



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

**Hearing before the
Committee on Rules
U.S. House of Representatives**

April 30, 2019

“H.R. 1384: The Medicare For All Act of 2019”

**Chairman Jim McGovern
Ranking Member Tom Cole**

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

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

Mr. Chairman, in calling this hearing today about the Medicare for All national health insurance bill introduced by Congresswomen Pramila Jayapal and Debbie Dingell with 107 co-sponsors, you acknowledge the growing interest in a bold proposal to achieve universal coverage in the United States.

Let me begin by saying I believe there are important shared goals for health reform:

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

There is no question that many millions of Americans are frustrated with our current health care system. Care costs too much, and many are simply priced out of the market for health insurance. Many who are not eligible for subsidies say the premiums are unaffordable, especially for exchange policies with such high deductibles and ultra-narrow provider networks.

Millions remain uninsured and even those with insurance can face thousands of dollars in “surprise billings.” Patients without generous cost-sharing subsidies can face out-of-pocket costs so high they say they might as well be uninsured.

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

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

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

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

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

STRUGGLING TO ACHIEVE PROMISED GOALS

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

Many Americans are frustrated that, nine years later, our nation still is struggling to achieve these goals of access and affordability. They are understandably skeptical of new promises. When informed that Medicare for All would mean higher taxes and losing the coverage they have now, support plummets.¹

Colorado and Vermont recently failed in their attempts to implement statewide single-payer systems. Colorado voters rejected a single-payer initiative in 2016 by a four to one margin, with residents especially concerned about the high taxes that would be required to finance it and about losing the coverage they have now to the uncertainties of the new system. Vermont officials worked feverishly to design a single-payer system but found that the costs of the program would be prohibitive and that the higher taxes required would seriously damage the economy.

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

TOO MUCH GOVERNMENT

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

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

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

Today, people in the individual and small group markets have few choices—they can either buy an expensive ACA-compliant plan or go uninsured. The Affordable Care Act rewrote the rules for health insurance policies, including mandating a rich benefits package. California spent \$100 million last fall trying to boost enrollment in its exchange, yet it saw the number of new enrollees [shrink by nearly 24%](#).

The problem is cost. The costs of premiums and deductibles can be prohibitive, especially for those who don't get subsidies.

But rather than dramatically expanding the role of government in the health sector, I believe we need to look more carefully at these problems and target appropriate solutions that empower consumers and build on what works.

THE MEDICARE MODEL

Today's Medicare is seen as a model for reform at least partly because it allows seniors in traditional fee-for-service Medicare to get care from the doctors of their choice. The Medicare for All bill, H.R. 1384, before the committee would:

- allow patients to choose the doctors, hospitals, and other providers they wish to see.
- provide a much more comprehensive list of covered benefits than seniors have today. It would cover all primary care, hospital and outpatient services, dental, vision, audiology, women's reproductive health services, maternity and newborn care, long-term services and supports, prescription drugs, mental health and substance abuse treatment, laboratory and diagnostic services, dietary therapies, transport, and more.

- guarantee that everyone would be able to access care without facing any private insurance premiums or deductibles. Upon receiving care, patients would not be charged any co-payments or other out-of-pocket costs.
- outlaw private health insurance, including employer-sponsored health insurance and Medicare Advantage or supplements, for any of the benefits covered under Medicare for All.
- eliminate Medicare, Medicaid, TriCare, the State Children’s Health Insurance Program, the Federal Employee Health Benefits Program, and ACA exchange coverage
- require the HHS secretary to determine policies and procedures to implement the new program, including determining benefit eligibility, enrollment, benefits provided, levels of funding, methods of determining payments to providers, appeal processes, planning for capital expenditures and health professional education, and set up a new system of “uniform reporting standards” to a national database.
- require the HHS secretary to “establish a national health budget, which specifies a budget for the total expenditures to be made for covered health care items and services” under the new program. Spending would be based upon “government negotiated prices.”
- require providers to provide information and allow examination of records that document items and services furnished to patients.
- begin the Medicare for All program two years after enactment of the bill.

