The Heritage Foundation

NO CHOICE, NO EXIT

The Left's Plans for Your Health Care

edited by

MARIE FISHPAW *and* ROBERT E. MOFFIT, PHD

More praise for

NO CHOICE, NO EXIT

The Left's Plans for Your Health Care

"

Big government is especially pernicious when asserting control over an individual's health care. A bill which received an all-day hearing in a House of Representatives committee would do just that, resulting in a complete government takeover of health care. This book provides a go-to source as we continue the difficult debates about the federal presence in health care.

—REP. MICHAEL C. BURGESS (R-TX-26), MD

"

No Choice, No Exit: The Left's Plans for Your Health Care cuts through the rhetoric to explain the consequences of proposals purporting to save a family money by raising their taxes and limiting their health care choices. The publication is timely as health care will be part of the debate for the presidential campaign and into the next Congress. Americans who wish to understand this debate should read this book.

—SEN. BILL CASSIDY (R-LA), MD

"

Health reform remains a top priority for Americans. They're concerned about high costs, access, and choice. This book explicitly shows how the Left's plan for your health care fails to address those concerns.

—JOHN GOODMAN, PHD, FATHER OF HEALTH SAVINGS ACCOUNTS AND CO-AUTHOR OF BEST-SELLING BOOK *PATIENT POWER*

"

This important collection cuts through the Left's rhetoric on health care to highlight the danger of over-centralization and government control. American health care faces real problems, but the Left would only double down on them.

—YUVAL LEVIN, PHD, DIRECTOR, SOCIAL, CULTURAL, AND CONSTITUTIONAL STUDIES AT AMERICAN ENTERPRISE INSTITUTE AND EDITOR IN CHIEF, *NATIONAL AFFAIRS*

"

It has never been more important than now to understand what a single-payer system would mean. This is a "must read."

—GAIL WILENSKY, PHD, ECONOMIST AND SENIOR FELLOW, PROJECT HOPE

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edited by

MARIE FISHPAW *and* ROBERT E. MOFFIT, PHD

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From the President of The Heritage Foundation

KAY C. JAMES

High-quality medical care is more than just having good insurance coverage. It is also about having the right medical professional who can accurately diagnose your issue, it is about getting timely access to the medical treatment or procedure you need, and it's about having a trusted relationship with your physician where you have confidence in the help and advice she is giving you.

Unfortunately, too many politicians want to insert government even further into these very personal aspects of our health care. They might dress up more government intrusion with nice-sounding terms like "free health care," "public option," "Medicare for All," or "moderate" alternatives. But do not be fooled. When the federal government gets more say in your health care decision-making than you do, you end up paying the price—both financially and with your health care options.

Even the so-called public-option plans—where the government becomes an insurer that competes with private insurance companies—are a path to "single payer" government-controlled care. Because the government can use its regulatory power to set its prices below those of its private-market competitors, private insurers would disappear and the government plan would become the only available coverage.

This book details the truly devastating impact that single-payer proposals would have on Americans. As seen in so many other countries, government-run health care would mean long wait times to see doctors and for surgeries. It would also mean reduced access to advanced life-saving

technologies and pharmaceuticals. Furthermore, the leading single-payer proposals in Congress would require massive tax increases that would result in most Americans paying more for health care than they do today.

That is right. Ultimately, under these "free" or "virtually free" single-payer proposals, nearly two-thirds of American households would end up paying more. Yet, few politicians who support such proposals will ever admit that.

When the government controls the health care system, patients do not have a choice of coverage. When government officials are in charge, they dictate which care you get, how you get it, under which circumstances you get it, and—depending on the length of the waiting lists—when you get it.

If you think your insurance company is stingy when it comes to covering certain claims or is terrible at providing customer service, wait until the government is the only "insurer" in the country and there is no competitor to drive prices down or drive quality up.

In a system that is already smothered in excessive rules, regulations, and paperwork, these bills would add new layers of government bureaucracy.

Today, the United States is the world's leader in medical innovations and in the development of breakthrough medicines. When it comes to combating cancer and heart disease—the world's leading killers—the United States outperforms every other advanced country on the planet. It is not surprising that the United States is a destination for citizens who live in countries with government-run health care systems, such as Britain and Canada.

There is no denying that there are some serious systemic problems in American health care. While almost every citizen has access to either public or private insurance, outdated laws and excessive regulation still frustrate their ability to choose plans that best meet their needs. The quality of care is uneven, especially in Medicaid and other public programs. Moreover, health care costs are still too high.

Most of these problems are the result of excessive government interference in health care in the first place. They certainly will not be solved by resorting to more government control. Instead, every one of these problems can be resolved with sound, targeted health care policies that expand the personal freedom of patients and the professional independence of doctors while reducing excessive regulation and outdated government interventions.

In the final analysis, the national debate on health care is a debate over power and control. The Left's agenda cedes control over health

care dollars and the delivery of medical benefits to government officials. Experience from other nations and extensive analyses of current proposals show that this kind of system leads to just the opposite of what is being promised: Costs go up and health care access and quality go down.

The way to better health care starts with getting government out of the way and shifting the power and decision-making authority from politicians and bureaucrats back to patients and their doctors. Ultimately, that will lead to lower costs, greater innovations, and better health care outcomes for everyone.

Kay C. James, President
The Heritage Foundation
September 2020

Government-Controlled Health Care: Rhetoric Versus Reality

MARIE FISHPAW *and* MERIDIAN PAULTON

Leading lawmakers are advocating proposals that would vastly increase the role of government in health care. Some argue for an approach that would abolish nearly all existing coverage arrangements and replace them with a single, government-controlled plan. Others argue for a more "moderate" incremental approach, that would create a new government-controlled health plan to "compete" with existing, private arrangements.

These ideas are increasingly popular with some Members of Congress and the public at large. Which should come as no surprise: Proponents of a government-controlled system (also known as a single-payer system) in the United States make numerous claims about the benefits of such a system. Among them are:

- "Public option" proposals are a more "moderate" version of single-payer that would allow Americans more choices of coverage, by creating a new government plan that would compete against existing private coverage.
- Single-payer health care can effectively build on the Medicare program via a proposal called Medicare for All.
- The average American family would be financially better off under Medicare for All.

- Government-controlled health care would ensure that everyone has equal access to high-quality health care.

- Single-payer health care would save money by eliminating the administrative costs generated by private health insurance.

These claims are false. There is a wide gap between the rhetoric and the reality. Policymakers should reject single-payer policies, which impose a high cost on patients and put medical coverage decisions in the hands of government bureaucrats. Leaders should support policies that reduce costs and empower consumers to make their own personal medical decisions.

Rhetoric: Public Option Proposals Are a "Moderate" Alternative to Single Payer.

The public option was once considered too far reaching … but it is now seen as a more moderate alternative to Mr. Sanders' plan, which would all but eliminate private health insurance and enroll everyone in a government-run plan.

—The New York Times[1]

Reality: "[T]he public option is a Trojan horse with single-payer hiding inside."

—Seema Verma, Administrator, Centers for Medicare and Medicaid Services, The Washington Post, July 24, 2019

The truth is that, other than timing, there is little difference between the public options and Medicare for All proposals. There are seven leading public option proposals, as outlined in this book. They each do slightly different things, but all rely on a government health plan competing directly against private health plans—rather than outlawing virtually all private coverage and replacing it with a single government plan. Yet, the economic and political dynamics of these public option proposals would still lead to a single, government-controlled health care system, though more gradually and generally without explicit initial tax increases.

And this is by design. As then-Representative Barney Frank (D–MA), who, during the debate on Obamacare, said, "I think that if we get a good public option, it could lead to single payer and that is the best way to reach single payer."

Research by Dr. Lanhee Chen, a health policy analyst with the Hoover Institution at Stanford, finds that public option proposals

> would increase the federal deficit dramatically and destabilize the market for private health insurance, threatening health-care quality and choice....

> The fiscal effects are even more pronounced over the long run. We estimate that federal spending on the public option would exceed total military spending by 2042 and match combined spending on Medicaid, the Children's Health Insurance Program and ACA subsidies by 2049. In the latter year the public option would become the third most expensive government program, behind only Medicare and Social Security....

> Beyond fiscal considerations, the public option would quickly displace employer-based and other private insurance. This would force some private insurers to exit the market and encourage greater consolidation among remaining insurers. Consumers seeking coverage would be left with fewer insurance options and higher premiums.

> Meanwhile, many health-care providers would suffer a dramatic drop in income, while at the same time experiencing greater demand for their services. Longer wait times and narrower provider networks would likely follow for those enrolled in the public option, harming patients' health and reducing consumer choice. Declines in provider payments would also affect investment decisions by hospitals and may lead to fewer new doctors and other medical providers.[2]

The end result? A "Medicare for All" program, just with more intervening steps.

Rhetoric: "Medicare for All" Builds on the Medicare Program.

> *We need to build on the strength of the 50 years of success of the Medicare program.*[3]
>
> *—Friends of Bernie Sanders*

Advocates point to the Medicare program as the foundation for their plan and claim their plan would add new benefits for seniors. They make use of the program's enormous popularity, not only with seniors, but with the public; they claim that it provides guaranteed benefits, financial security, and broad access to care.[4]

Reality: Medicare for All Would Abolish Medicare as We Know It.

