



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

**Hearing before the
United States Senate
Committee on the Budget on**

**“Medicare for All:
Protecting Health, Saving Lives, Saving Money”**

May 12, 2022

**Chairman Bernie Sanders
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**Testimony by Grace-Marie Turner
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Chairman Sanders, Ranking Member Graham and senators 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 concentrate on achieving affordable, quality 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 a presidential 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 need to achieve universal coverage in the United States.

While there are different views on how to reach that goal, I believe there are important values we share in 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
- And perhaps most important, we must work to protect the most vulnerable and marginalized communities.

There is no question that Americans are frustrated with our current health care system. Millions remain uninsured, and coverage and care cost too much. Many are priced out of the market for health insurance. The costs of premiums can be prohibitive, especially for those who don't get subsidies. Many face deductibles that are so high they say they might as well be uninsured.

Those on public programs are often frustrated as well, including Medicaid recipients who often struggle to find physicians who can afford to take the program's low payment rates. Recipients can find it especially difficult to get appointments with specialists for more serious health problems. They deserve the dignity of being able to have coverage that gives them more options and choices of plans that meet their needs.

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 our \$4 trillion health sector with little power to impact choices of care or coverage. Independent physicians are selling their practices and then find they now answer to more hospital executives and less to their patients. Some hospital systems have become virtual oligopolies, setting high prices and giving plans and purchasers little choice but to pay. Worse, because our health sector is so highly regulated, it relegates physicians and other health care professionals to checking bureaucratic boxes rather than spending more time listening to their patients.

These and other frustrations with the current system are generating interest in an alternative that would provide universal coverage for everyone, with no premiums, copayments, or deductibles, and the ability to choose any provider or hospital participating in the new system.

As I will document, a government-run system would have many if not more of the problems we experience today and would put even more health care decisions under the control of government, not doctors and patients.

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 they are accustomed to receiving in other sectors of the economy.

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

Wharton School Professor Mark Pauly, in a paper published by the American Enterprise Institute, has important findings about the controlling role that the federal government plays in

our health sector today.¹ 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.”

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 that providers throughout the health sector are forced to respond to legislative and regulatory demands rather than the needs and preferences of patients. Some physicians, nurses, and other health professionals now contend that the mess can only be solved by having the government take over.

I would argue that the growing presence of government is a significant contributor to these problems. In the health sector, government officials, not the needs of 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 also lead to significant disruptions in the market. Physicians and other health care professionals say they are forced to spend more time complying with bureaucracy than in innovating to develop better care solutions for their patients.

WHO LACKS COVERAGE?

In proposing a policy solution, it’s important to begin by clearly defining the problem to be solved.

According to the Congressional Budget Office,² of the 29.8 million people who were uninsured in 2019, two-thirds were eligible for coverage but not enrolled—either in expanded Medicaid programs, traditional Medicaid or CHIP, subsidized coverage in the ACA marketplaces, or subsidized employer-based coverage.

Of the remaining third, the greatest number—an estimated four million—were not lawfully present in the U.S. and therefore need to be addressed separately through immigration/citizenship policy. Slightly more than 3 million of the uninsured had income below the federal poverty level and lived in states that did not expand Medicaid. The remaining 2.6 million had incomes too high to receive subsidies in the marketplace in 2019 but chose not to purchase coverage.

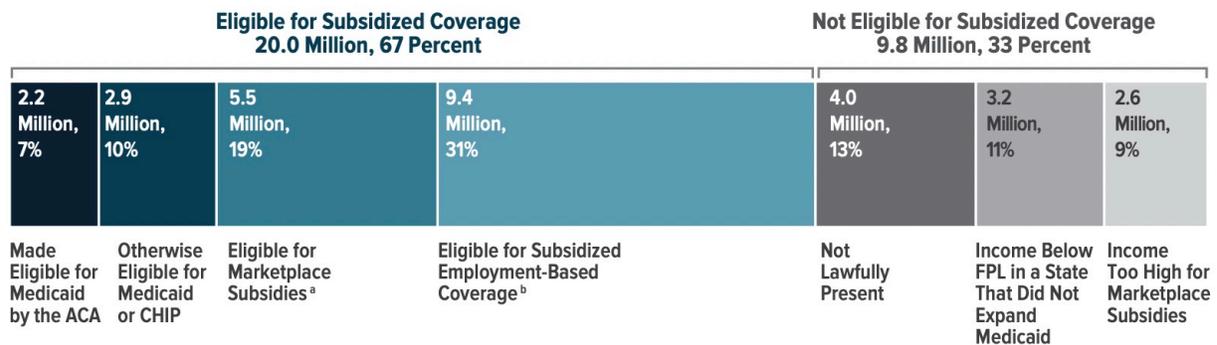
¹ Mark Pauly, “Will Health Care’s Immediate Future Look a Lot like the Recent Past?” American Enterprise Institute, June 7, 2019. <https://www.aei.org/publication/health-cares-future-public-sector-funding-delivery-administration/>

² Congressional Budget Office, “Who Went Without Health Insurance in 2019, and Why?” September 2020. <https://www.cbo.gov/publication/56504>

The chart below provides further detail:

Figure 1.