Proponents of a single-payer health care system argue that if all the money flowing through the health sector today were put into one program, the U.S. could more than afford the new program. But unrestricted access to benefits is virtually unprecedented, and it is difficult to anticipate the impact of this new system.

Rep. Jayapal’s bill implies a recognition of the cost risk by imposing global budgets to cap Medicare for All spending for institutional providers. The relatively few providers who are expected to work in non-institutional settings would be paid on a national fee schedule. In addition, the bill assigns to Washington the task of determining on an annual basis adjustments to the list of covered benefits.

WHAT GLOBAL BUDGETS WOULD MEAN

As Dr. Blahous likely will explain, if current Medicare rates are applied, assigning Medicare rates to hospitals would entail payment rates that are roughly 40% lower than commercial rates, while physicians would see 30% cuts. These payment reductions would gradually grow larger over time for both. Such dramatic payment reductions would mean many physician practices

would be operating in the red, 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.

A new report from the Association of American Medical Colleges finds that, even under our current health system, the U.S. will see a shortage of up to nearly 122,000 physicians by 2032. The demand for physicians is expected to grow faster than the supply, and rural areas will be hit especially hard, according to the report.² The payment cuts envisioned in H.R. 1384 are likely to exacerbate this trend as more physicians close their practices or otherwise withdraw because of the payment reductions.

THE HIGH PRICE OF FREE CARE

We do know from the experience of other countries that global budgets, such as would be implemented under H.R. 1384, and associated centrally-determined benefit structures lead to rationing, waiting lines, and lower quality of care. These and other forms of rationing seriously compromise access to care.

While patients in countries with nationalized health systems say they value their access to free care, many pay a very high price in other ways. Tragically, it is often the most vulnerable who are left behind when demand for services outpaces resources.

The Fraser Institute in Canada devotes considerable time and resources to tracking waiting lists for Canadians seeking care.³ In “Waiting Your Turn: Wait Times for Health Care in Canada, 2018,” it finds that the median wait time for medically necessary treatment in Canada was 19.8 weeks.

We regularly see articles in UK papers about patients stuck in ambulances for hours in London waiting for an opening to a hospital emergency room.⁴ And once patients are admitted, they can be warehoused in hallways for days, with some dying before a hospital bed becomes available.⁵

² 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

³ <https://www.fraserinstitute.org/categories/health-care-wait-times>

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

⁵ BBC, “Patients 'dying in hospital corridors',” January 11, 2018. <https://www.bbc.com/news/health-42572116>

Sally Pipes of the Pacific Research Institute, who was born and raised in Canada, writes that Britain's version of Medicare For All is struggling with long waits for care.⁶ “The [National Health Service] routinely denies patients access to treatment. More than half of NHS Clinical Commissioning Groups, which [plan and commission health services](#) within their local regions, are rationing cataract surgery. They call it a procedure of ‘[limited clinical value](#).’ It's hard to see how a surgery that can prevent blindness is of limited clinical value,” she writes.

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

Access to new medicines and other medical technologies also is limited in these countries. In just one example, my colleague Doug Badger recently surveyed access to new drugs in a number of countries with government-dominated health systems.⁷ He found the French have access to only 48% of new drugs introduced between 2011 and 2018. Americans, by contrast, have access to 89% of those innovative medications. Nor is France an exception. The Swiss have access to only 48% of newly-developed drugs, the Belgians 43%, and the Dutch 56%.

Prescription drug prices are a key focus of members of Congress on both sides of the aisle and both sides of the Capitol. Doug Badger’s analysis suggests that many of the distortions in drug pricing come from our own government programs: “The federal government requires manufacturers to pay rebates, grant discounts, and comply with various price-distorting directives across a range of programs. The Department of Veterans Affairs uses [multiple contracting systems](#) and a single national formulary that [restricts access](#) to pharmaceuticals to hold down prices. Medicare requires manufacturers to provide a [70 percent discount](#) on drugs in the Part D ‘coverage gap.’ Medicaid requires them to pay the federal government a rebate of [23.1 percent](#), and nearly every state exacts [additional rebates](#) from manufacturers. The government also mandates that drugmakers provide similar rebates to qualifying clinics and hospitals under its 340B program.”⁸ All put upward pressure on the prices consumers face.