Under the two leading congressional proposals, Medicare itself would be replaced by the new government health insurance program. Over 63 million seniors and disabled Americans would be displaced from their current Medicare coverage and transferred to the new national health insurance program.[5]

Medicare "as we know it" includes several programs. Traditional Medicare is a "fee-for-service" program that provides coverage for hospital services (Medicare Part A) and physician and outpatient services (Medicare Part B) and optional coverage for prescription drugs (Medicare Part D). Seniors and certain disabled citizens who choose these programs can also purchase and enroll in supplemental coverage (Medigap) to fill in significant coverage gaps in traditional Medicare, such as coverage for catastrophic illness. Alternatively, seniors can forgo the traditional program and enroll in Medicare Advantage (Medicare Part C), which is a defined contribution system of competing private health plans that offer comprehensive benefits packages. These plans must offer the traditional Medicare hospitalization and physicians' benefits but can also offer a variety of benefits that traditional Medicare does not cover, including catastrophic coverage. Under the House and Senate "Medicare for All" bills, those private health plan options, as well as the traditional Medicare program, would be abolished and replaced by the new government plan.

Rhetoric: The Average American Family Would Be Financially Better Off Under Medicare for All.

> *Under Medicare for All the average American family will be much better off financially than under the current system, because you will no longer be writing checks to private insurance companies.... While, depending on your income, your taxes may go up to pay for this publicly funded program, that expense will be more than offset by the money you are saving by the elimination of private insurance costs.*[6]
>
> *—Senator Bernie Sanders*

Government-controlled health care, according to its advocates, would be less expensive for working families. Diane Archer, founder of the Medicare Rights Center, writes, "Under Medicare for All, the typical family will see higher wages and lower expenses and spend much less on health care than it does today."[7] While single-payer advocates acknowledge that federal taxes would increase, they also claim that the overall

cost to the consumer would be less with the elimination of premiums and with the additional savings generated from a combination of consolidated administrative costs, reduced provider reimbursements, and superior government cost control.[8]

Reality: Americans Would be Financially Worse Off Under Medicare for All.

Original research by Heritage Foundation scholars shows this claim to be false. Politicians and advocates for government-controlled care are promising far more than they can deliver.

All told, roughly three-quarters of Americans would be worse off. That's because they would pay more in additional taxes than they would save from no longer paying privately for health care. Paying for the new program will require taxes to go up—a lot. Fully funding Medicare for All requires a new, additional tax of 21.2 cents on every dollar every American earns. That is on top of what they pay now (an average of 31 percent in total federal, state, and local taxes)—meaning that, under Medicare for All, working Americans would see half their paychecks going to the government.

Households that currently have employer-sponsored coverage would be particularly hard hit, as their disposable incomes would shrink by an average of $10,554, and 87 percent of them would be financially worse off. Even lower-income working families, currently getting health care through government programs such as Medicaid and the Children's Health Insurance Program, would be worse off. Their average household disposable income would decline by $5,592 per year. Depending on how much they earn and where they get their coverage today, Medicare for All would cost some working families more than what they pay for electricity; for others, it would exceed their gasoline budget; and for others, their food budget.[9]

Rhetoric: Single-Payer Health Care Would Ensure that Everyone Has Equal Access to High-Quality Health Care.

> *A single-payer system will ensure that everyone has access to a single tier of high-quality care, based on medical need, not ability to pay.*[10]
>
> *—Physicians for a National Health Program*

Advocates argue that single-payer health care would replace the current system of public and private coverage that exists today with guaranteed, universal coverage so that everyone would have a basic level of health care.

Reality: In Government-Controlled Health Care, Universal Health *Coverage* Is Not the Same as Universal Access to *Care*.

Coverage is not the same as *care*. The British National Health Service (NHS) and Canadian health systems (both single-payer systems) establish "global" budgets for health care spending. These take the form of annualized caps on aggregate heath spending. While these measures are designed to control costs, they often result in long waiting lists, and thus delays and denials of care. In both systems, these waiting lists are well documented, and they highlight the inevitable problems patients face in accessing care.

Waiting lists, in particular, are a significant problem in the Canadian system. In 2017, Canadians were on waiting lists for an estimated 1,040,791 procedures.[11] Physicians reported that only about 11.5 percent of patients "were on a waiting list because they requested a delay or postponement."[12] Often, wait times are lengthy. For example, the median wait time in Canada for arthroplastic surgery (hip, knee, ankle, or shoulder) ranges from 20 weeks to 52 weeks.[13]

By contrast, the United States outperforms other developed countries in wait times. A 2018 study of 11 developed countries published in the *Journal of the American Medical Association* found that in the United States, only 6 percent of patients waited two months or longer to see a specialist.[14] In Canada, 39 percent of patients had to wait that long, and in the United Kingdom, 19 percent experienced the same wait time.

In the British NHS, cancellations are common. In 2017, the NHS canceled 84,827 elective operations (in England alone) for non-clinical reasons on the very day the patient was due to arrive.[15] The same year, the NHS canceled 3,845 urgent operations in England.[16] Episodes of frequent illness tend to aggravate this problem. During the 2018 flu season, for example, the NHS canceled 50,000 "non-urgent" surgeries in England.[17]

American medical interventions, particularly for cancer, stroke and heart disease, are particularly impressive. In the aforementioned *JAMA* study, researchers noted that "the United States had among the highest breast cancer screening rates and the lowest 30-day mortality rates for acute myocardial infection and stroke."[18]

In the United States, the Veterans Administration (VA) health program and the Indian Health Services (IHS), both government-run health care programs, have a history of poor performance.[19] With the VA, America's veterans suffered from shocking delays and denials of care. A few years ago, the Chairman of the U.S. House Committee on Veterans Affairs

requested an investigation by the Office of Inspector General into concerns that tens of thousands of veterans had died waiting for care.[20] These concerns led to congressional efforts to allow veterans to seek care from private doctors outside the VA system.[21]

Not only patients, but also doctors, would face a more difficult practice environment under a single-payer program. Earlier this year, the *British Medical Journal* published a study of general practitioners who have left practice or are planning to leave.[22] The most commonly cited reasons were the lack of professional autonomy, administrative challenges, and increasingly unmanageable workloads.

Rhetoric: Single-Payer Health Care Would Save Money by Eliminating the Administrative Costs of Private Health Insurance.

> *Such a single-payer system would address one of the major deficiencies in the current system: the huge amount of money wasted on billing and administration.*[23]
>
> *—Senator Bernie Sanders*

Senator Sanders and other single-payer proponents argue that the country as a whole would save money under a government-controlled health care system, in part because of savings generated from reduced administrative costs. They argue that administrative costs (as a percentage of total costs) in Medicare are smaller than in private insurance,[24] and that therefore Medicare for All could squeeze out additional administrative costs through consolidating and centralizing administration at the federal level.[25]

Reality: Administrative Savings Would Likely Be Small, and Administrative Costs Would Shift to Health Care Providers.

Comparing Medicare and private sector-administrative costs (administrative costs versus benefit expenditures) is not as simple as it may seem. Medicare's administrative costs routinely appear low, but that is only because Medicare incurs such high claims costs that the administrative costs appear comparatively low. For example, a 2009 study by former Heritage Foundation Research Fellow Robert Book found that Medicare's administrative costs were somewhere between 3 percent and 8 percent of total costs, depending on whether calculations included costs incurred by non-Medicare agencies (such as the IRS).[26] In contrast, administrative costs in employer-sponsored insurance were between 14 percent and 22

percent.[27] Thus, on the surface it looked like Medicare was more efficient than employer-sponsored insurance by a wide margin.

The truth is the opposite. In 2005, according to the same study, Medicare's administrative costs were $509 per primary beneficiary, whereas private plans' administrative costs were $453 per beneficiary.[28] This is because employer-sponsored insurance costs less on a per capita basis than Medicare. Medicare's claims costs are high because its population consists of the elderly and disabled—populations with high claims costs. When Medicare's administrative costs are compared to claims costs, the administrative costs appear low. Conversely, employer-sponsored insurance covers a wider range of people, including those with much lower claims costs. Thus, when Medicare's per capita administrative costs are compared to per capita claims costs, the administrative costs appear high.

In any case, administrative costs are not necessarily a dead-weight loss. In private health insurance, administrative responsibilities include health care management and claims reviews, especially in efforts to reduce the costs of waste, fraud, and abuse. In sharp contrast to private health insurance, fraud and waste, including "improper payments" to providers, is rampant in federal health programs. The failure of competent administration also imposes a severe cost on the taxpayers. As Charles Blahous of the Mercatus Center noted, "The Government Accountability Office found approximately $96 billion in improper Medicare and Medicaid payments in 2016, by itself more than twice the total government expenditures on health insurance administration."[29]

A Better Alternative

It is not surprising that Americans are looking for a solution to America's health care problems—rising costs and gaps in coverage and quality. Government laws, regulations, and policies contributed to rising private market costs and reduced health plan choices

Naturally, this situation frustrates many Americans. According to a 2019 Gallup Poll,[30] 55 percent of respondents say they worry a great deal about the availability and affordability of health care—making health care their top concern.

These concerns can't be answered by further expanding government control over American health care. That path ends in unprecedented tax increases and public debt, discourages innovation, and gives politicians too much control over deeply personal—in some cases, life and death decisions.

A different approach is needed.

Opposition to a single-payer system or some form of public option is not an endorsement of the flawed American status quo. The status quo is far more costly than necessary; its insurance and delivery markets are consolidated and uncompetitive; it frustrates consumer choice as well as competition; its performance on quality measures is uneven and largely dependent on whether or not one is stuck in Medicaid or in a geographically remote area that is medically underserved. Policymakers should address these issues head on.

At the same time, American health care has many bright spots that policymakers should respect and build on. To name a few: rapid responsiveness, excellent performance in addressing big ticket items such as cancer and heart disease, encouragement of innovation in advanced medical technology. These all have a direct and positive impact on improving the quality of American lives and reducing mortality. And, despite the current dysfunctionality of American insurance markets and the top heavy burden of bureaucratic paperwork, generated in *both* the public and private sectors, there are still big islands of excellence and efficiency in care delivery that are largely absent in other countries, such as shorter lengths of hospital stays, a greater provision of outpatient services, and a greater reliance on less costly and widely available generic drugs.