Eligibility for Subsidized Coverage Among the Uninsured in 2019



Source: Congressional Budget Office.

ACA = Affordable Care Act; CHIP = Children’s Health Insurance Program; FPL = federal poverty level.

- a. A small number of people in this group would technically be eligible for subsidies, but those subsidies would equal zero dollars.
- b. A small number of people in this group were self-employed and could receive a subsidy by deducting their premiums from their federal income taxes.

Most of the uninsured have *access* to health coverage. Uninsured rates continue to be higher in certain populations, including Latinos (18.3%) and Blacks (10.4%), people with incomes below the poverty level (17.2%), and residents of states that have not expanded Medicaid (17.6%), according to an HHS Assistant Secretary for Planning and Evaluation report on “Tracking Health Insurance Coverage in 2020-2021.”³

Rather than dramatically expanding the role of government through Medicare for All or other new or expanded taxpayer-supported programs, I believe we need to target appropriate solutions to address the specific needs of those who are uninsured, focusing on those in marginalized communities.

COVERAGE AND COVID

Many experts had assumed there would be major losses of coverage during the economic shock of the COVID-19 pandemic, but the losses of coverage were much lower than expected.

³ <https://aspe.hhs.gov/sites/default/files/documents/2fb03bb1527d26e3f270c65e2bffc3a/tracking-insurance-coverage-2020-2021.pdf>

A Heritage Foundation analysis found that *5.7 million more people had coverage* in December 2020—nearly a year into the pandemic—than were insured in December 2019.⁴

Net enrollment in private coverage (group and non-group) decreased by 2 million individuals, or 1.2 percent, while enrollment in public coverage (Medicaid and the Children’s Health Insurance Program) increased by 7.8 million individuals, or 10.9 percent. Furthermore, the analysis found that enrollment in individual market plans increased by 605,000 individuals (or 4.4 percent)—an increase that occurred before Congress increased ACA premium subsidies.

In 2021, Congress passed the American Rescue Plan Act (ARPA)⁵, spending an estimated \$90 billion to subsidize more people with more generous coverage through the ACA.

But most of that new spending is federal payments that are going to insurance companies on behalf of people who already had health insurance. Making the expanded ACA tax credits permanent will do little to help expand access to coverage to the uninsured, but it may well encourage even more people who have coverage today to switch to taxpayer-supported plans.

ARPA made the wealthiest people eligible for subsidized coverage and gave them the biggest average benefits. Those with incomes between 400-600% of the FPL receive average monthly ARPA subsidies of \$213, a figure that is nearly seven times as high as the increased subsidy provided by ARPA to those with incomes less than 150 percent of the FPL, according to a paper by Heritage Senior Fellow Doug Badger.⁶

This is not the targeted solution we need.

THE HIGH COST OF SUBSIDIZED COVERAGE—FOR PATIENTS

For the unsubsidized in 2021, the average exchange plan’s annual premium plus deductible for a family of four was about \$25,000—meaning that a family needed to spend about \$25,000 before they received any real meaningful financial benefit from their insurance.⁷

⁴ Edmund Haislmaier, “COVID-19: Effects of the Response on Health Insurance Coverage in 2020,” Heritage Foundation Issue Brief No. 6079, May 14, 2021, <https://www.heritage.org/public-health/report/covid-19-effects-the-response-health-insurance-coverage-2020>.

⁵ <https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf>

⁶ Doug Badger, “Obamacare Subsidies: Six Reasons Congress Should Not Make Temporary Increases Permanent,” The Heritage Foundation, May 26, 2021. <https://www.heritage.org/health-care-reform/report/obamacare-subsidies-six-reasons-congress-should-not-make-temporary>

⁷ Davalon, “How Much Does Health Insurance Cost Without a Subsidy?” eHealth, January 21, 2022, <https://www.ehealthinsurance.com/resources/affordable-care-act/much-health-insurance-cost-without-subsidy>

In addition to the high cost, ACA plans tend to have narrow networks, excluding the best hospitals and doctors in local regions. The Goodman Institute surveyed ACA plans in Texas and found that none covers Houston’s world-renowned MD Anderson Cancer Center, as just one example.

Galen Senior Fellow and Paragon Health Institute President Brian Blase testified recently before the House Education and Labor Committee about the costs of ACA coverage.⁸

Rather than addressing underlying problems with the ACA that caused high premiums and deductibles and narrow plan networks, the American Rescue Plan Act (ARPA) further increased subsidies for this coverage. These subsidies have multiple problems, including being inflationary and inefficient. They push up prices and premiums, and they are a poor use of taxpayer dollars since much of the benefit accrues to higher-income people who are already insured.

Due to these problems, the projected subsidy expansion in ARPA equates to about \$17,000 each year per newly insured individual. The expanded subsidies will increase exchange enrollment but will do so by shifting more cost to the taxpayer. For example, an individual who faced a \$600 monthly premium and qualified for a \$500 subsidy and refused to purchase ACA coverage would likely enroll if an expanded subsidy covered the entire cost of the premium.

Chasing ever-rising health costs with more and more taxpayer dollars is not a sustainable solution.

