 56 percent indicated coverage remains a key factor in their decision to stay at their current job. In tight labor markets where companies are competing for workers, employers work hard to meet their employees' demands for quality coverage.

²⁶ Merrill Matthews, "Medicare's Hidden Administrative Costs," Council for Affordable Health Insurance, January 10, 2006. http://mforall.net/files/CAHI_Medicare_Admin_Final_Publication.pdf

²⁷ <https://www.ahip.org/majority-of-americans-satisfied-with-their-employers-health-plan-new-survey-shows/>

Employers negotiate fiercely to keep costs as low as possible and continually adjust their plans to meet the needs of their workers for the benefits they value.

Employers know that high quality health coverage leads to better health outcomes and a healthier workforce. They offered prescription drug coverage for many years before Medicare did. Long before the ACA, they offered preventive and wellness services because they know that addressing health issues before they become a crisis can minimize costs and lead to better outcomes. Employers continue to outpace public programs in the management of chronic illness, price transparency, the availability of health savings accounts, and other innovations to increase health care choices and reduce costs.

Employers and employees both have a vested interest in getting the best value for their health care dollars to obtain the highest quality care and coverage at the lowest cost.

My colleague Doug Badger provides a detailed history of how the employer-based health insurance system evolved in the United States and how central it is to the network of programs in our health sector today.²⁸ He explains that “The vast majority of workers—89 percent according to the Kaiser survey²⁹—worked for companies that sponsored health insurance coverage in 2016, and an estimated 79 percent of those employees were eligible to enroll in their firm’s plan. In all, 62 percent of those working for employers that sponsor coverage enrolled in that coverage in 2016.”³⁰

Badger describes the cost in terms of tax preference for employer-sponsored health insurance and how that is leveraged to produce a nearly 3-1 ratio in value to tax expenditures. He says the government leveraged nearly \$1 trillion in private health insurance spending at a net cost to the federal budget of less than \$350 billion.³¹ Creating a single-payer health system would mean the full \$1 trillion cost of financing health coverage for working Americans, dependents and retirees would now be paid by federal taxpayers.

ESI Supports Public Programs: Few recognize the significant cross-subsidization of today’s Medicare that sustain access to care. Badger points out the important role that employer-sponsored health insurance plays by paying doctors and hospitals more than Medicare and

²⁸ Doug Badger, “Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage: Considerations for Policymakers,” Galen Institute, December 2018. <https://galen.org/assets/Replacing-Empl-Spons-Insur-112618.pdf>

²⁹ Kaiser Family Foundation/Health Research & Education Trust 2016 Employer Health Benefits Survey. Sep 14, 2016. <https://www.kff.org/report-section/ehbs-2016-summary-of-findings/>

³⁰ Badger explains that some may have chosen to remain uninsured despite exposure to tax penalties on the uninsured. Others may have had other sources of coverage—through a working spouse, for example, a parent (in the case of those under 26), or through another public program such as Medicaid or Medicare.

³¹ Badger’s paper is concerned largely with federal expenditures and consequently makes no effort to estimate the effects of the exclusion on state tax revenues. A very rough estimate of the benefit to the government in 2016 can be derived by subtracting the amount of federal revenue lost to the exclusion (\$348 billion) from the total amount of ESI premiums (\$991.3 billion), yielding \$643.3 billion. That is a rough estimate of the net cost of supplanting ESI with direct government financing in 2016.

Medicaid do, providing the margins many providers need to maintain quality and even keep their doors open.

It can be argued that the employer-sponsored health insurance system is a vital part of the reimbursement matrix supporting the U.S. health sector.³²

Reimbursement rates to physicians and hospitals are generally substantially less under Medicare and Medicaid than under private employer plans. Proposals to extend Medicare coverage to all Americans would impose these reimbursement rates universally with a detrimental effect on quality and access to medical care.

OTHER GOVERNMENT-CENTERED REFORM OPTIONS

Single-payer and the States: Some have suggested that the movement to a federal single-payer system can start with state-based programs. But Colorado and Vermont recently failed in their attempts to implement statewide single-payer systems.

Colorado voters rejected a single-payer initiative in 2016 by a four to one margin, with residents especially concerned about the high taxes that would be required to finance it and about losing the coverage they have now to the uncertainties of the new system.

Vermont officials worked feverishly to design a single-payer system but found that the costs of the program would be prohibitive and that the higher taxes required would seriously damage the economy.

Public Option: Others have suggested creating a national “public option” government insurance plan to compete with private insurers. We have recent experience with a similar program—Consumer Oriented and Operated Plans—co-ops.³³ The ACA set aside \$6 billion to fund these entities but continued to cut back funding as Congress soon saw the programs floundering. The co-ops were founded on the idealistic belief that community members could band together to create health insurance companies that would be member-driven, service-oriented, and would not have to answer to shareholders or turn a profit.