Health care reform should be creative, and not, like the progressives' single-payer proposals, destructive. Policymakers should build on what is best in American health care, including its embrace of advanced medical technologies and its superior capacity to combat deadly disease.

Reform should more closely mirror the goals Americans have for their health care. Policymakers should prioritize flexibility in coverage design and care delivery, and transparency in medical pricing and clinical performance. They should empower entrepreneurial providers to adapt quickly to changing conditions in the same fashion as private firms. And reform should empower consumers and expand their personal choices, so markets are consumer driven—rather than corporate dominated.

Any change should be evaluated by one, clear metric: Does it give Americans more control over their health care dollars and decisions?

Progressives' ideas fall far short on that metric. Americans deserve, and can do, much better.

SECTION 1

Public Option: The Trojan Horse to Government-Controlled Health Care

Introduction

Progressive policymakers advance public option proposals under the claim of moderation, but these proposals are a Trojan Horse for moving toward single-payer, government-controlled health care. And many of them are forthright about this goal. As the authors of Chapter 1 note: "Americans should not be surprised...that a public option leads to a single-payer, government-run health care system. And they should look to other government-run health care schemes, such as in Britain or Canada, to see the results—longer wait times, fewer providers, and less access to innovative treatments."

Prominent Democrats in the U.S. House and Senate tout the public option as a less radical approach to Medicare for All. But in reality, other than timing, there is not much difference between the two. The public option's incremental approach to a government takeover crowd out private insurance plans by shifting the cost of medical care to health care providers and the taxpayer, coercing doctors and other providers into joining the new government plan, consolidating participation in government coverage, and ultimately limiting access to care and services.

Public option proposals lessen personal choices in both the short and long run. By effectively subsidizing the government plan, it will appear less expensive than the private competitors in the near future. Then, once private plans are squeezed out, there will be no other choice but that which the government dictates. The public option would even drive out employer-based health insurance, leaving Americans with very

little agency over their own health care. As the authors state, "According to the U.S. Census, approximately 213 million Americans have private health insurance, primarily through their place of work. These public option proposals would undermine and erode private coverage in favor of government-run heath care."

To some public option advocates, this is a feature of their proposal, not a bug. Representative Jan Schakowsky (D–IL), who has co-authored legislation to advance a public option, notes: "I know that many of you... are single payer advocates, and so am I... Those of us who are pushing for a public health insurance option, don't disagree with the goal... This is a fight about strategy for getting there and I believe we will."[1]

Americans should be skeptical of public option proposals as they take away personal choice and replace it with an ill-equipped government health plan.

In Chapter 1, Heritage Foundation scholars Nina Owcharenko Schaefer and Robert E. Moffit, PhD, examine the leading public option proposals in the U.S. Congress, assess their negative impacts, and how these proposals would be used to achieve Medicare for All. They make it clear that this is one of the most pressing policy issues facing the country today—and why Americans should not be deceived by claims that a new government-run health plan would merely be another option.

CHAPTER 1

The "Public Option": Government-Run Health Care on the Installment Plan

NINA OWCHARENKO SCHAEFER *and* ROBERT E. MOFFIT, PHD

Don't get caught up in reports of divisions within the Democratic Party over "Medicare for All" vs. "public option" legislation.

Its candidates act as if there is some meaningful difference between the goals of Medicare for All and the so-called moderate public option legislation, but in truth, other than timing, there is little difference between the two.

Rather than outlawing virtually all private coverage and replacing it with a single government plan, as Medicare for All does, public option proposals would create a government health plan to compete directly against private health plans. Yet, the economic and political dynamics of a public option would still lead to a single government-controlled health care system.

One needs only to repeat the words of then-Rep. Barney Frank, D-Mass., who, during the debate on Obamacare, said, "I think that if we get a good public option, it could lead to single payer and that is the best way to reach single payer."

We looked at six leading public option legislative proposals. The bills differ in design, but all these proposals would tilt the playing field in favor of the public option, drive out existing private health coverage options, and ultimately leave the government plan as the dominant, or only, health plan in the insurance markets.

Setting aside the individual differences, here's how a public option scheme would work:

Step One: Create the illusion the government plan is less expensive by shifting costs to doctors, hospitals, and other providers.

All the public option proposals depend on some version of government payment. Government payment rates, such as those used in Medicare or Medicaid rates, serve as a warning against applying them more broadly.

For example, the Medicare trustees report that keeping the current Medicare payment rates for hospitals, nursing homes, and home health agencies will lead to less availability of medical services and "jeopardize" seniors' access to quality care.

In Medicaid, low payment rates also have led to less patient access to doctors and other medical professionals and diminished access to quality of care.

Step Two: Keep doctors and other providers from rejecting these low government payment rates by coercing them into joining the new government health plan.

This is done in the public option proposals by linking provider participation in other government plans to participation in the new government plan.

For instance, doctors who do not sign up for the public option could be forbidden from participating in Medicare or Medicaid.

Directly or indirectly, the public option proposals would establish a compulsory program by pressuring providers in one form or another to join the new public option or be banned from all government business. This would compromise the personal freedom and professional independence of physicians and other practitioners.

Step Three: Make private alternatives unaffordable.

After being pressured to participate in the public option and accept government rates, doctors and other medical professionals likely would seek to make up these losses by demanding higher payment from private health plans.

To keep their provider networks intact, private plans would have little choice but to either pay the higher rates or reduce their capacity.

This, of course, would lead to higher insurance premiums for consumers. The higher premiums would leave the private competitors with fewer enrollees and even higher costs.

Ultimately, many, if not most, of the private options would be driven out of the nation's insurance markets altogether.

Step Four: Consolidate power and control.

With more private competitors out of the way, the new government plan would either be the dominant health plan or the only plan available,

leaving patients without much choice in a shrinking private health insurance market.

Faced with the true and ever-growing cost of maintaining a government-run health plan, it would only be a matter of time before Congress compels taxpayers and patients to cover the losses and foot the bill for the new health care program.

The End Game. Given the underlying economic and political dynamics of these public option proposals, the results are predictable: a collapse of choice and competition in the health insurance markets, more costs shifted onto taxpayers and providers, and the erosion and elimination of private health care alternatives for patients and their families.

In the end, Americans should not be surprised by the consequences of a public option that leads to a single-payer, government-run health care system. And they should look to other government-run health care schemes, such as Britain or Canada, to see the results—longer wait times, fewer providers, and less access to innovative treatments.

Don't be fooled. In the end, a public option will be no different than so-called Medicare for All. It would just materialize on the installment plan.

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CHAPTER 2

The Public Option: Single Payer on the Installment Plan

NINA OWCHARENKO SCHAEFER *and* ROBERT E. MOFFIT, PHD

> *Whether conceived as an expansion of Medicare or the creation of a government health-care plan, the public option is a Trojan horse with single-payer hiding inside.*
>
> *—Seema Verma, Administrator, Centers for Medicare and Medicaid Services, The Washington Post, July 24, 2019*

Tactical differences aside, many liberal Democrats in Congress are diligently pursuing a common strategic goal: a government takeover of American health care.

The two leading legislative proposals to achieve that goal, the so-called Medicare for All proposals, S. 1129, sponsored by Senator Bernie Sanders (I–VT),[1] and H.R. 1384, sponsored by Representative Pramila Jayapal (D–WA),[2] would abolish virtually all existing coverage arrangements, private and public, and replace them with a single, national health insurance plan, centrally controlled and directed by federal officials in Washington, DC.

Short of such a drastic and direct federal takeover of American health care, a number of prominent congressional leaders and presidential candidates are proposing a more incremental approach to a government-controlled health care system through a "public option." A public option (public = government) is a new government health plan that would compete directly against private health plans. Proponents of this approach purport that it would enhance competition in the nation's health

insurance markets, expand choice for consumers, and reduce America's overall health care costs.

Yet, the dynamics inherent in the leading public option proposals would guarantee an outcome quite the opposite of the claims. The underlying components of these proposals—the power of the government to drive out private competition and coverage, compel provider participation in the government plan, consolidate enrollment into the government plan, and shift costs to taxpayers and providers—are the cornerstones of a single payer, government-run health system. Although touted as less radical than "Medicare for All," a government option would ultimately result in near-total government control of American health care.

The Public Option Concept

The public option and its purpose are not new. Helen Halpin, director of the Center for Health and Public Policy Studies at the University of California, and public option advocate Peter Harbage traced the origins of the public option concept to a 2001 state health care reform project in California.[3] From there, a national version of the public option concept was introduced in 2003 as part of the *Covering America Series*, funded by the Robert Wood Johnson Foundation. At the time Halpin wrote in a piece for the series that the public option, then called the CHOICE program, "is a new approach to health care reform that very quickly achieves nearly universal access to a single-payer health insurance system for all U.S. residents."[4] For liberals in Congress, arming the government with strong statutory and regulatory advantages to undercut private insurance emerged as the mechanism to achieve their long-sought single payer victory.

A Down Payment for Single Payer. In 2008, Democratic presidential candidate Barack Obama incorporated a version of the "public option" as a key component of his comprehensive health care reform agenda.[5] A public option was also a part of the 2009 legislative debate over the Affordable Care Act's (ACA's) creation. Though this public option was later excluded from the final version, during the 2009 congressional debate, then-Representative Barney Frank (D–MA) said: "I think that if we get a good public option it could lead to single payer and that is the best way to reach single payer. Saying you'll do nothing till you get single payer is a sure way never to get it.... [T]he only way, is to have a public option and demonstrate the strength of its power."[6]

Fully arming the government with powerful statutory or regulatory advantages, the public option would be the mechanism to, over

time, undercut private insurance, and pave the way for a single payer, government-run health care system.

