GALEN INSTITUTE

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

Hearing before the

Committee on Oversight and Reform
U.S. House of Representatives

"Examining Pathways to Universal Health Coverage"

March 29, 2022

Chairwoman Carolyn B. Maloney
Ranking Member James Comer

Testimony by Grace-Marie Turner
President
Galen Institute

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Chairwoman Maloney, Ranking Member Comer, 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 achieving 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.

Madam Chairwoman, 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 many millions of 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 and deductibles 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 private 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 must then answer to hospital executives. Some hospital systems have become virtual oligopolies, setting 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 focusing on listening to their patients.

These and other frustrations with the current system, I believe, 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, which 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 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"

[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/

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 the 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 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 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 rules and regulations than focusing on the individual needs of their patients and innovating to develop better care solutions.

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.

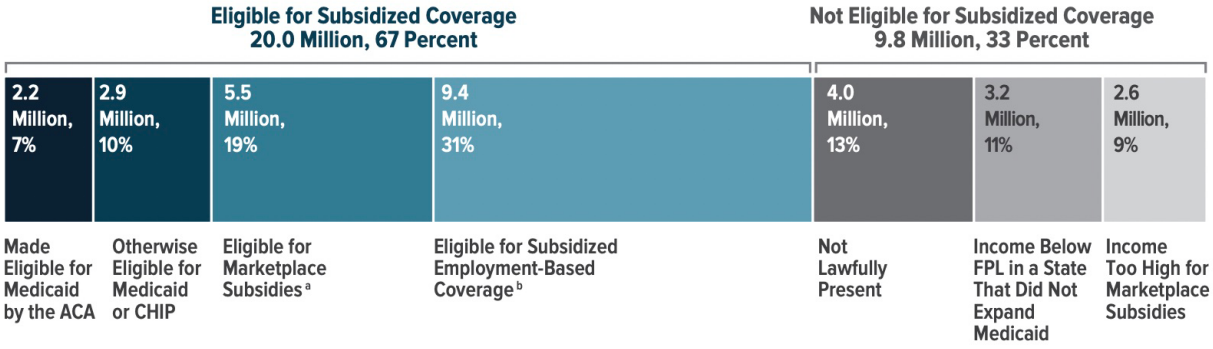
Of the remaining third, the greatest number—an estimated four million—were not lawfully present in the U.S. and therefore need to be addressed separately through immigration/citizenship policy. Slightly more than 3 million of the uninsured had income below the federal poverty level and lived in states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

The chart below provides further detail:

[2] Congressional Budget Office, "Who Went Without Health Insurance in 2019, and Why?" September 2020. https://www.cbo.gov/publication/56504

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/2fb03bb1527d26e3f270c65e2bfffc3a/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 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]

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[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. For example, in Texas, not a single ACA plan covers Houston's world-renowned MD Anderson Cancer Center.

Galen Senior Fellow and Paragon Health Institute President Brian Blase testified recently before the House Education and Labor Committee about health costs:[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.

THE HIGH PRICE OF MEDICAID WASTE

Pouring more money into Medicaid without reforming the program is reckless. "A recent federal audit examined 2,301 files of people enrolled under ObamaCare's expansion, and eligibility review errors occurred in 29% of them," according to a review by Brian Blase.[9]

The audit found eligibility errors for nearly one third of Medicaid enrollees. 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

[8] https://edlabor.house.gov/imo/media/doc/BlaseBrianTestimony%200217221.pdf
[9] 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

failure doesn't just reduce health-care access for the truly eligible, it also harms taxpayers who fund it." [10]

These studies provide further evidence that more government spending is not the answer.

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 members of Congress 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.[11]

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 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?

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[10] Brian Blase, "Medicaid is hemorrhaging $100B on Americans ineligible for the program," New York Post, Nov. 28, 2020. https://galen.org/2020/alarming-unlawful-medicaid-spending-brian-blase-in-ny-post/

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

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 Children's' 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 paying sharply increased taxes as federal indebtedness soars, putting at even greater risk future prosperity for our children and grandchildren.