OPINION POLLING SWINGS

The Kaiser Family Foundation⁹ regularly asks Americans about health policy issues as part of its Health Tracking Poll series. Its 2019 comprehensive survey found that 56% of Americans support a “national health plan, sometimes called Medicare for All” and an even larger 71% support the idea when told that it would “guarantee health insurance as a right for all Americans.”

But then come the details. When the surveyors focused on the costs of a single-payer system, support for Medicare for All dropped below 40%. Support fell even further to 37% when they learned the plan would eliminate private health insurance and require people to pay more in

⁸ <https://edlabor.house.gov/imo/media/doc/BlaseBrianTestimony%200217221.pdf>

⁹ “The Public On Next Steps For The ACA And Proposals To Expand Coverage,” Ashley Kirzinger, Cailey Muñana, and Mollyann Brodie. Kaiser Family Foundation, Jan. 23, 2019. <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/>

taxes. And when they learned that some medical treatments and tests could be delayed, support dropped even further, to 26%.

More recent focus group testing has found that soaring inflation in our economy makes calls for more health spending and expansion of government programs “seem reckless, not compassionate.”¹⁰

CAN GOVERNMENT MANAGE PROGRAMS MORE EFFICIENTLY?

The government also doesn’t have a terrific track record in efficiently managing massive complex programs. For example, a recent federal audit found eligibility errors for nearly one third of Medicaid enrollees. The audit examined a sample of 2,301 files of people enrolled under the ACA expansion authority, and eligibility review errors occurred in 29% of them, according to a review by Brian Blase.¹¹

What does this cost taxpayers? “The federal government’s improper Medicaid payments now exceed \$100 billion a year,” Blase reports. “This means that more than one-in-four dollars flowing out of Medicaid — our nation’s third-largest government program — do not meet program rules. This staggering failure doesn’t just reduce health-care access for the truly eligible, it also harms taxpayers who fund it.”¹²

A new paper also underscores how difficult it is for government to take the lead on innovation.

The National Taxpayers Union recently published an in-depth analysis¹³ of the track record of the Center for Medicare and Medicaid Innovation, created as part of the Affordable Care Act with the promise that its demonstration projects would save tens of billions of dollars in Medicare.

¹⁰ <https://www.cahc.net/newsroom/2022/4/29/cahc-presents-to-house-education-and-labor-committee-to-advocate-for-a-new-small-business-health-care-platform>

¹¹ Brian Blase, “Mismanaging Medicaid, One Improper Payment at a Time,” The Wall Street Journal, Feb. 3, 2022. <https://www.wsj.com/articles/medicaid-health-care-benefits-eligibility-improper-waste-obamacare-expansion-11643845321>

¹² Brian Blase, “Medicaid is hemorrhaging \$100B on Americans ineligible for the program,” New York Post, Nov. 28, 2020. <https://galen.org/2020/alarmed-unlawful-medicare-spending-brian-blase-in-ny-post/>

¹³ Pete Sepp, Andrew Lautz, Doug Badger, “Center for Medicare and Medicaid Innovation: 12 Years into the Game, Taxpayers Still Don’t Know the Score,” National Taxpayers Union, May 3, 2022. <https://www.ntu.org/publications/detail/center-for-medicare-and-medicare-innovation-12-years-into-the-game-taxpayers-still-dont-know-the-score>

The NTU paper shows how far CMMI is missing the mark in facilitating innovation and cost savings in programs as committed administrators and private sector participants crash into restrictive rules and regulation that limit their ability to achieve demonstrable results. Yet taxpayers still are spending \$1 billion a year on this government program that is supposed to help us innovate our way out of high costs but which has little to show for the investment.

These studies provide further evidence that it would be extremely difficult to get health spending under control through regulation-bound government programs. The private sector is the answer, not expanded government programs.

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, 12 years later, our nation still is struggling to achieve these goals of access and affordability. They are understandably skeptical of new promises.

IF YOU LIKE YOUR PLAN...

As senators examine 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 2013.¹⁴

While the promises of Medicare for All sound utopian, what about the large portion of at least 173 million people don’t want to give up their job-based insurance? What if 64 million seniors like their current Medicare and Medicare Advantage plans and don’t want the program abolished and replaced? And what about union members who have made significant sacrifices in wages to earn their generous health benefit packages? Will they and others who like the coverage they

¹⁴ <https://www.politifact.com/truth-o-meter/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/>

have now be forced to pay significant new taxes to finance a government program that is inferior to the one they have now?

Medicare for All would mean that virtually everyone would lose the plan they have now in exchange for a 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 Children's Health Insurance Program all would shut down.

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

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

CONGRESSIONAL BUDGET OFFICE REPORTS ON SINGLE-PAYER

The Congressional Budget Office has produced a number of reports analyzing single-payer systems. The first, issued in 2019, evaluated key design elements and came to sobering conclusions.¹⁵

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.”

Washington would assume the task of determining the list of covered benefits and updating it on an annual basis. This would inevitably lead to significant restrictions on access to care,

¹⁵ 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>

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 where demand outpaces supply. The most vulnerable patients would be the most severely impacted as they try to navigate a complex, bureaucratic system to get the care they need.