The Leading Public Option Proposals: Single Payer on the Installment Plan

Short of launching an immediate, full-scale government takeover of American health care, as provided under the House and Senate "Medicare for All" bills, a number of House and Senate Democrats are sponsoring bills that create a "public option."[7] These proposals would grant the government the power to drive out private competition and coverage, coerce provider participation in the government plans, consolidate enrollment in favor of the government option, and shift costs of the government plan to taxpayers and health care providers. While these public options do not explicitly outlaw private coverage, all of these proposals put in place the infrastructure to facilitate a transition to a single payer system of government-run health care and an end to private coverage as we know it.

The Medicare for America Act of 2019 (H.R. 2452). Representative Rosa DeLauro (D–CT) is sponsoring H.R. 2452, the Medicare for America Act,[8] which has 24 Democratic co-sponsors and no Republican co-sponsors.[9] This proposal would establish a temporary public option and transition to a more robust government-run health plan, which lays the foundation for a potential single payer model in the future.

A Transitional Public Option. The bill would establish a temporary public option that would be offered through the ACA exchanges for two years, and would be made available to those individuals eligible to purchase coverage through the exchanges and who are in an area where the Secretary of Health and Human Services (HHS) offers the public option.[10] This temporary public option must meet the benefit requirement of a qualified health plan as defined under the ACA, including ACA essential benefits.[11]

The HHS Secretary would set premiums for the public option. Premiums would be capped so that no individual or household will pay more than 8 percent of adjusted gross monthly income toward premiums. Federal subsidies would be set so that individuals with household incomes below 200 percent of the federal poverty level (FPL) ($24,980 for an individual/$51,500 for a family of four) would pay no premium, and those between 200 percent of FPL and 600 percent of FPL ($74,940 for an individual/$154,500 for a family of four) would receive a sliding scale subsidy.[12]

Payment rates for reimbursing services would be based on Medicare rates and set as necessary to "maintain network adequacy."[13] A health care

professional who is a participating provider in Medicare or Medicaid on the date of enactment would be a participating provider for the public option. The HHS Secretary would be required to establish a process to allow additional providers that are not in Medicare or Medicaid to participate in the public option.[14]

The act also states that "health care providers may not be prohibited from participating in the public health insurance option for reasons other than their ability to provide covered services."[15] Further, health care providers, hospitals or other institutions would be prohibited from denying individuals access to *any* covered benefits or services because of "religious objections."

The Medicare for America Act would establish a fund for the administration of the public option and would appropriate "such sums as may be necessary" from funds not otherwise obligated to operate the public option.[16] It also specifies that there would be no restriction on federal funds for the use toward *any* reproductive health services.[17]

The Medicare for America Plan. In 2023, the HHS Secretary would establish the "Medicare for America" plan, a more robust version of the initial, temporary public plan.

An individual who is a resident of the United States, who is lawfully present[18] or would be eligible for coverage under immigration exceptions described in Medicaid at the time of enactment,[19] would be eligible for enrollment in the Medicare for America plan.

Starting in 2023, the Secretary would automatically enroll in the Medicare for America government plan those individuals who are eligible at the time of birth, those Medicare beneficiaries enrolled in fee-for-service Medicare, future Medicare beneficiaries when they turn 65, and those individuals deemed to not have "qualified" health coverage as defined by the act.[20] Members of Congress and staff would also be enrolled.[21]

Under full implementation, traditional Medicare,[22] Medicaid, CHIP, and the ACA exchanges would be terminated, and enrollees of those programs would be enrolled in the Medicare for America plan.[23]

Individuals enrolled in "qualified" health plans, including newly defined qualified employer coverage,[24] military/TRICARE coverage, services through the Veterans Administration, the Federal Employees Health Benefit Program, and the Indian Health Services, would have the option of remaining on their existing plan or enrolling in the Medicare for America government plan.[25] The Secretary would also set up a process for allowing employers to enroll their employees into the plan.[26]

Moreover, as part of the enrollment process, the Secretary would issue Medicare for America identification cards. Participating providers in the

Medicare for America plan would be required to facilitate enrollment, as would state entities responsible for enrolling individuals in Medicaid and the Children's Health Insurance Program (CHIP).[27]

The Medicare for America plan would provide all benefits as covered under Medicare Parts A and B, Medicaid, and those "as determined to be medically necessary," including an extensive and highly specified list of services.[28] The Medicare for America Act would also prohibit a private insurer from selling coverage that duplicates benefits under the Medicare for America plan.[29]

Under the Medicare for America plan, individuals would pay a monthly community-rated premium set by the HHS Secretary. The premium would be based on benefit and administrative costs and family composition. Like under the transition, no individual or household would pay more than 8 percent of monthly income toward a premium, and federal subsidies would prevent individuals with household income below 200 percent of the FPL from paying a premium, and a sliding scale subsidy would be set for those individuals with household incomes between 200 percent and 600 percent of the FPL.[30] The Medicare for America Act would also set cost-sharing subsidies based on ACA gold-level coverage rather than silver-level coverage (as under the ACA), and would further reduce cost-sharing requirements by income.[31]

There would be no deductibles in the Medicare for America plan. The maximum out-of-pocket limit would not exceed $3,500 for an individual or $5,000 for a household, and there would be no lifetime or annual limits for services or benefits that are covered under the Medicare for America plan.[32]

The HHS Secretary would set provider reimbursement rates based on Medicare or Medicaid, whichever is higher. If benefits or services are not covered under Medicare or Medicaid, the Secretary would set a rate to ensure "adequate access" to services. In addition to other payment changes, the bill provides exceptions for inpatient and outpatient hospital services, where the payment rate would be set at 110 percent of the Medicare or Medicaid rate, whichever is higher. For hospitals serving underserved areas, the Secretary would increase the rate as necessary.[33] Moreover, providers would be prohibited from billing patients above government set payment rates, and providers would also be prohibited from entering into private contracts with individuals for services covered under the Medicare for America plan.[34]

As with the temporary public option, a health care provider who is a participating provider under Medicare or Medicaid on the date of

enactment would remain a provider under Medicare for America.[35] The HHS Secretary would also be required to establish a process to allow additional providers, who are not in Medicare or Medicaid, to participate in the public option.

The Secretary would "negotiate" rates for prescription drugs under the Medicare for America plan. If the Secretary is unable to reach an agreement with a manufacturer, the Secretary is authorized to use any patent, clinical trial data, or other exclusivity granted for the purposes of manufacturing the drug for sale to Medicare for America.[36] The bill also establishes a Prescription Drug and Medical Device Board to monitor and enforce a "prohibition on excessive drugs prices."[37]

The Medicare for America Act would establish a unified Medicare Trust Fund for the administration and operation of the Medicare for America plan. Any revenues attributable to Medicare for America and premiums collected would be taken from the general fund and deposited into the Trust Fund; as well as any amounts that would have been appropriated for Medicare and Medicaid[38] starting in 2027. Additional appropriations would be authorized "as needed to maintain maximum quality, efficiency, and access…"[39]

The act also stipulates that there would be no restrictions on federal funds for any reproductive health service, including abortion. The act also states that providers may not be prohibited from participating in Medicare for America "for reasons other than their ability to provide covered services," and that providers would be prohibited from "denying covered individuals access to covered benefits and services because of their [the providers'] religious objections" and would explicitly supersede any conscience protections.[40]

While the Medicare for America plan would not eliminate the Medicare Advantage (MA) program, it does set new requirements for MA plans. For example, an insurer could only offer coverage in the individual market if the insurer also agrees to sponsor coverage under the new Medicare Advantage (MA) for America program. The provider payment rates for MA for America would be set at 95 percent of the average Medicare for America cost in each county, and the payment rate for prescription drugs under MA for America would not exceed the amount set for prescription drugs under the Medicare for America plan.[41]

In addition to a variety of other health-related initiatives,[42] the act would establish a new services and support program for federal, home, and community-based, long-term care. Any individual who is eligible for Medicare for America and is unable to perform at least one activity as

defined under IRS rules would be eligible for services and support under this new program. State entities responsible for administering such services under Medicaid would be legally responsible for administering services under this new federal program.[43]

New Taxes. Title II of the act outlines a sundry list of new tax increases for taxpayers.[44] It would sunset the entire Tax Cuts and Jobs Act, add a 5 percent surtax on incomes that exceed $500,000, revise tax treatment related to inheritance property, increase the Medicare payroll tax from 2.9 percent to 4 percent, increase the net investment tax from 3.8 percent to 6.9 percent, terminate deduction for contributions to health savings accounts (HSAs), increase the excise tax on various tobacco products, increase the excise tax on alcohol, add a tax on sugared drinks, and repeal the ACA's excise tax on high-cost employer-sponsored health coverage.

Choose Medicare Act (S. 1261/H.R. 2463). Senator Jeff Merkley (D–OR) and Representative Cedric Richmond (D–LA) are sponsoring the Choose Medicare Act.[45] The bill has 15 Democratic co-sponsors in the Senate and seven Democratic co-sponsors in the House of Representatives. Neither have Republican co-sponsors.[46] The bill would establish a government-run plan (Medicare Part E) that would be in the individual, small group, and large group markets. Although not explicit, this proposal would put in place the regulatory infrastructure from which a single payer model could evolve from in the future.