³² The number of employers offering health coverage has remained steady over the last five years at 55%, even as firms are struggling to provide this valued benefit despite steadily rising health costs. But that number still is down from the 65% of firms that offered coverage in 2001. Badger argues that the employer mandate instituted by the ACA appears to have had very little effect on the percentage of workers enrolled in ESI. In general, it appears that larger firms, which are subject to the mandate, sponsored health insurance before the government required them to do so, while a fairly substantial percentage of smaller firms, which are generally exempt from the mandate, did not offer coverage to their employees.

³³ <https://galen.org/2015/obamacare-co-ops-cause-celebre-or-costly-conundrum-2/>

But the 23 co-ops that were created had significant start-up costs, no experiential data upon which to set premiums, generally had to pay extra to lease physician and hospital networks, and had few people in the companies and none on their boards with insurance experience. The idealism has quickly faded.

Only a few co-ops remain,³⁴ and they are being closely watched by regulators after seeing so many failures, wasting federal tax dollars and forcing millions of people out of their co-op plans and scrambling to find new coverage.

Medicare Buy-In: Still others suggest a Medicare Buy-In approach. But that also leads to a slippery slope of government running an ever-larger share of health coverage and adding even more costs to the Medicare program.

It is hard to see what problem Medicare Buy-in would solve. If early retirees were able to buy into the Medicare program and pay their full share, the cost would be an estimated \$1,111 per person.³⁵ For many, that would be prohibitively expensive, possibly requiring yet another federal program to provide taxpayer-financed subsidies. In the ACA exchanges, a 50 year old pays an average premium of \$668 for a Silver plan; for a 60 year old, it's \$723. Exchange coverage is cheaper, even without subsidies.

In conclusion, I would like to recount the experience of “Janet,” a patient in Colorado who wrote to us about her experience with a government program that was her only option for coverage.³⁶

A woman with serious health problems provided a testimonial about why further reforms are needed. Janet reported to us:

“In 1999, I was diagnosed with Hepatitis C, which made me ineligible for insurance, (denied for pre-existing conditions),” she said. “I live in Colorado, and they had a high-risk pool that covered people like me. I applied for that and was accepted.

“My premiums in 2010 were \$275/month with a total out of pocket of \$2,500. [While I was on] this plan, my liver failed, and I needed a liver transplant. It was approved without a question. My \$600,000 transplant was covered 100% with a \$2,500 out of pocket maximum!”

³⁴ https://www.naic.org/cipr_topics/topic_health_co-op.htm

³⁵ Medicare premiums are community rated, and they don't vary by age. A disabled 40 year old disabled beneficiary pays the same premium as a 90 year old. The monthly premium for Part A is \$437. Part B is \$135.50, but 75 percent is subsidized. The full, unsubsidized premium would thus be \$542. The average Part D premium is \$33. Eliminating the subsidy would raise that to \$132. Thus, without government subsidies, the monthly premium for Medicare would be \$1,111. Source for A and B premiums:

<https://www.cms.gov/newsroom/fact-sheets/2019-medicare-parts-b-premiums-and-deductibles>

Source for D premiums: <https://www.mymedicarematters.org/costs/part-d/>

³⁶ See www.HealthCareChoices2020.org testimonials

When Obamacare went into effect, Colorado's high-risk pool was closed. "I was forced into the regular marketplace that everyone was telling me was a good thing because I couldn't get denied. I think my first year on that policy, my premiums were in the \$450 range—which I thought wasn't too terrible, but still more than I had been paying.

"The thing I noticed from the start was that instead of full coverage, almost everything I needed was denied, which threw me into the world of having to appeal (sometimes several times) to get the basic care I needed.

"Since then, my premiums skyrocketed. In 2017, I paid \$735 a month with total out-of-pocket costs of \$5,500. In 2018, my premiums went up to \$1,100 a month with a deductible of \$6,300. Once I hit that mark, I'm covered 80%.

"Further, none of my anti-rejection meds are on the formulary of my insurance. If I could not afford them, my body would most certainly reject my liver, causing another liver transplant that would not be covered 100%.

"I don't get any [tax] credits from the government to reduce my premiums. Those of us who are self employed but make more than the threshold for tax credits wind up footing the whole bill ourselves. I have to spend \$19,500 before my insurance pays anything, and it doesn't cover all my prescription costs. My old plan was almost a third of what I have to pay now.

"I have many friends and work associates in the same boat as me. Many of them are doing without insurance and are betting that they won't need more than what they can afford to pay out of pocket. I cannot do that, because if something happened and I needed another transplant, it would bankrupt my family."

Janet received coverage under the ACA but said her access to care was inferior to the state high-risk pool coverage she had before—but with much higher costs for her coverage.