I am pleased you have invited the Honorable Phillip Swagel, CBO director, to testify today, likely focusing on recent CBO reports which describe the cost and economic effects of various single-payer models.^{16 17} I also am pleased that Prof. Blahous is testifying today to address the CBO's analyses based upon his expertise as an economist.

The CBO, of course, acknowledges the incredible complexity of making assumptions and projections about sweeping changes impacting nearly one-fifth of our economy, calling it “an enormously complex endeavor,” and acknowledging that “A high degree of uncertainty surrounds CBO's estimates.”

The 2022 CBO report projects a number of positive outcomes, writing that “patients' cost sharing would generally be lower, more people would have insurance coverage, and there would be fewer restrictions on use of care and provider networks.” But it also says: “Factors of a single-payer system that are explicitly not reflected in this paper's results include the effects of financing such a system and the system's effect on business dynamism, workers' job mobility, states' budgets and their policy response,” which could be significant.

From my perspective regarding the impact on people and patients, the CBO assumes single-payer systems would:

- Reduce payment rates to physicians, hospitals, and other providers compared to private payers, the consequences of which I will address in a later section of my testimony
- Increase demand for health care, but this increase is expected to exceed the capacity to provide those services. “The increase in unmet demand would correspond to increased congestion in the health care system—including delays and forgone care—particularly under scenarios with lower cost sharing and lower payment rates,” according to CBO.
- Increase taxable wages for employees that currently have health insurance through their workplace
- If labor taxes were increased to finance the single-payer system, it would reduce after-tax wages, hours worked, and unfortunately provide further incentives for workers to exit the workforce
- Result in the loss of at least 400,000 jobs in the insurance industry alone.

¹⁶ Congressional Budget Office. “Economic Effects of Five Illustrative Single-Payer Health Care Systems.” February, 2022. <https://www.cbo.gov/system/files/2022-02/57637-Single-Payer-Systems.pdf>

¹⁷ Congressional Budget Office. “How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program.” December, 2020. <https://www.cbo.gov/system/files/2020-12/56811-Single-Payer.pdf>

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,¹⁸ 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 more expensive services to the smaller number 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.¹⁹

According to the Association of American Medical Colleges, even under our current health system, the U.S. will see a shortage of up to nearly 120,000 physicians by 2030.²⁰ The demand for physicians is expected to grow faster than the supply, and rural areas will be hit especially hard, according to the report.²¹ The payment cuts envisioned under Medicare for All are likely to exacerbate this trend as more physicians close their practices or otherwise withdraw because the payment reductions will force many to close or curtail their practices.

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 current system and assess the risks of such sweeping changes.

¹⁸ https://meps.ahrq.gov/data_files/publications/st497/stat497.pdf

¹⁹ 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>

²⁰ https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/

²¹ Association of American Medical Colleges, “The Complexities of Physician Supply and Demand: Projections from 2017-2032,” April 2019. https://aamc-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

Today, 64 million people rely on Medicare for their health insurance coverage.²² Seniors value Medicare, and many believe their access would be undermined if 268 million more Americans were competing with them for services from the same underpaid providers. Seniors have paid into the Medicare program throughout their working lives in order to have reliable access to medical care in their retirement years.

In 2021, 26 million Medicare beneficiaries, or about 42% of those eligible for the program, were enrolled in a Medicare Advantage plan.²³ Medicare For All would take away the private coverage that these 26 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. The federal 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.²⁴

Dramatic federal spending increases: Using Medicare fee-for-service as a model for health reform risks incomprehensibly large deficit spending well into the future. I am pleased to share the witness table with Prof. Charles Blahous who has researched extensively the costs of a single-payer health care system.²⁵

Restricted access to new medicines and other medical technologies also occurs in countries with government-centric health systems. In just one example, my organization published a report surveying access to new drugs in a number of countries with government-dominated health systems.²⁶ We found the French, for example, 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.²⁷ Our hospitals and physicians offer top quality care where Americans have access to the latest medical diagnostics. Americans are accustomed to better quality and

²² <https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf>

²³ <https://www.fiercehealthcare.com/payer/medicare-advantage-industry-s-hottest-market-2022-don-t-expect-to-change#:~:text=In%202021%2C%2026%20million%20Medicare,%2C%22%20the%20KFF%20analysts%20said.>

²⁴ 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>

²⁵ 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>

²⁶ 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/>

²⁷ <https://www.americanactionforum.org/weekly-checkup/new-drug-patents-country/>

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.

Recent studies have shown the impact that price control restrictions would have in the U.S.²⁸ that would cut spending on pharmaceutical research and development by hundreds of billions of dollars. Economic modeling estimates that show that price-control legislation would snuff out 56 new drugs—including 16 new cancer treatments—that would have otherwise been available to patients.²⁹

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 primary and specialty care to lab services, pharmaceutical benefits, and hospital services.

In addition to improving the quality and effectiveness of health care, providing personalized care is more cost effective and humane. 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 documentation 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 of the Institute for Policy Innovation and colleagues analyzed Medicare administrative costs vs those of private insurers.³⁰ 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 other government agencies perform, such as collecting premium revenue, are considered.