An individual would be eligible for the new public option if he is a resident of the U.S., as defined by the Secretary of HHS, and is not eligible for, or enrolled in, Medicare; is not eligible for Medicaid; and is not enrolled in CHIP.[47]

The Part E plans would be required to offer ACA gold-level coverage and meet the requirements of a "qualified" health plan as defined in the ACA, including ACA essential benefits, Medicare benefits, and all reproductive services, including abortion.[48]

The act would extend the ACA health insurance rating rules to the large-group market,[49] and would permit new federal rules and restrictions on insurance rates that the Secretary deems "excessive, unjustified, or unfairly discriminatory."[50] The bill would also pre-empt any state actions prohibiting the Part E plan from being offered in the state or prohibiting the outlined benefits.[51]

These plans would be available to employers on a voluntary basis one year after enactment. An individual who is enrolled in a Part E plan through her employer and later separates from her employer would be

able to maintain her enrollment in the Part E plan, regardless of whether that individual has access to new coverage through a new employer.[52] It would also require employers who do not provide "qualified" coverage, meaning the employer coverage is deemed "unaffordable" or does not meet minimum actuarial value, to refer employees to an ACA Navigator and authorizes appropriations for "such sums as may be necessary" for the Navigator program to carry out related tasks.[53]

The Secretary would set premiums for the Part E plans based on its offering in the individual, small-group markets, or large-group markets, and their rating areas. The plan's premiums would be required to be sufficient to fully finance the benefits and administrative costs of the plans and to comply with the requirements under the ACA.[54]

The act would change the benchmark for ACA premium tax credits from the second-lowest silver-level plan to the second-lowest gold-level plan, and would expand eligibility for the subsidy for persons with incomes from 400 percent to 600 percent of the FPL. The act would change the ACA cost-sharing subsidy from silver-level coverage to gold-level coverage, and would further reduce cost sharing by income level.[55]

The Secretary would set reimbursement for services at levels that are not lower than Medicare rates and not higher that the average rates in the ACA exchanges. [56] The bill would also require the Secretary to negotiate rates for prescription drugs in Medicare Part D, Medicare Advantage Prescription Drug plans, and for the new Medicare Part E plans.[57] If the Secretary is unable to reach an agreement with a drug manufacturer after one year of negotiations, reimbursement rates will be set at the price paid by the Veterans Administration or as set by the federal government through the Federal Supply Schedule.

A health professional who is a participating provider under Medicare would be assigned as participating provider under the new Medicare Part E plan and a process would be established to accept providers who do not participate in Medicare.[58] The bill would also impose the same Medicare balance-billing limitations—the prohibition on medical professionals to charge any amount above the Medicare payment—on participating providers in Part E.[59]

The bill would appropriate $2,000,000,000 out of funds not otherwise obligated for fiscal year (FY) 2020 for purposes of establishing the Part E program, and "such sums as may be necessary" for the first year to fund initial claims. The bill would establish a reinsurance fund and appropriates $30,000,000,000 out of funds not otherwise obligated for two years for the states to provide reinsurance payments to insurers or to provide

assistance to reduce out-of-pocket costs for individuals enrolled in plans through the exchanges.[60]

The proposal would remove any federal funding restriction for reproductive health services, including abortion.[61] In a similar vein, the bill includes a Sense of Congress supporting open access to reproductive services.[62]

Medicare-X Choice Act of 2019 (S. 981/ H.R. 2000). Senator Michael Bennett (D–CO) and Representative Brian Higgins (D–NY) are sponsoring the Medicare-X Choice Act.[63] The bill has 11 Democratic co-sponsors in the Senate and 25 Democratic co-sponsors in the House of Representatives. Neither has a Republican co-sponsor.[64] Similar to the Choose Medicare Act, the bill would establish a new government-run health plan (Medicare-X) that would be available in the individual and small group markets. This proposal, although not explicit, would put in place a regulatory framework for a single payer model to evolve from in the future.

The Medicare-X Choice Act would offer a government plan (Medicare-X) through the ACA exchange. An individual would be eligible to enroll in the Medicare-X plan if the individual is qualified to purchase coverage through the ACA exchanges and is not eligible for Medicare.[65]

Starting in 2021, the plan would be available in priority areas, as determined by the Secretary, where no more than one health plan is offering coverage in the ACA exchange or where there is a shortage of health care providers or a lack of competition. Availability of the Medicare-X plan would increase so that the plan is available to all residents in all rating areas by year 2024 and to the entire small-group market by 2025.[66]

The Medicare-X plan would have to comply with the same requirements as those of the ACA, as well as other federal health insurance requirements.[67] The Medicare-X plan would offer ACA silver-level and gold-level coverage, and may offer no more than two versions of the plan for each of the four ACA coverage levels. After 2021, all enrollees in a state would be in a single risk pool, unless the Secretary establishes, or the state has established, a separate risk pool for the individual and small-group markets.[68]

The Secretary would set premiums to cover the plan's full actuarial costs and administrative costs. The premiums would vary by geographical region and between the small-group and individual markets.[69] The bill would require that, if premiums collected are in excess of costs, the funds will remain available to the Secretary for administration in subsequent years. The bill would also expand availability of the ACA premium tax credit for those individuals earning below 100 percent of the FPL and for

those earning above 600 percent of the FPL, and make it more generous for certain groups.[70]

The Secretary would set reimbursement for health care providers at Medicare fee-for-service rates.[71] The Secretary would be able to increase reimbursement rates by 25 percent for services in rural areas. The proposal would require the Secretary to "negotiate" prescription drug payment rates for Medicare-X, and would remove the existing prohibition forbidding government intervention in setting prices for in Medicare Part D.[72]

The proposal would set as a requirement that a provider must participate in Medicare-X if he is also participating in Medicare or Medicaid.[73] The Secretary would establish a process for providers who wish to opt out of Medicare-X, and to accept new providers who are not participating in Medicare or Medicaid.

The Treasury Department would establish a Plan Reserve Fund, and the Secretary of HHS would administer the fund.[74] The bill would appropriate $1,000,000,000 out of funds not otherwise obligated for FY 2020. There would also be a fund established at the Treasury, also administered by the Secretary of HHS, for updating technology and data collection for purposes of establishing appropriate premiums.

The bill would also direct the Secretary to establish a national reinsurance mechanism to pool the cost of the highest-cost patients with individual coverage (on and off the ACA exchange). The bill would authorize the appropriation of $10,000,000,000 each fiscal year for 2021, 2022, and 2023.[75]

Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act (S. 1033/H.R. 2085). Senator Sheldon Whitehouse (D–RI) and Representative Jan Schakowsky (D–IL) have sponsored this bill.[76] It has eight Democratic co-sponsors in the Senate and 20 Democratic co-sponsors in the House. Neither has Republican co-sponsors.[77] Like others, the CHOICE Act would establish a new government-run health plan and would put in place the regulatory framework needed for a single payer model in the future.

The CHOICE Act would make a government plan available through the ACA exchanges at the silver and gold levels, and may also offer coverage at the bronze level. The government plan would comply with the ACA's various insurance requirements and would be required to offer "comprehensive" benefits, including ACA essential health benefits.[78] The bill would pre-empt any state laws that would prohibit a public option.

The Secretary would establish geographically adjusted premium rates for the public option based on ACA premium-rate requirements

and other data collected, at levels sufficient to fully finance benefit and administrative costs.[79] A state could establish a state advisory council to provide recommendations to the Secretary on policies to integrate quality improvement and cost-containment mechanisms, mechanisms to facilitate public awareness of the public option, and an alternative payment mechanism. The Secretary would be able to apply those recommendations to that state, in any other state, or all states.[80]

The Secretary would negotiate the plan's payment rates with providers. If the Secretary and providers are unable to reach an agreement, the Secretary would set provider reimbursement rates at Medicare fee-for-service rates and set payment rates for services not covered under Medicare. Similarly, the Secretary would negotiate payment rates for prescription drugs as well. If the Secretary were unable to reach an agreement, the Secretary would use Medicare fee-for-service rates, and would set payment rates for drugs not covered under fee for service.[81]

An account would be established at the Treasury for the administration of the public option. The bill authorizes "such sums as necessary" for start-up funding with the Secretary required to repay those start-up funds over a 10-year period, and authorizes additional appropriations as necessary. The bill also states that there would be no prohibitions on federal funding for "any reproductive health service," presumably including abortion.[82]

Health care professionals who are participating providers under Medicare or Medicaid would automatically be participating providers under the public option, unless the medical professional opts out of participating in the public option through a process determined by the Secretary. The Secretary would also establish a process to allow non-Medicare and non-Medicaid providers to participate in the new public plan. Participating providers would have to be licensed and certified under state law, and a provider could not be excluded for reasons other than his or her ability to provide covered services.[83]

Medicare at 50 Act of 2019 (S. 470). Senator Debbie Stabenow (D–MI) is sponsoring the Medicare at 50 Act, to expand the Medicare program.[84] The bill has 20 Democratic Senate co-sponsors and no Republican co-sponsors.[85] This bill would expand the Medicare program to individuals ages 50 to 64, and, although not explicit, its regulatory design, would put in place an infrastructure for a single payer model to emerge from in the future.