Some pharmaceutical companies have voluntarily announced rollbacks of price increases, cuts in prices, price freezes, or other ways to improve affordability for patients. As one example,

⁶ Sally Pipes, “Britain's Version Of 'Medicare For All' Is Struggling With Long Waits For Care,” *Forbes*, April 1, 2019. <https://www.forbes.com/sites/sallypipes/2019/04/01/britains-version-of-medicare-for-all-is-collapsing/#2c4418a536b8>

⁷ 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/>

⁸ Doug Badger, “Trump Blames the Wrong Government for High Drug Prices,” *RealClearHealth*, March 22, 2019. https://www.realclearhealth.com/articles/2019/03/22/trump_blames_the_wrong_government_for_high_drug_prices_110887.html

Amgen, a leading biologics company, announced it was breaking through the complex and opaque drug pricing maze with a simpler pricing model that reduced the list price of its innovative biologic, Repatha, by 60%.⁹ This is a healthy response to market competition and political pressure.

Administrative costs: While H.R. 1384 does not specify funding mechanisms, 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 as any insurance system. Physicians, hospitals, labs and other service providers would have to be approved and payment rates set. The government would need verification that approved services were actually provided, and there would need to be even greater need for safeguards against fraud and abuse.

Merrill Matthews, now with the Institute for Policy Innovation, analyzed Medicare administrative costs vs those of private insurers.¹⁰ 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 agencies of government perform in collecting premium revenue are considered.

Value of 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.¹¹ Our hospitals and physicians offer top quality care where Americans have access to the latest medical diagnostics. Generations of people in the UK have grown up knowing no system other than the National Health Service, but Americans are used to better quality and access and are unlikely to be satisfied with restrictions and rationing.

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

In addition to inevitable restrictions on access to medical technologies and newest treatments, seniors value their current Medicare coverage, and many believe their access would be undermined if 265 million more Americans were competing with them for services to the same underpaid providers.

Medicare and Medicaid recipients, federal employees, kids on the Children's Health Insurance Program, workers and retirees getting insurance through the workplace, and those receiving coverage through ACA exchanges all would all be moved into the new program within the short span of two years. Many would see this as severely disruptive.

⁹ <https://www.amgen.com/media/news-releases/2018/10/amgen-makes-repatha-evolocumab-available-in-the-us-at-a-60-percent-reduced-list-price/>

¹⁰ 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

¹¹ <https://www.americanactionforum.org/weekly-checkup/new-drug-patents-country/>

Today, [60 million people](#), including 51 million older adults and 9 million younger adults with disabilities, rely on Medicare for their health insurance coverage. In 2018, two-thirds of Medicare beneficiaries were in traditional Medicare, and [one-third had chosen to enroll in private Medicare Advantage plans](#).¹² Medicare For All would take away the private coverage that 22 million seniors have voluntarily chosen under the existing Medicare Advantage program.

The Medicare Trustees' Report issued April 22 presents warning signs about the sustainability of the Medicare program we have today.

Medicare is on track to bankruptcy in 2026. According to the report, Medicare had a cash shortfall in 2018 of \$363 billion. The program paid \$740 billion for medical goods and services for today's seniors but collected only \$377 billion in payroll taxes and seniors' monthly premiums.¹³ Medicare has accumulated a \$5.1 trillion cash shortfall since the program started in 1965, and covering this shortfall is responsible for one third of U.S. federal debt.