The current system is not working for Janet and others like her in receiving the care she needs. Americans want more, not fewer choices in health coverage, and Medicare for All would put them all on a single government program. When government officials are making decisions about what services will be covered, how much providers will be paid, and how much citizens must pay in mandatory federal taxes, consumers will have even fewer choices and less control than they do today. Medicare for All surely will pay providers less, reduce access to new technologies, stifle innovation, and result in much higher tax burdens. Other proposals to expand government control would only be smaller steps to the same outcomes.

Thank you for inviting me to offer this perspective. I look forward to your questions and would welcome the opportunity to work to with you to achieve the goals of better access to more affordable coverage and better protection for the vulnerable.

APPENDIX

BETTER OPTIONS

The Trump administration is offering several options through its regulatory authority to help increase access to more affordable health coverage.

Association Health Plans: First, the administration has created new options for smaller and medium-sized firms through its new Association Health Plans rule.

The Washington Post reported that: “Chambers of commerce and trade associations have launched more than two dozen of these ‘association health plans’ in 13 states in the seven months since the Labor Department finalized new rules making it easier for small businesses to band together to buy health coverage in the same way large employers do. And there are initial signs the plans are offering generous benefits and premiums lower than can be found in the Obamacare marketplaces.”³⁷

There have been some criticisms that these plans might not be offering the same protections as ACA-compliant plans. But a new study shows that they are offering benefits comparable to most workplace plans, and they haven't tried to discriminate against patients with preexisting conditions, according to an analysis by Kev Coleman, a former analyst at the insurance information website HealthPocket.³⁸ “We’re not seeing skinny plans,” he said.

Short-Term Limited Duration Plans: The Trump administration last year finalized a rule to expand access to short-term, limited-duration plans to give Americans access to health insurance coverage that better fits their needs. The Obama Administration had limited the policies to three months of coverage and prohibited their renewal. Under the new rule, these plans can be offered for up to 364 days and renewed for up to 36 months, subject to state regulation.

Short-term plans³⁹ are helpful to people with gaps in employment, to early retirees who no longer have employer-sponsored health insurance and need bridge coverage before they qualify for Medicare, people between jobs, young people who no longer have coverage from their parents and are working in the gig economy, people who are leaving the workforce temporarily to attend school or training programs, and entrepreneurs starting new businesses. Premiums for short-term health plans typically are less than half those of ACA plans.

³⁷ Paige Winfield Cunningham, “The Health 202: Association health plans expanded under Trump look promising so far,” January 30, 2019, *The Washington Post*. https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/01/30/the-health-202-association-health-plans-expanded-under-trump-look-promising-so-far/5c50ba751b326b29c3778d05/?noredirect=on&utm_term=.6435676a70d4

³⁸ Kev Coleman, “First Phase of New Association Health Plans Reveal Promising Trends,” Association Health Plan News, January 2019. <https://www.associationhealthplans.com/reports/new-ahp-study/>

³⁹ <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance>

The administration's rule also extended consumer protections. Under the Obama administration's previous 2016 rule, people could lose their coverage after three months if they acquired a medical condition during the three-month period. By extending the contract period, people can be protected from a period of uninsurance until the next ACA open enrollment period.

The plans are not required to cover the comprehensive list of benefits required by the ACA, and consumers education is important in understanding how they differ from ACA-compliant plans.

An estimated 1.7 million people who would otherwise be uninsured are expected to enroll in an STLD plans.⁴⁰ Several states limit their residents' access to STLD plans, but in so doing, they deny them what may be their only realistic option for coverage.⁴¹

A White House report on "Deregulating Health Insurance Markets: Value to Market Participants"⁴² provides important data showing the positive impact of this consumer-friendly health policy change. Economists estimate that STLDs would produce a marginal social benefit of \$80 billion over ten years, even taking into account concerns that they might raise premiums for some people with ACA-compliant coverage.

While some say that STLD plans are "junk" insurance that sabotages the ACA, this report provides solid evidence that consumers will benefit, both in expanded coverage and lower costs. The Trump administration believes this policy option, together with other deregulatory reforms, will generate benefits to Americans that are worth an estimated \$450 billion over the next 10 years.

Health Reimbursement Arrangements: The administration also is finalizing a rule to enhance employer and employee options through Health Reimbursement Arrangements (HRAs), originally created by the Bush administration to give employers more options in their benefit offerings. Under those rules, HRAs, which are tax-preferred, notional accounts, can be integrated with group health coverage sponsored by the employer. They cannot be integrated with individual health insurance coverage. Many workers who are offered health coverage at work do not participate in their employer plans, often because of costs, and therefore are more likely to be uninsured.