Under the act, individuals who are between 50 and 64 would be eligible for the new buy-in program.[86] Individuals who are eligible for Medicaid would not be eligible for the Medicare buy-in program, and states would

be prohibited from buying-in their Medicaid enrollees between 50 and 64 to Medicare, unless their Medicaid coverage does not meet "minimum essential coverage" under government-sponsored-plan requirements.[87]

Eligible individuals enrolled in the program would be entitled to the same benefits available in Medicare Parts A, B, C, and D. Individuals who enroll in the Medicare buy-in program would also be eligible to purchase Medigap coverage on a guaranteed-issue basis when they first enroll.[88]

The Secretary would determine a monthly premium based on an estimated combined per capita average for benefits and administrative expenses. Nothing would preclude an individual from choosing a Medicare Advantage or Part D plan that requires a higher premium, understanding the individual would be responsible for the premium difference.[89]

Medicare buy-in enrollees would not be eligible for traditional Medicare cost-sharing assistance, but enrollees would be eligible to receive assistance that is "substantially similar to the assistance the individual would have received" if obtaining coverage through the exchange.[90] The Secretary, with certification from Centers for Medicare and Medicaid Services (CMS) Actuaries and in consultation with the Department of the Treasury, would determine amounts that would be transferred from what otherwise would have been allocated to individuals in the exchange.

While not explicit in the text, the bill would presumably depend on participating Medicare providers and reimbursement rates for new enrollees. Section 3 of the bill would strike the current legal prohibition that forbids the Secretary to intervene in setting prices for Medicare prescription drugs.[91] In short, the bill would eliminate existing private market negotiations between health insurers and drug manufacturers.

The Secretary would award grants to entities, either states or nonprofit community-based organizations,[92] to carry out outreach, public education, and enrollment activities "to raise awareness of the availability of, and encourage enrollment" in this program, as well as the availability of premium assistance and cost-sharing reductions.[93] The bill would appropriate $500,000,000 out of funds not otherwise obligated for each year and prioritizes grants to those geographic areas with no qualified health plans available in the individual market.

Finally, the bill would establish a Medicare Buy In Oversight Board to oversee implementation and make periodic recommendations,[94] as well as a Medicare Buy In Trust Fund that would collect premiums and follow the same rules as applied to Medicare Part B.[95]

State Public Option Act of 2019 (S. 489/H.R. 1277). Senator Brian Schatz (D–HI) and Representative Ben Ray Lujan (D–NM) re-introduced the

State Public Option Act.[96] The bill has 22 Democratic co-sponsors in the Senate and 51 Democratic co-sponsors in the House of Representatives. Neither has Republican co-sponsors.[97] This proposal would allow states to open the Medicaid program as a government-run option for those individuals not currently eligible for Medicaid. Here, too, the regulatory design sets in place a framework for a single payer model in the future.

The bill would create, at state option, a new category of individuals eligible for Medicaid benefits who are residents of the state and who are not enrolled in another health plan.[98] It would require states to provide coverage that meets minimum "benchmark" coverage as defined in Medicaid,[99] and would require coverage of comprehensive reproductive health care services, including abortion services, as a condition of state Medicaid plan approval.[100] A state could also require an individual who obtains coverage through the Medicaid buy-in program to enroll in a managed care plan as a condition of receiving such services.[101]

A state would be able to impose premiums, deductibles, cost sharing, and other charges, but may only vary the premium based on those factors described in the ACA.[102] Premiums would not exceed 9.5 percent of household income, and cost-sharing requirements would be limited as set in the ACA.[103] An individual who qualifies for a premium tax credit and cost-sharing reductions under the ACA would also be eligible for a premium tax credit under the Medicaid buy-in program.[104]

With regard to reimbursement rates, while not explicit in the text, presumably state Medicaid payment rates would generally apply, with certain exceptions. For example, Section 4 of the act would set a federal floor for primary care services at the 100 percent of Medicare, and not less than the rate that was set in Medicaid for 2013 and 2014 or on the first day after enactment of this proposal.[105] Section 5 of the act would allow states that adopt the ACA Medicaid expansion to receive the full, enhanced match rate.[106] Additionally, it would extend an enhanced federal match rate of 90 percent for expenses related to the administration of the Medicaid buy-in program.[107] Finally, the bill would direct the Agency for Healthcare Research and Quality to develop standardized, state-level metrics on Medicaid enrollee access and satisfaction.[108]

How Public Option Schemes Expand Government Control and Weaken Access to Care

Though seemingly less radical than the leading House and Senate "Medicare for All" bills, the public option proposals nonetheless lay a firm foundation for a single payer, government-run health care system to

take hold in the future. All these proposals—whether they create a new government plan or broaden the scope of existing government programs (Medicare and Medicaid)—would erode and eventually eliminate private alternatives to the government health plan, compel provider participation, consolidate enrollment in the government plan, and shift costs to taxpayers and health care providers.

These public option schemes would:

1. **Drive Out Private Competition and Coverage.** According to the U.S. Census, approximately 213 million Americans have private health insurance, primarily through their place of work.[109] These public option proposals would undermine and erode private coverage in favor of government-run heath care.

   All the public option proposals either create or expand a government-run health program. The Medicare for America Act extends a public option as a transition to a robust government-run model. The Choose Medicare Act, the Medicare-X Act, and the CHOICE Act create a new government plan to be available in the private market. The Medicare at 50 Act and the State Public Option Act expand existing government programs—Medicare and Medicaid—as the base for the public option.

   An analysis of a plan broadly similar to the Medicare for America proposal found that job-based coverage would drop by 33 million, and that coverage in the individual market would drop by 12 million.[110] Similarly, analysis of the Medicare-X proposal found that job-based coverage would drop by 22.6 million persons and coverage in the individual market would drop by 12.6 million.[111] An Urban Institute analysis of various public option concepts found similar outcomes, with the number of persons enrolled in employer coverage dropping between 3 million and 16 million, depending on the scenario.[112]

   As Hoover Institute economist Scott Atlas points out, "[G]overnment insurance options erode, or 'crowd out,' private insurance, rather than provide coverage to the uninsured."[113] He also points out that Jonathan Gruber, a key architect of the ACA, found that public insurance expansions "clearly show that crowd-out is significant," with a crowd-out rate of about 60 percent.[114]

Reducing the un-insurance gap is important. However, the magnitude of the problem is less dramatic than proponents claim. The reason: Many of the uninsured are, in fact, eligible for coverage either with generous federal subsidies or coverage under other government health programs, such as Medicaid.[115] And yet, these public option proposals would undermine the existing coverage arrangements that the majority of Americans have today.

2. **Compel Provider Participation in the Government Plan.** In an attempt to prevent an exodus of health care providers unwilling to accept government payment rates, all the public option proposals, either explicitly or implicitly, would compel providers in existing government programs to also participate in the new government plan.

   The Medicare for America Act,[116] the Medicare-X Act,[117] and the CHOICE Act[118] would compel existing providers in Medicare and Medicaid to participate in the new government health plan. The Choose Medicare Act (Part E)[119] and the Medicare at 50 Act[120] would depend on existing Medicare providers, and the State Public Option Act[121] would depend on existing Medicaid providers.

   While the Medicare X Act[122] and CHOICE Act[123] would theoretically provide an opt-out for providers, the HHS Secretary would be in charge of establishing such an opt-out process for physicians who might prefer to not participate.[124] The Secretary, in other words, would be given the legal right to act like judge in his or her own cause, whether or not a physician or class of physicians can opt out of the Secretary's administered program.

   Armed with the power to determine conditions of participation, the federal government would obviously not be operating on anything resembling a level playing field. By force of law, the public option would have an inherent and unfair competitive advantage in securing provider participation and undermining private provider alternatives for consumers.

3. **Consolidate Enrollment in the Government Plan.** Despite what supporters purport, the public option would not expand choice. By design, the public option would drive out private competition and provide government privileges to the public option over private plans.

There are a variety of ways public option proposals would accomplish this objective. As directed under the Medicare for America Act, the government would simply auto-enroll groups into the government plan over time.[125] Other proposals would boost taxpayer-financed organizations. The Choose Medicare Act would use ACA's Navigators to expand enrollment in the public option,[126] while the Medicare at 50 Act would use "outreach" entities to promote the public option.[127] This, of course, is intended to drive consumers away from private alternatives and toward the public option; in short, deploy additional government resources to tilt the playing field in favor of the government plan. As explicitly noted in the Medicare at 50 Act, these entities are directed "to carry out outreach, public education activities, and enrollment activities to raise awareness of the availability of, and encourage, enrollment" related to this program.[128]

Other proposals would expand the availability of the government option through the exchanges.[129] Others, as outlined in the Medicare for America Act[130] and the Choose Medicare Act,[131] would expand availability of the public option to employers outside the exchanges. The Medicare at 50 Act and the State Public Options Act would offer new groups access through existing government programs.

Fueled by its unfair advantages, the public option will not increase competition nor increase choice. As private alternatives are driven out by the appearance of lower premiums and generous benefits in the government plan, those left in a rapidly shrinking individual private health insurance market are likely to experience even higher premiums and even fewer health plan choices.[132] Ultimately, it will drive competitors out of the market and enrollees into the government plan.

4. **Shift New Costs to the Federal Taxpayers.** There are a variety of ways the public option proposals would shift costs on to the federal taxpayer. While many of the proposals assume that the government premiums would cover benefits and administrative costs, it is unclear exactly how these proposals would be financially sustained over the long term.

   All the bills foresee new federal spending for the public option. For example, the Medicare for America plan would allocate "such sums as may be necessary" from Treasury funds not otherwise obligated to operate the temporary public option and would authorize future

appropriations "as needed to maintain maximum quality, efficiency and access."[133] The Medicare for America Act would also create an assortment of tax increases borne by federal taxpayers.[134]

The Choose Medicare Act would appropriate $2 million out of Treasury funds not otherwise obligated for initial operations and $30,000,000,000 for its reinsurance program, and would authorize "such sums as may be necessary" for its Navigator program.[135] The Medicare-X Act would appropriate $1,000,000,000 out of funds not otherwise obligated and authorize funding for its reinsurance program.[136] The CHOICE Act would authorize "such sums as may be necessary" for start-up funding, which in theory would be repaid by the Secretary, as well as other funds as may be necessary.[137] The Medicare at 50 Act would appropriate $500,000,000 in grants for outreach entities. The State Public Option Act would have the federal government assume a larger share of the cost to administer the Medicaid program.[138]

In the end, the political dynamics of such an arrangement are predictable: As private competitors leave the market, the public option absorbs more enrollees. Then, the resources to provide the promised benefits become scarce, and demand for more taxpayer dollars will intensify likely through the proverbial back door to keep the government plan afloat.[139]

5. **Shift Other Costs to Providers of Care and Treatments.** These public option proposals create the illusion that the government plan offers a lower cost option. In reality, the true costs are shifted not only to taxpayer but also to providers. All the public option proposals impose non-market, government payment rates as a way to shift costs to providers; and they put patient access to private care and medical treatments at risk.