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

Instead of expanding Medicare, Congress could consider instead ways of securing Medicare's promise for future generations. The part of Medicare that is working best is Medicare Advantage, which deploys private insurers to provide better access and better-coordinated care to seniors. MA plans have lower premiums, broader benefits, and better health outcomes. The best way to reform Medicare is to enact reforms that will further improve the quality and affordability of Medicare Advantage plans, and to build on this model to improve coverage for working-age Americans.¹⁴

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

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

¹² <https://www.kff.org/medicare/issue-brief/sources-of-supplemental-coverage-among-medicare-beneficiaries-in-2016/>

¹³ Tara O'Neill Hayes and Gordon Gray, "The Future of America's Entitlements: What you need to know about the Medicare and Social Security Trustees Reports," American Action Forum, April 22, 2019. <https://www.americanactionforum.org/research/the-future-of-americas-entitlements-what-you-need-to-know-about-the-medicare-and-social-security-trustees-reports-2/>

¹⁴ 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>

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

A survey by Luntz Global Partners shows the critical importance of employer-sponsored health coverage to American workers.¹⁵ It found 71% of Americans are satisfied with their current employer health coverage. Further, 56% indicated coverage remains a key factor in their decision to stay at their current job. In tight labor markets where companies are competing for workers, employers work hard to meet their employees' demands for quality coverage. Employers negotiate fiercely to keep costs as low as possible and continually adjust their plans to meet the needs of their workers for the benefits they value. Many employees say ESI is a prime reason for picking the employer they do.

Employers know that high quality health coverage leads to better health outcomes and a healthier workforce. 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 and employees both have a vested interest in getting the best value for their health care dollars to obtain the highest quality care and coverage at the lowest cost.

My colleague Doug Badger provides a detailed history of how the employer-based health insurance system evolved in the United States and how central it is to the network of programs in our health sector today.¹⁶ He explains that “The vast majority of workers—89 percent according to the Kaiser survey¹⁷—worked for companies that sponsored health insurance coverage in 2016, and an estimated 79 percent of those employees were eligible to enroll in their firm’s plan. In all, 62 percent of those working for employers that sponsor coverage enrolled in that coverage in 2016.”¹⁸

Badger describes the cost in terms of tax preference for employer-sponsored health insurance (ESI) and how that is leveraged to produce a nearly 3-1 ratio in value to tax expenditures:

¹⁵ <https://www.ahip.org/majority-of-americans-satisfied-with-their-employers-health-plan-new-survey-shows/>

¹⁶ 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>

¹⁷ Kaiser Family Foundation/Health Research & Education Trust 2016 Employer Health Benefits Survey. Sep 14, 2016. <https://www.kff.org/report-section/ehbs-2016-summary-of-findings/>

¹⁸ Badger explains that some may have chosen to remain uninsured despite exposure to tax penalties on the uninsured. Others may have had other sources of coverage—through a working spouse, for example, a parent (in the case of those under 26), or through another public program such as Medicaid or Medicare.

ESI offers considerable benefits to the government. Premiums for those with ESI totaled nearly \$991.3 billion in 2016.¹⁹ Of that amount, 73 percent was contributed by employers and 27 percent by workers.²⁰ Government does not tax health benefits. If it treated ESI the same as it does wages, federal income and payroll tax revenues would increase.²¹ The Treasury Department estimates that, absent the tax exclusion, federal revenues would have been \$348 billion higher in fiscal year 2016.²²

By not taxing ESI, the government leveraged nearly \$1 trillion in private health insurance spending at a net cost to the federal budget of less than \$350 billion.²³ To finance that sum through payroll taxes in 2016 would have required raising the OASDI [Old-Age, Survivors, and Disability Insurance] tax by 9.6 percentage points, from 12.4 percent to 22.0 percent of taxable payroll.²⁴

... Instead of taxing workers and corporations and directly financing their medical care, the U.S. government exempts ESI from taxation, leveraging \$2.85 in health insurance spending for every \$1 in federal revenue losses.²⁵

¹⁹ CMS, National Health Expenditures, Table 24.

²⁰ CMS, National Health Expenditures, Table 24. It is generally accepted that the employer contribution is, in fact, a form of compensation or, to put it somewhat differently, a labor cost.

²¹ Firms do, of course, deduct their contribution to ESI from their corporate taxes but they also deduct the wages they pay. The difference between wage and non-wage compensation is the latter's exclusion from federal income and payroll taxes.

²² Department of Treasury, "Tax Expenditures," Table 1, line 128 and footnote 12. Line 128 estimates the FY 2016 federal income tax loss at \$216.1 billion. Footnote 12 estimates lost payroll tax revenue of \$131.6 billion.