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

²⁸ Peter Pitts, “Rejuvenating American Healthcare,” *Journal of Commercial Biology*, May 2022. <http://www.commercialbiotechnology.com/index.php/jcb/article/view/1018>

²⁹ <https://vitaltransformation.com/2019/11/international-reference-pricing-under-h-r-3-would-devastate-the-emerging-biotechnology-sector-leading-to-56-fewer-new-medicines-coming-to-market-over-10-years/>

³⁰ 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

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 public health programs that too often pay less than the cost of providing care.

The great majority of Americans who receive health coverage through the workplace, either as an employee, retiree, or dependent,³¹ highly value their coverage—coverage that would be eliminated under Medicare for All.

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 was created. They innovate in offering 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, and 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.

Most large firms offer coverage to their employees (99 percent of all firms with more than 200 employees offer health coverage). Sixty-seven percent of firms with 10 to 100 employees offer health coverage to their workers, but just 30 percent of employers with fewer than 50 employees offer coverage.

These companies want to provide coverage to their workers.

According to a July 2021 survey of small businesses:³²

- 37% said they felt they couldn't expand their workforce because of the cost of health coverage for workers.
- 47% said they felt their company would lose out on the best workers if they couldn't offer competitive benefits.
- 60% said they limited healthcare benefit options because of high costs.
- 59% said they felt they couldn't compete with the benefit offerings at larger companies.

³¹ U.S. Census Bureau, Health Insurance Coverage in the United States: 2020. Chart: Number and Percentage of People by Health Insurance Coverage Status and Type: 2018 to 2020.
<https://www.census.gov/library/publications/2021/demo/p60-274.html>

³² Council for Affordable Health Coverage, letter to Affordability Task Force, February 4, 2022.

The smaller the firm, the less likely they are to offer coverage. Small businesses need the option to get the economies of scale that larger businesses enjoy by pooling together through Association Health Plans, which I discuss later in my testimony.

Senior Fellow Doug Badger provides much more detail about the importance of employer-based health insurance in a paper he wrote for the Galen Institute, “Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage: Considerations for Policymakers.”³³ He explained the crucial role that higher-paying private plans, primarily employer-sponsored insurance (ESI) that covers half of Americans, play in financing the U.S. health care system:

Replacing our admittedly inelegant health care financing system with single payer is not like swapping U.S. customary units for metric measurements. It could have profound and unforeseeable consequences on the capacity of doctors, hospitals and other providers to deliver quality care.

Displacements, even if temporary, carry potentially grave consequences. Planting a new financing system requires uprooting another, one that has grown, adapted and evolved over decades. Policymakers should carefully weigh the risks of scuttling an employer-based system that provides health security to the majority of Americans and that largely finances public programs that provide coverage to others...

Shifting people with ESI to a federally financed program that pays Medicare rates [has great] potential for adverse consequences.

Table 6 shows 2016 payments to hospitals by private insurers, Medicare and Medicaid and what those payments would have been—holding utilization constant—if all hospitals had been paid at Medicare rates.

Table 6 -- 2016 Payments to Hospitals				
	<i>PHI</i>	<i>Medicare</i>	<i>Medicaid</i>	<i>Total</i>
Current Law	\$426.7	\$267.5	\$189.8	\$884.0
M4A	\$255.5	\$267.5	\$187.9	\$710.9
Change	-\$171.9	\$0	-\$1.9	-\$173.1
<i>Source: NHE, Table 7 and MedPAC</i>				

[T]his table compares hospital financing in 2016 with what it would have been had Medicare rates applied to Medicare and private health insurance (PHI, which includes ESI). Assuming that utilization remained unchanged, hospitals would have received a

³³ 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>

total of \$173.1 billion less in 2016 from the three major sources of revenue had Medicare reimbursement rates applied.

One might argue that hospitals could absorb a 40 percent reduction in payments on behalf of privately insured patients through greater efficiencies. It is also worth considering, however, that the rates paid by private insurers—predominantly through ESI—may be helping preserve access to medical care for those enrolled in public programs...

[H]ospitals have consistently run negative margins on their Medicare patients. That margin in 2016 was -9.6%. Since Medicaid payments are only slightly higher than Medicare (and a smaller source of funds), it is likely that the combined Medicare-Medicaid margins are very close to that negative margin. Putting all Americans on the Medicare payment scale would worsen those margins by sharply reducing reimbursement rates for services provided to those who currently have private insurance.

We can see, by driving just a short distance from Capitol Hill, the impact of these low payment rates on hospitals.

Nearby Providence Hospital ended its acute care services in 2018. Founded in 1861, it had been the city's oldest continuously operated hospital, serving some of the District's poorest residents. At least half of its patients were on Medicaid.

And Providence is far from alone. In downtown Philadelphia, Hahnemann University Hospital announced in 2019 that the hospital would close for good in August. A majority of the more than fifty thousand patients that the hospital treated each year had publicly funded medical insurance or none at all. Other hospital closures in that city have followed: Brandywine Hospital in Chester County and Jennersville Hospital in West Grove. These are just a few of the growing list of urban medical centers sinking in red ink.

Medicare and Medicaid, which account for more than sixty per cent of all U.S. hospital care, often pay less than the cost of treatment. According to an analysis by the American Hospital Association, in 2018 Medicare and Medicaid underpaid the cost of care by a combined \$76.6 billion.