⁴⁰ Linda J. Blumberg, Matthew Buettgens, Robin Wang, "Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending," Urban Institute, March 2018. https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf

⁴¹ Doug Badger and Whitney Jones, "Five Steps Policymakers Can Take to Permit the Sale and Renewal of Affordable Alternatives to Obamacare Policies," The Heritage Foundation, April 26, 2018. <https://www.heritage.org/health-care-reform/report/five-steps-policymakers-can-take-permit-the-sale-and-renewal-affordable>

⁴² Council of Economic Advisers, "Deregulating Health Insurance Markets: Value to Market Participants," February 2019. <https://www.whitehouse.gov/wp-content/uploads/2019/02/Deregulating-Health-Insurance-Markets-FINAL.pdf>

In a 2017 executive order, President Trump directed administration officials to “increase the usability of HRAs, to expand employers’ ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage.”⁴³

The proposed rule would allow HRAs to be integrated with individual health coverage. This would allow workers to use their accounts to fund both premiums and out-of-pocket costs associated with individual health insurance coverage.⁴⁴

The Galen Institute submitted public comments encouraging the administration to take the rule one step further by allowing spouses to integrate HRA funds to obtain a family plan.⁴⁵ We argue that current law would allow the integration of HRAs with group health plans sponsored by the employer of a spouse.⁴⁶

As an example, consider that one spouse is offered health insurance at work. The employer may allow the plan to be extended to cover the family but only if the employee pays the full extra costs, which may be prohibitive for this lower-income worker.

If the other spouse’s employer offers an HRA contribution, that employee could use the funds to buy into the first spouse’s plan. This working couple could benefit from the ability to combine the HRA funds and obtain a family health insurance plan.

We believe the administration has the authority to include this change when it publishes the final rule. This would provide a new funding option and could expand insurance coverage, especially for those currently shut out of the market.

State Innovations: The solution is more, not fewer, choices. States have much more experience than the federal government in overseeing health insurance markets and greater flexibility to meet the needs of their residents.

One part of the ACA provides an option for State Innovation Waivers to allow states to reallocate existing resources to take better care of those with pre-existing conditions, for example.

States that have used early waiver authority to create risk-mitigation programs have seen in many cases dramatic results with no new federal spending.

⁴³ Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States, The White House, October 12, 2017. <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/>

⁴⁴ <https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans>

⁴⁵ <https://galen.org/2019/increasing-access-to-health-insurance-for-working-families/>

⁴⁶ Doug Badger and Grace-Marie Turner, “Give Working Families A Break,” *RealClearHealth*, January 7, 2019. https://www.realclearhealth.com/articles/2019/01/07/give_working_families_a_break_110856.html

Doug Badger and Heritage scholar Ed Haislmaier explain how early targeted waivers granted to states are helping them to better manage patients with chronic and pre-existing conditions.⁴⁷ “Several states have successfully used a waiver to change market conditions sufficiently that premiums fell for individual health insurance while still protecting the ability of people with high health care costs to access care,” they write.

After the waiver reform in Alaska, premiums for the lowest-cost Bronze plans fell by 39 percent in 2018, they report. Oregon showed similar results in 2018, with premiums for the lowest-cost Bronze plans falling by 5 percent. Premiums for the highest-cost Bronze plans plunged by 20 percent. In Minnesota, the third state with an approved waiver, premiums dropped in both 2018 and 2019. Average premium for ACA coverage in 2019 will be lower for every Minnesota insurer than they were in 2017. Four other states have had waivers approved for 2019: Maryland, Maine, New Jersey, and Wisconsin.⁴⁸

According to the paper, “States repurpose a portion of federal money that would otherwise have been paid to insurers as premium subsidies, supplement this federal money with non-federal sources, and then use the resulting pool of money to pay medical claims for policyholders who incur high medical bills. Since this process would reduce premiums, it also would reduce federal premium subsidies, making it budget neutral to the federal government.”

States are employing various risk mitigation strategies to finance coverage for those with high health costs, repurposing federal money to pay medical bills for residents in poor health. By separately subsidizing those with the highest health costs, they can lower premiums for individual health insurance, and the lower premiums also mean increased enrollment.

The administration is offering states additional flexibility through new Section 1332 guidance to tailor solutions to the needs of their residents.

⁴⁷ Doug Badger, Ed Haislmaier, “State Innovation: The Key to Affordable Health Care Choices,” The Heritage Foundation, September 27, 2018. <https://www.heritage.org/health-care-reform/report/state-innovation-the-key-affordable-health-care-coverage-choices>

⁴⁸ Grace-Marie Turner, Doug Badger, “Several States Have Found Ways To Mitigate Obamacare's Damage To Their Health Insurance Markets,” *Forbes*, October 3, 2018. <https://www.forbes.com/sites/gracemarieturner/2018/10/03/several-states-have-found-ways-to-mitigate-obamacares-damage-to-their-health-insurance-markets/#56d1b71730da>