



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

April 19, 2022

The Honorable Carolyn B. Maloney
Chairwoman
Committee on Oversight and Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC. 20515

Dear Madam Chairwoman:

Please find attached responses to the additional questions directed to me by your office from Ranking Member James Comer, following my testimony before your March 29, 2022, hearing on “Examining Pathways to Universal Health Coverage.” I am submitting replies for the official hearing record.

Thank you for the opportunity to testify. Please let me know if you have further questions or need additional information.

Sincerely,

President

Cc: The Honorable James Comer, Ranking Member
Amy Stratton, Deputy Chief Clerk

Questions submitted by: **Ranking Member James Comer**
Committee on Oversight and Reform

Response from: Grace-Marie Turner
President, Galen Institute

Re: March 29, 2022, hearing,
“Examining Pathways to Universal Health Coverage”

1. What evidence do you have to support your claim that hospitals would have to close or would have to significantly curtail their services if they were overly reliant on Medicare/Medicaid payments?

(Question submitted by Ranking Member James Comer.)

I reported in my testimony that “assigning Medicare rates to hospitals would entail payment rates that are roughly 40 percent lower than commercial rates. 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.”

Senior Fellow Doug Badger provides much more detail in a paper he wrote for the Galen Institute, “Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage: Considerations for Policymakers.”¹ He explained the crucial role that higher-paying private plans, primarily employer-sponsored insurance (ESI) that provide health coverage for 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

¹ 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>

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

Source: NHE, Table 7 and MedPAC

[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 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 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 186, 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 are forced to close because they have become 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?

2. In your testimony you stated that, “choice and competition” may lead to more options for affordable health coverage for Americans. What evidence do you have to support that claim?

(Question submitted by Ranking Member James Comer.)

There are innumerable examples of the value of choice and competition throughout our economy and in the health sector. I detailed in the Appendix to the written testimony I submitted to the committee some policy changes that support more choices of more affordable care and coverage.

Legislative action is needed from Washington to unleash the innovation and energy that have been pent up in our health sector.

Incalculable resources are being wasted in our regulatory-driven health sector today. The federal government is micro-managing health coverage with tens of thousands of pages of rules and regulations in its effort to overhaul the individual health insurance market. 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.

Empowering consumers with more choices of coverage, greater transparency, and loosening the regulatory reins will allow innovators to better meet the needs of patients with more flexible programs and more focused assistance to those who most need help.

I would like to offer two examples of public programs that have successfully deployed choice and competition—the Medicare Prescription Drug program and Section 1332 of the Affordable Care Act.

My colleague Doug Badger and I described the Medicare Part D programs success:²

The federal government’s largest prescription drug program is Medicare Part D. The program has made prescription medicines more affordable for millions of seniors, offering them broad coverage choices while holding down costs for taxpayers.

Part D, established in 2003 through the Medicare Modernization Act, has led to more than nine out of 10 seniors having drug coverage, and they are paying less than predicted for their coverage. Their premiums average \$33.50 in 2018, less than the Congressional Budget Office said they would average in 2006, the program’s first year.³

Part D has consistently come in under budget. Under the initial 10-year budget projections, Part D was expected to cost \$770 billion. Actual cost after 10 years: \$421 billion. That’s 45 percent less than expected.

That underestimates the value of Part D. Innovative new medicines reduce the need for hospital stays and physician visits. A 2016 study found that Part D actually resulted in net Medicare savings of \$679 billion over its first nine years.

Instead of building on this island of success in the sea of red ink in other government programs, Congress has chipped away at the unique features that have produced its success—a judicious use of regulation, genuine market competition, transparency and consumer choice.

In the Medicare Prescription Drug Benefit Program, plans compete for enrollment based on the premiums and coverage design. Unlike ObamaCare, which has caused insurers to abandon individual health insurance markets and leave consumers with few choices, Part D offers seniors a broad array of

² “Rescuing seniors and Part D from Congress,” by Doug Badger and Grace-Marie Turner, *The Hill*, May 11, 2018. <https://thehill.com/blogs/congress-blog/healthcare/387332-rescuing-seniors-and-part-d-from-congress/>

³ The average premium in 2022 is \$30. “Here’s what to know about your 2022 Medicare costs,” by Sarah O’Brien, CNBC, Dec. 31, 2021. <https://www.cnbc.com/2021/12/31/heres-what-to-know-about-your-2022-medicare-costs.html#:~:text=would%20be%20%2411%2C300.-,Part%20D,in%202022%20up%20from%20%24445>

options. As a result, plans have a big incentive to negotiate the lowest price they can get to make their premiums attractive.

While Congress has made changes that have made the program less consumer-centric, the basic structure of the program is a highly successful model for future reform.

And there is another example of a government program that been successful in engaging market forces to lower costs and increase choices and coverage:

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.

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"⁴ 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,

⁴ "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>

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.”

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.⁵

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 to set up consumer-centered programs.

⁵ “Health Care Choices 20/20: A vision for consumer-directed health reform,” Health Policy Consensus Group, September 2021. <http://www.healthcarechoices2020.org>

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 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:⁶

“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.

⁶ John E. McDonough, “Wyden’s Waiver: State Innovation on Steroids,” *Journal of Health Politics, Policy, and Law* (2014) 39(5): 1099-1111.

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.⁷

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.

3. Madam Chairwoman Maloney and Ranking Member Comer, I would like to enter into the record substantiation for the comments I made in response to a question by Mr. Comer about the 70 changes that have been made to the ACA since its enactment in 2010.

The Galen Institute tracked 70 major changes⁸ that were made to the ACA in the first six years after enactment. At least 43 of the changes were made by the Obama administration unilaterally. In addition, Congress passed and former President Obama signed 24 more changes—such as repealing the onerous 1099 reporting requirement for small businesses and repealing the inadequately financed and poorly structured long-term care program. And three more changes were made by the Supreme Court, such as making Medicaid expansion voluntary for states. Our paper provides details of all of these changes and is available at <https://galen.org/2016/changes-to-obamacare-so-far-3/>

⁷ CCHIO Data Brief Series, “State Relief and Empowerment Waivers: State-based Reinsurance Programs, June 2020. <https://www.cms.gov/CCHIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief- June2020.pdf>

⁸ “70 CHANGES TO OBAMACARE... — SO FAR,” GALEN INSTITUTE, MOST-RECENT UPDATE, JANUARY 28, 2016. [HTTPS://GALEN.ORG/2016/CHANGES-TO-OBAMACARE-SO-FAR-3/](https://galen.org/2016/changes-to-obamacare-so-far-3/)