   Some of the public option proposals would rely exclusively on Medicare payment rates to pay providers or reduce costs. This is the case with the Medicare-X Choice Act,[140] the CHOICE Act,[141] and the Medicare at 50 Act.[142] The Medicare for America Act[143] and the Choose Medicare Act[144] would use a hybrid system based on Medicare, Medicaid, or commercial plans in the ACA exchanges. The State Public Option Act assumes Medicaid payment rates, which are historically even lower than the relatively low Medicare payment rates.[145] In some cases, the negative impact of these artificial government payment

rates would be compounded by the prohibition of private contracting between patients and their physicians, outside of the government program. This restriction on personal freedom and privacy is an explicit feature of the Medicare for America Act[146] and the Choose Medicare Act,[147] and in the Medicare at 50 Act and State Public Option Act.

These public option proposals would also impose non-market, government pricing for prescription drugs. Virtually all of these bills would authorize the Secretary to "negotiate" directly with drug manufacturers and establish a government payment rate for prescription drugs. Some of the proposals go even further by creating a government fallback rate, as outlined in the Medicare for America Act, the Choose Medicare Act, and the CHOICE Act. Such triggers only make the "negotiations" even more one-sided, with the government threatening the power of a fallback payment.

Government "negotiation" over payment rates or prices does not normally resemble the kind of "give and take" negotiations that regularly take place between buyers and sellers within the private sector. Indeed, such government "negotiations" mean little when the main, or sole, purchaser of medical benefits and services *is* the government.

Government payment setting or price fixing, moreover, can also weaken patient access to care. The Veterans Administration's government pricing model for pharmaceuticals offers an example of how government rate setting affects patient access. A recent report by Avalere, a national research firm, found that "24 of the top 50 non-vaccine [Medicare] Part B drugs are not on the U.S. Department of Veterans Affairs' National Formulary."[148]

The government payment setting in Medicare also raises access concerns. The CMS Office of the Actuary and Medicare Trustees have repeatedly stressed that keeping even the current Medicare payment rates is on track to undermine access to care and the quality of care that would be available to senior citizens. As the 2019 Medicare Trustees report states:

> By 2040, simulations suggest approximately 40 percent of hospitals, roughly two thirds of skilled nursing facilities, and nearly 80 percent of home health agencies would have negative total

> facility margins, raising the possibility of access and quality of care issues for Medicare beneficiaries.[149]

Government-set payment rates have also led to access issues for patients in the Medicaid program. A 2019 study by MACPAC found that health care providers were less likely to accept new Medicaid patients than those privately insured.[150] Specifically, only 68 percent of general practice physicians accept new Medicaid patients, while 91 percent of general practice physicians accept new privately insured patients; only 37 percent of psychiatrists accept new Medicaid patients, while 62 percent accept new, privately insured patients; and 78 percent of pediatricians accept new Medicaid patients compared to 91 percent who accept new, privately insured patients.

Adopting a universal government price-setting model might make the public option plans appear less costly than private plans, but similar experience shows that it would undoubtedly have a negative effect on patient access to, and quality of, care.

The End Game: Government-Controlled Health Care for All

The original architects of the "public option" were clear in their objective: to deploy a government health plan in competition with private health plans in order to ultimately secure a single payer system of government-controlled health care.[151]

These proposals use measures that would drive out private competition, reduce choice, and increase costs for taxpayers.

As the government plan, with its statutory and regulatory advantages, consolidates enrollment and pushes out private competitors, the demand to keep the public option afloat will intensify. Rather than recognizing the failure of the public option to increase choice and competition, champions of more government control would likely pursue an even more robust, government-run a single payer model.

Public option proposals are gaining interest in Congress, and they are often presented as a less radical approach to single payer. While these proposals are sold as merely a government "option," in reality, these public option proposals lay the groundwork for a single payer system on the installment plan.

This paper was originally published as Heritage Foundation *Backgrounder* No. 3462 on February 4, 2020, and is available at https://www.heritage.org/health-care-reform/report/the-public-option-single-payer-the-installment-plan.

SECTION 2

Leading House and Senate Bills

Introduction

Single Payer. Medicare for All. These slogans for government-run health care proposals do little to illuminate the proposals' details or implications. This section takes a deep dive into what these proposals would do by examining the leading congressional bills to advance them. These bills enjoy broad support from congressional Democrats, sponsored by more than half of Democrats in the U.S. House of Representatives and 14 U.S. Senators.

The bills contain shockingly authoritarian measures. Americans could not keep their existing health plans. Instead, virtually all private coverage would be outlawed, and people would be enrolled in a new government health plan. Federal officials would have near-total control over America's health care financing, organization and delivery—meaning that nearly one-fifth of the economy would be run by the Washington bureaucracy. Politicians and bureaucrats in Washington would determine all benefits and coverage, and collect vast amounts of data to implement and enforce the government program. Doctors would face severe restrictions on their ability to practice medicine outside of the government program. While promising equality in coverage, only elites could access anything other than what government officials determine to be in Americans' best interest. And, while none of the bills contain any funding provisions, they do authorize a massive amount of new federal spending. Heritage Foundation scholars estimate that such an expansive program would require over a 20 percent tax increase on income. What the authors of these bills lack

in forethought, they more than make up for with their ambitious attempt to centralize power in Washington.

In this section, Heritage Foundation scholar Robert E. Moffit, PhD, takes a close look at the House and Senate bills' details and shows just how sweeping a change the authors of these proposals envision.

CHAPTER 3

House Democrats Unveil Plan to Bring Total Government Control Over American Health Care

ROBERT E. MOFFIT, PHD

Liberal House Democrats just unveiled the "Medicare for All Act of 2019," a comprehensive bill to abolish virtually all private health plans—including employer-sponsored coverage—and impose total federal government control over Americans' health care.

Despite its sweeping and detailed government control, as well as the imposition of huge but unknown costs, the 120-page bill has nonetheless initially attracted 106 Democrat co-sponsors, almost half of all Democrats in the House.

The legislation is profoundly authoritarian.

For example, section 107 ensures that no American, regardless of their personal wants or medical needs, would be able to enroll in any alternative health plan that "duplicates" the government's coverage.

Rep. Pramila Jayapal, D-Wash., the bill's primary sponsor, is at least open about the bill's intent: "The Medicare for All bill really makes it clear what we mean by 'Medicare for All.' We mean a system where there are no private insurance companies that provide these core comprehensive benefits."

Under section 201, Congress would decide the content of the health benefits package, what is and is not to be available in the new government health plan. The bill forbids cost sharing, a statutory prohibition guaranteed to induce demand and hike Americans' overall health costs.

Americans would not be able simply to spend their own money for medical care from a doctor of their choice. Personal contracts between

doctors and patients outside of the government plan would be tightly restricted. Under section 301, "...no charge will be made to any individual for any covered items or services than for payment authorized by this Act."

Under section 303, a provider "...may not bill or enter into any private contract with any individual eligible for benefits under the Act for any item or service that is a benefit under this Act."

Even private contracts for "non-covered" medical services require the doctor to report them to the Health and Human Services secretary. Section 303 also stipulates that a private contract between a doctor and a patient for "covered" services would be permissible if and only if the doctor signs and files the affidavit with the secretary of HHS and refrains from submitting any claim for any person "enrolled under this Act" for two full years.

Altogether, these restrictions, layered atop the prohibition on private insurance coverage, would virtually eliminate private agreements between doctors and patients.

In practice, Americans could spend their own money on their own terms with just the very few doctors who could afford to see cash-paying patients entirely outside the system.

In most respects, the new House bill is broadly similar to Sen. Bernie Sanders', I-Vt., bill. Beyond creating a government monopoly of health insurance, it centralizes key health care decisions in the office of the secretary of HHS; establishes a national health budget; and it creates a temporary Medicare-style "public option" (along with subsidies for enrollees) in the moribund Obamacare exchanges.

Like Sanders' bill, the House bill would also eliminate Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Federal Employees Health Benefits Program (FEHBP), the Obamacare exchange plans, and Tricare, the health program for military dependents. All of these beneficiaries would be absorbed into the new government plan; it would not be a matter of personal choice.

In striking contrast to the earlier version of the House "Medicare for All" bill, the new House bill contains no tax or funding provisions. This is a conspicuous omission. This is especially so because the House sponsors (under section 204) also incorporate long-term care coverage, including nursing home and community-based care, into the basic benefit package. This coverage would likely be hugely expensive.

Recall that independent analysts from the Mercatus Center and the Urban Institute roughly agree that the true 10-year cost of Sanders' similar plan would be approximately $32 trillion.

Ken Thorpe of Emory University, formerly an advisor to President Bill Clinton, estimates that the federal taxation needed to finance the Sanders' plan would amount to an additional 20 percent tax on workers' income, and more than seven out of ten working families would end up paying more for health care than they do today.