²³ Badger's paper is concerned largely with federal expenditures and consequently makes no effort to estimate the effects of the exclusion on state tax revenues. A very rough estimate of the benefit to the government in 2016 can be derived by subtracting the amount of federal revenue lost to the exclusion (\$348 billion) from the total amount of ESI premiums (\$991.3 billion), yielding \$643.3 billion. That is a rough estimate of the net cost of supplanting ESI with direct government financing in 2016.

²⁴ Wages subject to OASDI taxes totaled \$6.7 trillion in 2016. 2017 SSA Trustees Report, Table VI.G6, p. 216. This is not to suggest that the government would finance health care through an increase in the OASDI payroll tax, but merely to provide perspective on the amount of private health spending government leverages through the exclusion.

²⁵ Others have arrived at a higher ratio. The American Benefits Institute has estimated that employers paid \$4.45 to finance health benefits for every \$1.00 in foregone federal revenue. (See *American Benefits Legacy: The Unique Value of Employer Sponsorship*, American Benefits Institute, October 2018, p. 31. <https://www.americanbenefitscouncil.org/pub/?id=b949f447-f1ca-4dd0-817a-a7e96d8e3bfc>.) There are several reasons for the difference between this ratio and the one used in this paper. First, the American Benefits Institute (ABI) paper derives its employer payments for group health insurance from the Commerce Department's National Income and Products Accounts. This paper uses National Health Expenditures data compiled by the CMS Actuary. Second, ABI uses tax expenditure data compiled by the Joint Committee on Taxation. Badger's paper uses Treasury Department data. Most importantly, this paper takes into account both foregone income and payroll taxes that result from the tax treatment of ESI. That yields a denominator of \$348 billion in this paper, compared with \$155.3 billion in the ABI report.

ESI Supports Public Programs: Few recognize the significant cross-subsidization of today’s Medicare that sustain access to care. Badger points out the important role that employer-sponsored health insurance plays by paying doctors and hospitals more than Medicare and Medicaid do, providing the margins many providers need to maintain quality and even keep their doors open.

It can be argued that the employer-sponsored health insurance system is a vital part of the reimbursement matrix supporting the U.S. health sector.²⁶

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

BETTER OPTIONS

Instead of supplanting ESI with a government-run system, Congress should build on ESI. The Trump administration is offering several options through its regulatory authority to help employers and employees get and keep more affordable coverage.

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

The Washington Post reported that: “Chambers of commerce and trade associations have launched more than two dozen of these ‘association health plans’ in 13 states in the seven months since the Labor Department finalized new rules making it easier for small businesses to band together to buy health coverage in the same way large employers do. And there are initial signs the plans are offering generous benefits and premiums lower than can be found in the Obamacare marketplaces.”²⁷

²⁶ The number of employers offering health coverage has remained steady over the last five years at 55%, even as firms are struggling to provide this valued benefit despite steadily rising health costs. But that number still is down from the 65% of firms that offered coverage in 2001. Badger argues that the employer mandate instituted by the ACA appears to have had very little effect on the percentage of workers enrolled in ESI. In general, it appears that larger firms, which are subject to the mandate, sponsored health insurance before the government required them to do so, while a fairly substantial percentage of smaller firms, which are generally exempt from the mandate, did not offer coverage to their employees.

²⁷ 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

There have been some criticisms that these plans might not be offering the same protections as ACA-compliant plans. But a new study shows that they are offering benefits comparable to most workplace plans, and they haven't tried to discriminate against patients with preexisting conditions, according to an analysis by Kev Coleman, a former analyst at the insurance information website HealthPocket.²⁸ “We’re not seeing skinny plans,” he said.

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

In a 2017 executive order, President Trump directed administration officials to “increase the usability of HRAs, to expand employers’ ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage.”²⁹

The proposed rule would allow HRAs to be integrated with individual health coverage. This would allow workers to use their accounts to fund both premiums and out-of-pocket costs associated with individual health insurance coverage.³⁰

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.³¹ We argue that current law would allow the integration of HRAs with group health plans sponsored by the employer of a spouse.³²

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.

