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TESTIMONY

A Single-Payer Health Care System That Is Based on Medicare's Fee-for-Service Program

Phillip L. Swagel
Director

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Chairman Sanders, Ranking Member Graham, and Members of the Committee, thank you for inviting me to today's hearing. There are various ways to achieve near-universal health insurance coverage using some form of automatic coverage.[1] A single-payer system is one approach, and it could be implemented in different ways.[2]

Today, I will discuss how single-payer health care systems based on the Medicare fee-for-service program would affect our nation's health care and budget and its economy. The Congressional Budget Office has analyzed five options in detail among many possibilities.[3] Those options illustrate the effects of differences in providers' payment rates, patients' cost sharing, and the system's coverage of long-term services and supports. The system proposed by Chairman Sanders in S. 1129, the Medicare for All Act of 2019, is like the options in some ways and different in others; CBO has not analyzed S. 1129.

Effects on Health Care and the Budget

For the single-payer options analyzed, CBO found the following effects relative to what would occur under current law:

- Federal subsidies for health care in 2030 would be significantly larger, with the increases in subsidies ranging from $1.5 trillion to $3.0 trillion.
- National health expenditures would change by amounts ranging from a decrease of $0.7 trillion to an increase of $0.3 trillion depending on the system's design features. The most important factors tending to reduce national health expenditures are lower payment rates for providers and reductions in payers' administrative spending. The most important factor tending to increase those expenditures is increased use of care—especially if long-term services and supports are a covered benefit.
- Health insurance coverage would increase, as virtually all U.S. residents would be enrolled in the system.
- The total amount of out-of-pocket costs would be smaller.
- The supply of personal health care—that is, medical services and goods provided to individuals—would increase because of fewer restrictions on utilization, less money and time spent by providers on administration, and providers' responses to increased demand for care. The amount of care used would rise, and in that sense, overall access to care would be greater.
- The increase in demand for personal health care would exceed the increase in supply, resulting in greater unmet demand than the amount under current law. Those effects on overall access to care and unmet demand would occur simultaneously because people would use more care and would have used even more if it were supplied. The increase in unmet demand would correspond to increased congestion in the health care system, including delays and forgone care.

Differences in payment rates for health care could have large effects. To illustrate the potential size of such effects, CBO estimated the outcomes for single-payer systems under scenarios in which payment rates differed and the other specifications remained the same. In the higher-rate scenario, the average payment rates for health care providers under the single-payer system would be close to the average of the rates that the agency projects for all payers in 2030 under current law. In the lower-rate scenario, rates would be 13 percent lower for hospitals and 7 percent lower for physicians, on average. Also, prices for prescription drugs would be 23 percent lower, on average. The differences between the scenarios were related to the differences between payment rates for private insurers and for Medicare and Medicaid under current law. Relative to what would occur under the higher-rate scenario, the outcomes under the lower-rate scenario would be as follows:

- Federal subsidies for health care would be 12 percent lower.
- National health expenditures would be 9 percent lower.
- The supply of personal health care would be 2 percent lower, with the demand for such care roughly unchanged.
- As a result, the demand for personal health care that was not met would increase by 2 percentage points.

1. See Congressional Budget Office, *Policies to Achieve Near-Universal Health Insurance Coverage* (October 2020), www.cbo.gov/publication/56620.
2. See Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System* (May 2019), www.cbo.gov/publication/55150.
3. See CBO's Single-Payer Health Care Systems Team, *How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program*, Working Paper 2020-08 (Congressional Budget Office, December 2020), www.cbo.gov/publication/56811.

In the long term, payments lower than those projected under current law might cause fewer people to enter health care professions and fewer new drugs to be developed. If providers were unable to adjust to slower growth in payment rates by operating more efficiently and remaining financially viable, they could cease to operate, possibly leading to greater congestion in the health care system. Although effects in the long term are especially hard to predict, I want to emphasize that all of CBO's estimates of the effects of a single-payer system are inherently uncertain.

Effects on the Economy

Turning to the economic effects, I will describe the outcomes under the five options CBO analyzed if the system was financed by either a payroll tax or an income tax—and the estimates differ depending on the type of tax.[4] CBO made these projections:

- Gross domestic product (GDP) would be approximately 1 percent to 10 percent lower by 2030 than the amount projected under current law, and aggregate nonhealth consumption per capita would change by amounts ranging from an increase of 3 percent to a decline of 7 percent.
- Lifetime nonhealth consumption would rise among lower-income households and decline among higher-income households relative to the levels under current law, and the number of lifetime hours people choose to work would be lower for most households across the income distribution.

The net reductions in GDP would occur primarily because of the effects of increased taxes on labor and capital income. Taxes on labor income reduce after-tax wages, so they reduce the return on each additional hour worked. They also lower people's expected future income, which creates an incentive to work more to make up for their lost after-tax income. On average, the former effect is greater than the latter in CBO's assessment; therefore, higher labor taxes tend to reduce the number of hours worked in the economy. Higher taxes on capital income, such as dividends and capital gains, lower the average after-tax rate of return on private wealth holdings (or the return on investment), which reduces the incentive to save and invest and leads to reductions in the capital stock. Those effects lead, in turn, to lower income.

If the system was financed through other types of taxes, government borrowing, or reductions in other types of government spending, the net effect on the economy and the distributional implications would be different. Perpetually financing any of the single-payer systems CBO analyzed through increased borrowing—without a corresponding increase in revenues or a reduction in other spending at some point in the future—would be unsustainable.

In addition to the effects of its financing, a single-payer system would have the following economic effects:

- The composition of workers' labor compensation would change because employers would no longer provide health care benefits and would pass along the savings to employees, increasing their taxable wages.
- Households' health insurance premiums would be eliminated, and their out-of-pocket health care costs would decline.
- Because administrative expenses in the health care sector would decline, productive resources for other sectors would be freed up and would ultimately increase economywide productivity.
- Reduced payment rates would cause providers to find ways of providing care with fewer resources. Some of the reduction in payment rates would initially lower wages for workers in the health care sector and throughout the supply chain. In the long run, that effect on wages would diminish as labor markets adjusted.
- Longevity and labor productivity would increase as people's health outcomes improved.
- Long-term services and supports, if included in the system, would further reduce out-of-pocket spending, provide payments for care that is currently unpaid, increase wages among workers providing care, and allow some unpaid caregivers to increase the hours they work at their primary occupation.

4. See Jaeger Nelson, *Economic Effects of Five Illustrative Single-Payer Health Care Systems*, Working Paper 2022-02 (Congressional Budget Office, February 2022), www.cbo.gov/publication/57637.

This testimony summarizes information provided in two of the Congressional Budget Office's working papers: *How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program* and *Economic Effects of Five Illustrative Single-Payer Health Care Systems*. In keeping with CBO's mandate to provide objective, impartial analysis, neither the working papers nor this testimony makes any recommendations.

The testimony was reviewed by Leigh Angres, Alice Burns, Chad Chirico, Carrie Colla, Devrim Demirel, Berna Demiralp, Mark Doms, Noelia Duchovny, Theresa Gullo, Tamara Hayford, Grace Hwang, Deborah Kilroe, John Kitchen, Jeffrey Kling, Leo Lex, Paul Masi, Sarah Masi, John McClelland, Alexandra Minicozzi, Eamon Molloy, Jaeger Nelson, Karen Stockley, Robert Sunshine, Emily Vreeland, Jeffrey Werling, and Chapin White. John Skeen was the editor. The testimony is available on CBO's website at www.cbo.gov/publication/57973.

Phillip L. Swagel
Director