As is too often the case, those with the lowest incomes and the greatest health care needs are impacted most. If these hospitals were forced to close because they became overly reliant on payments from Medicare and Medicaid, what will that mean for the health care system overall if the private plans cease to exist and are replaced by Medicare for All?

ALTERNATIVE 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 single-payer programs. But in Colorado, in the Chairman's

state of Vermont, and most recently in California, attempts have failed to develop 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.

In 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.

And California, which has veto-proof legislative majorities and a willing governor, recently shelved a single-payer bill because costs and tax levies would have been prohibitive.³⁴ AB 1400 would have all but eliminated private health coverage and replaced it with a centralized state-run financing system known as CalCare. The program was estimated to cost between \$314 billion and \$391 billion *a year*, requiring major tax increases in the already highly taxed state.

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 created through Affordable Care Act financing.³⁵

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 insurance co-ops and would not have to answer to shareholders or turn a profit.

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.

Medicare Buy-In: Still others suggest a Medicare Buy-In approach.

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

³⁴ “California’s Single-Payer Bill Dies,” Politico, January 31, 2022.

<https://www.politico.com/news/2022/01/31/californias-single-payer-bill-dies-00003924>

³⁵ <https://galen.org/2015/obamacare-co-ops-cause-celebre-or-costly-conundrum-2/>

person.³⁶ For many, that would be prohibitively expensive, possibly requiring yet another federal program to provide taxpayer-financed subsidies.

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. I believe there is a better path to achieve the goals I outlined at the beginning of my testimony.

A PATH TO PATIENT-CENTERED REFORM

Americans are concerned about a range of health policy issues, and their attentions have shifted since the Covid era. Better health, health security, and secure coverage are more important than ever.

BETTER OPTIONS

I would like to commend Ranking Member Graham for his hard work in developing proposals to unleash the innovation and energy that have been pent up in our health sector, returning power to doctors and patients. The Ranking Member has provided ideas and guidance for the work of 82 health policy leaders and organizations in the Health Policy Consensus Group to develop the Health Care Choices proposal.³⁷

Our proposal contains 35 specific policy recommendations organized around the idea of choice and competition to provide every American an opportunity to get affordable health care and coverage. It would begin to help states' revive their individual and small group health insurance markets that have been so damaged by the ACA. The plan would increase the number of people with health insurance and lower the cost of coverage by up to 25% without any new taxpayer spending.³⁸ Choice and competition are the centerpiece of the plan, not more top-down, government-managed centralized programs.

³⁶ 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/>

³⁷ <https://healthcarechoices2020.org>

³⁸ <https://www.healthcarechoices2020.org/wp-content/uploads/2020/10/The-Health-Care-Choices-Proposal-Score.pdf>

The plan would provide states with resources to assist people who need help in purchasing health insurance, especially those with pre-existing conditions, and it would empower states with new flexibility to create more affordable options for coverage. It would redirect resources to the states coupled with new incentives to better meet the needs of their citizens by providing more flexible health care and coverage arrangements and more effective assistance to those who most need help.

The Health Care Choices proposal we have been proud to work on with Sen. Graham would get the federal government out of the business of micro-managing the individual and small group health insurance markets.

Government has created tens of thousands of pages of regulations that rule our health sector in its clumsy and misguided effort to overhaul the market, as I have described in my testimony. It has driven up costs, reduced choices, and made it harder for sick people to get care—all while giving a blank check from taxpayers to health insurers, hospitals, and other big health care businesses.

Health care is too local and personal for a one-size-fits-all approach to work. Here is what the Health Care Choices plan would do...

1. Give patients personal, individual, portable coverage with patients and doctors, not government bureaucrats, in control of health care decisions.
2. Offer a wide variety of competing plans with transparency in pricing and benefits. The coverage would be secure and portable to give people and families protection.
3. Modeling³⁹ has shown that premiums would fall by up to one third—and even more for young people.
4. More people would be able to own and keep health insurance because premiums would be more affordable.
5. The Health Care Choices proposal would do a better job of taking care of people with pre-existing conditions with focused resources, unlike the Affordable Care Act.

Many of the problems with health care and costs are *because* of big government intervention so we don't need *more* of it.

The Health Care Choices plan contains many other provisions to lower costs and enhance access to modern coverage arrangements like Health Savings Accounts plus ways to create much greater price transparency so newly empowered consumers can get better value in their health spending.

We believe the Health Care Choices Plan would give states more power to make sure their healthy residents can get and keep affordable health coverage and that their most vulnerable citizens have better options for care.

³⁹ *Ibid.* [<https://www.healthcarechoices2020.org/wp-content/uploads/2020/10/The-Health-Care-Choices-Proposal-Score.pdf>]

The magic of individual choice and competition that is transformative in the rest of our economy also can work in health care to produce an explosion of options for care and coverage. But first we need to free up innovators and states to allow more affordable consumer-focused solutions.

There is more information about the proposal at www.HealthCareChoices2020.org, where we explain our vision of how states would be empowered to free up their health care markets to provide many more choices of plans and innovative options for more affordable care.