²⁸ 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/>

²⁹ Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States, The White House, October 12, 2017. <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/>

³⁰ <https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans>

³¹ <https://galen.org/2019/increasing-access-to-health-insurance-for-working-families/>

³² 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

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

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

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

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

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

Doug Badger and Heritage scholar Ed Haislmaier explain how early targeted waivers granted to states are helping them to better manage patients with chronic and pre-existing conditions.³³ "Several states have successfully used a waiver to change market conditions sufficiently that premiums fell for individual health insurance while still protecting the ability of people with high health care costs to access care," they write.

After the waiver reform in Alaska, premiums for the lowest-cost Bronze plans fell by 39 percent in 2018, they report. Oregon showed similar results in 2018, with premiums for the lowest-cost Bronze plans falling by 5 percent. Premiums for the highest-cost Bronze plans plunged by 20 percent. In Minnesota, the third state with an approved waiver, premiums dropped in both 2018 and 2019. Average premium for ACA coverage in 2019 will be lower for every Minnesota insurer than they were in 2017. Four other states have had waivers approved for 2019: Maryland, Maine, New Jersey, and Wisconsin.³⁴

According to the paper, "States repurpose a portion of federal money that would otherwise have been paid to insurers as premium subsidies, supplement this federal money with non-federal

³³ 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>

³⁴ 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>

sources, and then use the resulting pool of money to pay medical claims for policyholders who incur high medical bills. Since this process would reduce premiums, it also would reduce federal premium subsidies, making it budget neutral to the federal government.”

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

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

OTHER OPTIONS TO SOLVE THE PROBLEMS IN OUR HEALTH SECTOR

A group of policy experts—the Health Policy Consensus Group³⁵—has developed a plan³⁶ to help the millions of people who are struggling to afford health insurance, particularly in the small group and individual markets, to have access to more choices of more affordable insurance while protecting the poor and the sick, including those with pre-existing conditions.

It is based upon formula grants to the states, using existing Obamacare resources, but with guidelines that incentivize states to provide people with more choices of more affordable coverage (and even provide an option for some people on Medicaid and CHIP to obtain private coverage, if that is their choice). It provides generous resources for those needing help in purchasing coverage and important protections for those with expensive and chronic illnesses. It is based upon a plan that came closer than is commonly believed to passage in the Senate in the fall of 2017.

Unlike the ACA, the Health Care Choices plan has money dedicated to creating guaranteed protection programs. Rather than forcing those participating in the ACA insurance pools to pay extra to support people with high medical expenses, we would stipulate that dedicated resources be devoted to providing extra financial support for their care.

By putting the sickest people in the same pool with others, premiums are higher, often much higher, for those not eligible for subsidized exchange coverage. Virginia State Sen. Bryce Reeves read in a recent speech³⁷ an email he received from one of his constituents in

³⁵ The Health Policy Consensus Group is comprised of state health policy experts, national think tank leaders, and members and leaders of grassroots organizations across the country. Participants are committed to market-based policy recommendations that give people access to the health plans and doctors they choose at a price they can afford so that they can get the care they need, with strong protections for the most vulnerable.

³⁶ www.healthcarechoices2020.org

³⁷ Grace-Marie Turner, “Health Care Choices Proposal: A New Generation of Health Reform,” *Forbes*, June 22, 2018. <https://www.forbes.com/sites/gracemarieturner/2018/06/22/health-care-choices-proposal-a-new-generation->

Fredericksburg. The constituent wrote he made a good living and tried to provide for his family. But his insurance premiums cost \$4,000 a month! “That’s more than my mortgage,” he told Sen. Reeves. There is only one carrier offering coverage in his area. “What am I supposed to do?”

An analysis by the Center for Health and Economy has shown the Health Care Choices Plan would reduce premiums by one third while keeping coverage numbers level.³⁸ By encouraging healthy people to remain covered, insurance pools are healthier, and resources can be directed to help those with greater health 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 takes away coverage options, will pay providers less, reduce access to new technologies, stifle innovation, and result in a near-doubling of the tax burden.

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.

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³⁸ <http://healthandeconomy.org/the-health-care-choices-proposal/>