CONGRESSIONAL BUDGET OFFICE REPORT ON SINGLE-PAYER

The Congressional Budget Office was asked to evaluate key design elements of a single-payer system and came to sobering conclusions.[12]

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."

While CBO was not asked to produce budget estimates of a single-payer system, it recognizes the cost risk by imposing global budgets to cap spending for institutional providers through a Medicare for All system. In addition, 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, as CBO expects, including the long waiting lines and other barriers

[12] 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

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 because they would be forced to navigate a complex, bureaucratic system to get the care they need.

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 smaller 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]

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.[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 are likely to exacerbate this trend as more physicians close their practices or otherwise withdraw because the payment reductions will force many to close 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 system and assess the risks of such sweeping changes.

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[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-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.[17] 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.

In 2021, 26 million Medicare beneficiaries, or about 42% of those eligible for the program, were enrolled in a Medicare Advantage plan.[18] 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. [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 in an earlier hearing on universal coverage 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.

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.[21] 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.[22] Our hospitals and physicians offer top quality care where Americans have access to the latest medical diagnostics. Americans are accustomed to better quality and

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[17] https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf
[18] 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.
[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
[21] 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/
[22] 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.

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.[23] 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

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 can pay less than the cost of providing care.

Nearly 175 million Americans receive health coverage through the workplace, either as an employee, retiree, or dependent.[24] The great majority highly value their coverage that would be eliminated under Medicare for All.

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[23] 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

[24] 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

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, 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:[25]

- 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.

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 in the Appendix to my testimony.

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 Colorado, Vermont, and most recently California have failed in their attempts.

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.

[25] Council for Affordable Health Coverage, letter to Affordability Task Force, February 4, 2022.

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.[26] AB 1400 would have all but eliminated private health care 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 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.[27]

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 person.[28] For many, that would be prohibitively expensive, possibly requiring yet another federal program to provide taxpayer-financed subsidies.

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[26] "California's Single-Payer Bill Dies," Politico, January 31, 2022.
https://www.politico.com/news/2022/01/31/californias-single-payer-bill-dies-00003924

[27] https://galen.org/2015/obamacare-co-ops-cause-celebre-or-costly-conundrum-2/

[28] 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/

A Path to Patient-Centered Reform

House Republicans are working to create a fresh legislative agenda on health care, the economy, Big Tech, energy, and a host of key issues.

We are, of course, particularly interested in the Healthy Future task force, jointly chaired by Reps. Brett Guthrie of Kentucky and Vern Buchanan of Florida. Each task force has up to 18 members, drawn from various committees to facilitate conversations among Members serving on various committees with differing jurisdictions. And it is a Member-driven process. Too many bills have failed because leaders didn't even have buy in from their own team.

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.

We have been invited to provide our ideas to the Healthy Future task force, and we are relying heavily on our Health Care Choices proposal[29] that has the support of 82 health policy leaders and organizations participating in the Health Policy Consensus Group.

It 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. 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.[30] Choice and competition are the centerpiece of the plan, not more top-down, government-managed centralized programs.

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

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.[31] 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.

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[29] https://healthcarechoices2020.org

[30] https://www.healthcarechoices2020.org/wp-content/uploads/2020/10/The-Health-Care-Choices-Proposal-Score.pdf

[31] See www.HealthCareChoices2020.org testimonials

"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.

"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

Several options are now available, implemented through regulatory authority, to help increase access to more affordable health coverage.

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."[32]

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.[33] "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 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.

[32] 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

[33] 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/

Short-term plans[34] 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.[35]

A White House Council of Economic Advisers (CEA) report on "Deregulating Health Insurance Markets: Value to Market Participants"[36] 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 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.

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[34] https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance

[35] 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

[36] 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 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 proposed rule comment period, 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.[37] We argue that current law would allow the integration of HRAs with group health plans sponsored by the employer of a spouse.[38]

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.

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.[39]

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[37] https://galen.org/2019/increasing-access-to-health-insurance-for-working-families/

[38] 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

[39] 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

"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.[40] Georgia also 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.

[40] 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