In addition to this legislative proposal, the Trump administration led with regulatory changes that also open the door for more choices and competition in the health sector. Several examples:

Association Health Plans: After the passage of the ACA, smaller employers found it increasingly difficult and costly to offer health insurance to their workers. The Trump administration created new options for smaller and medium-sized firms through its new Association Health Plans rule.

The rule took effect in the fall of 2018 and was off to a successful start. *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.”⁴⁰

There have been some criticisms that these plans might not be offering the same protections as ACA-compliant plans. But a 2019 by Kev Coleman, a former analyst at the insurance information website HealthPocket, found that they were offering benefits comparable to most workplace plans, without any discrimination against patients with preexisting conditions.⁴¹ “We’re not seeing skinny plans,” he said.

Expanded access to Association Health Plans has been stuck in court since March 2019.

Short-Term Limited Duration Plans: The Trump administration 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

⁴⁰ 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

⁴¹ 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/>

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 plans⁴² 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, among others. Premiums for short-term health plans typically are less than half those of ACA plans.

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 losing their coverage if they fall ill.

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

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.⁴³

A White House Council of Economic Advisers (CEA) report on "Deregulating Health Insurance Markets: Value to Market Participants"⁴⁴ provides important data showing the positive impact of this consumer-friendly health policy change.

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

Health Reimbursement Arrangements: The administration also finalized a rule to enhance employer and employee options through Health Reimbursement Arrangements (HRAs). HRAs are tax-preferred, notional accounts that employers use to reimburse employee medical expenses. The Obama administration issued rules that prohibited people from using their HRA to purchase

⁴² <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance>

⁴³ 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>

⁴⁴ 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>

individual market 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.

In 2019, the Departments of HHS, Labor, and the Treasury issued a final rule permitting employers to offer HRAs that reimburse individual market premiums. Through these individual coverage HRAs, employees use tax-preferred employer contributions to buy coverage in the individual market that works best for them. The projection in the final rule indicated that 800,000 employers would offer individual coverage HRAs later this decade with 11 million people enrolled in the individual market with these HRAs.

During the comment period on the proposed rule, 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 encourage Congress to consider legislation to expand this new funding option to expand insurance coverage options and portability of health insurance.

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.

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 Ed Haislmaier of Heritage explain how early targeted waivers granted to states helped 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 a 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 Georgia currently has an innovative waiver pending with the Biden administration.

According to the Heritage 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.

This offers states flexibility through new Section 1332 guidance to tailor solutions to the needs of their residents.

A few states have found a key to undoing some of Obamacare’s damage to their individual health insurance markets by redirecting some federal funding to better help sick people. These states are providing separate assistance to those with the highest health costs, thereby reducing premiums and increasing enrollment for healthy people driven out of the market by soaring costs.

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>

In a paper published by The Heritage Foundation, scholars Doug Badger and Ed Haislmaier detail how several states have successfully used Obamacare’s Section 1332 waiver authority to begin to revive their non-group health insurance markets with better risk-mitigation strategies.

They explain in “State Innovation: The Key to Affordable Health Insurance Choices”⁴⁹ that Obamacare’s rigid and centralized federal regulation of the nongroup market has driven premiums up, choices down, and forced millions of people out of the individual health insurance market.

Section 1332 of the Affordable Care Act permits states to seek waivers from certain federal health insurance requirements if they believe they can do a better job as long as their program doesn’t cost the federal government more money. But the rules the Obama administration subsequently issued were so strict that they make it very difficult for states to get approval for the broader innovative reform proposals envisioned by the provision’s authors.

Alaska, Minnesota, and Oregon received waivers from the Trump administration for targeted reform initiatives that have been successful in lowering premiums for individual health insurance by separately subsidizing those with the highest health costs. And the lower premiums also mean increased enrollment.

According to the paper:

“Alaska was the first state to obtain a section 1332 waiver to implement this type of approach. The state sought a waiver of Obamacare’s ‘single-risk-pool’ requirement, under which people who are likely to file large medical claims must be pooled with those who might never see a doctor. This Obamacare mandate had touched off a vicious cycle, in which insurers charge ever higher premiums, repelling the healthiest customers but not the sickest, resulting in premiums that are increasingly affordable only to those who receive federal subsidies.

“Alaska instead proposed to move customers with one of 33 medical conditions into a separate pool. Their medical claims would be funded in part by a portion of federal premium-subsidy payments diverted to the pool. Non-federal funding sources include ceded premiums (meaning, in the case of an enrollee whose claims costs the insurer transfers to the pool, the insurer must also transfer to the pool some portion of the premium it received from that enrollee), state assessments on insurers, and state general fund contributions. Based on an actuarial analysis commissioned by Alaska in support of its waiver application, the state concluded that it would reduce premiums and increase enrollment in the individual market at no additional cost to the federal government.”

⁴⁹ “State Innovation: The Key to Affordable Health Care Coverage Choices,” by Doug Badger and Ed Haislmaier, The Heritage Foundation, September 27, 2018. <https://www.heritage.org/health-care-reform/report/state-innovation-the-key-affordable-health-care-coverage-choices>

The analysis was correct. After the waiver reform in Alaska, premiums for the lowest-cost Bronze plans fell by 39 percent in 2018.

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 Obamacare coverage in 2019 were lower for every Minnesota insurer than they were in 2017.

Four other states had waivers approved for 2019: Maryland, Maine, New Jersey, and Wisconsin. Insurers in Maryland had sought 2019 premium increases averaging over 30 percent. Insurers filed those rate requests before the federal government approved Maryland's waiver application. After receiving approval, Maryland announced that 2019 rates would drop by more than 13 percent. Instead of a 30 percent premium hike, Maryland consumers will pay 13 percent less, on average, than they did in 2018.

Waivers alone, however, are not enough. Congress should enact legislation to empower states to establish consumer-centered approaches that reduce health care costs and increase choices with the Health Care Choices proposal.⁵⁰

The proposal would rely on states to devise even more creative ways to provide help for the sick as well as those needing assistance in purchasing health coverage. The Health Care Choices plan would repeal Obamacare's federal entitlements to premium assistance and Medicaid expansion and replace them with formula grants to the states so they can set up consumer-centered programs.

Instead of asking Washington's permission for some limited flexibility, states would use federal resources to finance approaches that best serve the needs of their residents. The limited experience of redirecting funds toward risk mitigation shows that states can and should be leading on health reform.

The Health Policy Consensus Group, a project of the Galen Institute, submitted public comments to HHS regarding the Section 1332 State Relief and Empowerment waiver program, encouraging codification of the 2018 Guidance regarding the waivers:

Section 1332 of the Affordable Care Act (ACA) permits the Secretary of Health and Human Services (HHS) and the Secretary of the Treasury to approve a state's proposal to waive specific provisions of the ACA, provided the proposal meets certain requirements. The "State Relief and Empowerment Waivers" guidance issued in the Federal Register (83 FR 53575) (hereinafter referred to as the "2018 Guidance") superseded previous guidance published on December 16, 2015, in the Federal Register (80 FR 78131). We

⁵⁰ "Health Care Choices 20/20: A vision for consumer-directed health reform," Health Policy Consensus Group, September 2021. <http://www.healthcarechoices2020.org>

strongly support CMS’s proposal to codify the agency’s 2018 Guidance into federal regulation.

John McDonough, a Harvard professor who served as a senior advisor to the U.S. Senate Committee on Health, Education, Labor, and Pensions from 2008 through 2010 when the ACA was debated and enacted, in 2014 wrote:⁵¹

“Section 1332 of Title I of the Affordable Care Act offers to state governments the ability to waive significant portions of the ACA, including requirements related to qualified health plans, health benefit exchanges, cost sharing, and refundable tax credits. It permits state governments to obtain funding that otherwise would have gone to residents and businesses through the ACA and to use those funds to establish, beginning in 2017, an alternative health reform framework within statutory limits.”

Unfortunately, the 2015 Guidance served to restrict states’ ability to utilize 1332 waivers to improve their health insurance markets by tightening the statutory “guardrails” that must be satisfied for waiver approval. Three of these guardrails pertain to the number of people with coverage as well as the affordability of that coverage and nature of that coverage. The fourth guardrail requires that the waiver not increase the federal deficit. This 2015 guidance was far more restrictive than the statutory requirements and virtually nullified states’ ability to innovate through section 1332.

As a result of the restrictive guidance and approach, only one state submitted and had a 1332 waiver approved prior to January 1, 2017.

Fortunately, the 2018 Guidance offers both an interpretation of the guardrails that makes 1332 waivers more useful for states as well as an interpretation that is more consistent with the statute. By codifying the 2018 Guidance, the Departments will further the intended aim of 1332 waivers to promote state policy innovation in designing programs that expand options, lower costs, and promote coverage without increasing the federal deficit...

Twelve states received 1332 waivers since 2017 in addition to three states with waivers approved in 2017. States with approved 1332 waivers have generally experienced positive results. A June 2020 CMS analysis of the effect of 1332 waivers found that premiums were an average of 17.7 percent lower during the 2020 plan year in the 12 states that had approved 1332 waivers in place than they would have been without those waivers.⁵²

⁵¹ John E. McDonough, “Wyden’s Waiver: State Innovation on Steroids,” *Journal of Health Politics, Policy, and Law* (2014) 39(5): 1099-1111.

⁵² CCIIO Data Brief Series, “State Relief and Empowerment Waivers: State-based Reinsurance Programs, June 2020. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-June2020.pdf>

In 2020, another three states secured 1332 waivers. Consumers have thus benefited from 1332 waivers that are consistent with the existing guardrails.

These programs could be models for future health reform, devolving power away from centralized federal programs to states and ultimately to consumers in a market catering to their needs rather than to Washington’s bureaucracy.

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.⁵³ Her story encapsulates for me the problems with federal government control over health care.

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!”

When Obamacare went into effect in 2014, 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 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.

⁵³ See www.HealthCareChoices2020.org testimonials

“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

CONCLUSION

The Galen Institute is non-partisan, and we welcome the opportunity to work with health policy colleagues on both sides of the aisle. We seek out colleagues and legislators who are open to our ideas on patient-centered health reforms that would rely on competition and choice to produce better, more affordable health care and coverage options.

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.