The federal spending and taxation needed to fund the new House bill would certainly be larger. Beyond the potential impact of the bill on the nation's deficits and debt, independent analysts and economists will also focus laser-like on the size and impact of the new federal taxes on individuals and families at various income levels.

Simply taxing "The Rich" will not cut it.

The House cosponsors of the Medicare for All Act intend a rapid transformation of American health care.

Under section 106 of the bill, they authorize the completion of this massive disruption of today's public and private health insurance arrangements within just two years.

In the meantime, analysts at the Congressional Budget Office have a very big job to do.

They need to get on it. Now.

Let the debate begin.

This article was originally published in The Daily Signal on February 28, 2019, and is available with links to sources at https://www.dailysignal.com/2019/02/28/house-democrats-unveil-plan-to-bring-total-government-control-over-american-health-care/.

CHAPTER 4

Total Control: The House Democrats' Single-Payer Health Care Prescription

ROBERT E. MOFFIT, PHD

Representative Pramila Jayapal (D–WA) and 112 other House Members are sponsoring the Medicare for All Act of 2019 (H.R. 1384). The bill thus enjoys the support of almost half the entire Democratic membership of the U.S. House of Representatives, while similar Senate legislation is being co-sponsored by leading candidates for the Democratic presidential nomination.[1]

The House bill, like its Senate companion—the Medicare for All Act of 2019 (S. 1129)—would confer enormous power on Washington officials, creating an authoritarian system of detailed federal control over virtually every aspect of American health care financing and delivery.[2] As Dr. Niran S. Al-Agba, an assistant professor at the University of Washington Medical School, and a practicing physician, explains, "Recent polls show a majority of Americans support 'Medicare for All,' but few seem to realize that no other system in the world operates like the current single payer proposals in Congress."[3]

The legislation would create a national health insurance program, while outlawing almost all private and employer-sponsored health insurance. It would abolish virtually all of the federal government's existing health programs, including Medicare, Medicaid, and the Federal Employees Health Benefit Program (FEHBP). It would also impose severe restrictions on the ability of doctors and patients to engage in private agreements outside the system.

According to a complete set of 2017 data, approximately 9 percent of the Americans are uninsured.[4] To achieve "universal coverage," the

congressional sponsors of the legislation nonetheless insist on outlawing the existing coverage of almost every other American. Only the relatively small number of enrollees in the U.S. Department of Veterans Affairs' (VA's) health benefits and the Indian Health Service would be allowed to keep their current coverage.

The Secretary of the U.S. Department of Health and Human Services (HHS) would be the central decision maker in the system. The Secretary would exercise enormous control over the financing and delivery of health care benefits and medical services and the availability and pricing of prescription drugs, as well as the conditions of participation and practice of doctors, nurses, and other medical professionals.

Major Consequences of "Medicare for All"

If the House bill were to become law, Americans could expect major changes to their health coverage, including:

Elimination of Existing Private and Employer-Sponsored Insurance and Coverage Plans. Under Section 107 of Title I of the House bill, it would be "unlawful" for any private health plan to offer any coverage that "duplicates" the coverage of the government health insurance program. With regard to employer-sponsored insurance, Section 801 of Title VIII, declares that "no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Act of 2019." That provision would outlaw the existing job-based health coverage of approximately 160 million Americans, regardless of whether they liked their health plans or not.[5]

Involuntary Enrollment of Medicare Beneficiaries and Other Health Program Recipients. Under Title IX of the House bill, two years after the date of enactment, all coverage ends for Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), the Tricare program for military dependents, the FEHBP, and the health insurance plans created under the Affordable Care Act (ACA) of 2010. As noted, only the VA and Indian Health Service programs (with a combined enrollment of just 9.9 million) would remain.

New Restrictions on Independent Doctor–Patient Agreements. The House bill would restrict the rights of doctors and patients to contract privately for medical services outside the national health insurance program. For physicians who "participate" in the program, there would be a financial penalty for entering into a private contract with a patient: The doctor would have to refrain from treating any other patient enrolled in the program for one full year. A tiny number of physicians might be able to

sustain a private, independent medical practice; the vast majority of doctors could not. As Dr. Adam Gaffney, president of Physicians for a National Health Insurance Program, admits: "Whether there's someone out in Beverly Hills who sees the stars and doesn't partake—that would be possible. The way the whole program is structured is really to make it such that that's a very insignificant overall phenomenon."[6] Escaping the system would be the prerogative only of well-situated elites.

Compulsory Taxpayer Funding of Abortion. According to Section 201 of Tile II, the bill provides coverage for "comprehensive, reproductive, maternity and newborn care." As *Politico* reports, "Though the word 'abortion' does not appear anywhere in the text, its authors have confirmed that it's covered."[7] The House bill also creates a Universal Medicare Trust Fund for the disbursement of all program funds, including provider reimbursements. Under Section 701 of Title VII, "Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health services shall not apply to monies in the Trust Fund."[8] In other words, the House bill would effectively nullify the Hyde Amendment and all other legislative restrictions on the use of federal funds for abortion.

Aside from reversing decades of federal policy restricting the use of taxpayer money for abortion, Section 103 of Title I specifies that no person can be "denied the benefits" of the program, and section 301 of Title III mandates that services are to be "furnished by the provider without discrimination." In short, the bill would apparently override the ethical objections of medical professionals who do not want to participate in abortion.[9]

Mysterious Financing and the Imposition of Large and Unknown Costs. Neither the Congressional Budget Office (CBO) nor the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) have released any cost analysis or budget estimates of either the House or Senate "Medicare for All" bills.

The House bill has no financing provisions, a notable departure from the earlier version of the House bill, H.R. 676.[10] Senator Bernie Sanders' (I–VT) bill also has no financing provisions. Like Senator Sanders, Representative Jayapal, however, has said that she would release a separate list of "potential taxes" to finance the program.[11] The congresswoman has not yet released such a list.

Focusing on Senator Sanders' broadly similar Senate plan, analysts from the Urban Institute and the Mercatus Center have previously estimated that the 10-year additional cost to federal taxpayers would be

approximately $32 trillion. In recent congressional testimony, Charles Blahous of the Mercatus Center and a former trustee of the Medicare program, noted that, based on his previous analysis of the Senate bill, the additional federal costs of Medicare for All could be as much as $38.8 trillion; and the total costs of health care—including the costs currently incurred by Medicare and Medicaid and other government and private health programs—could range between $54.6 trillion and $60.7 trillion over the first 10 years.[12] The addition of long-term care coverage to the House bill—a cost not included in Blahous's initial estimates—would mean that total costs of the most recent versions of the House and Senate bills would be higher.[13] As Blahous further noted: "We have no experience with enacting federal cost assumptions of this magnitude, which renders these numbers especially difficult for many to conceptualize."[14]

Thus far, the true cost of the legislation remains an elusive target of sophisticated guesswork. As noted, the CBO has not yet released a cost or tax estimate of the House bill, or of its Senate counterpart. Based on a variety of previous estimates of the Senate bill, however, aggregate federal spending would surely double, at the very least, along with the enormous taxes to sustain the program. Contrary to the claims of its champions, it is also unlikely that Medicare for All would yield significant overall savings.[15]

Displaced Workers and Families. Because the House bill would eliminate virtually all existing private health insurance, Representative Jayapal, the chief sponsor of the House bill, has conceded that the enactment of the legislation would cause an estimated 1 million health insurance workers nationwide to lose their jobs. To compensate, the bill would provide funding for a new program for displaced insurance industry workers and their families. Displaced workers would be able to receive financial assistance for up to five years following the date of the enactment of the act. The special assistance for the newly unemployed health insurance workers would compensate them for lost wages and retirement, as well as provide for job training and education benefits.[16]

However, the economic impact of the abolition of all private health insurance, as well as the anticipated government payment reductions to doctors, hospitals, and medical professionals, could be severe.[17] Moreover, the legislation would not only affect insurance company employees negatively, but also those engaged in ancillary services.

The Creation of a National Health Insurance Program

The House bill would create a "national health insurance program to provide comprehensive protection against the costs of health care and

health related services, in accordance with the standards specified in, or established under, this Act."[18] All people living in the U.S.—regardless of their legal status—would be eligible for the program.[19] According to the CBO, based on 2018 data, this would include an estimated 11 million people.[20] To deter migration for additional enrollment, the bill provides: "In regulating such eligibility, the Secretary shall ensure that individuals are not allowed to travel to the United States for the sole purpose of obtaining health care items and services provided under the program established under this Act."[21]

The Secretary "shall" also provide a "mechanism" for enrollment, including automatic enrollment at the time of birth and upon the establishment of residency in the United States. In all cases, the beneficiaries are to be issued a "Universal Medicare card."[22]

Universal Enrollment. Under Title I, Section 101, of the House bill, the HHS Secretary would be required to issue regulations for determining U.S. residency, and thus eligibility, for the program. The purpose of the bill is to ensure that "every person in the United States has access to health care."[23]

Under Section 103, the bill would establish "freedom of choice," meaning that an "eligible" person would be able to secure benefits and services from any "institution, agency or individual 'qualified' to participate under this Act."[24]

Under Section 104, the bill would forbid discrimination or the denial of medical benefits, items, or services to any resident of the United States. "Discrimination" would not only encompass discrimination based on race, sex, religion, or national origin, but also, "sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including the termination of pregnancy)."[25]

The House bill further provides that any person claiming to be a victim of discrimination would have a right to present a grievance through administrative channels, under procedures to be established by the Secretary, as well as a right of action in federal courts. The text makes clear that nothing in the new language of the bill concerning discrimination is to be construed in such a way as to invalidate the existing rights of persons who claim grievances under Section 1557 of the ACA, the Civil Rights Act of 1964, or any state laws that provide additional protections to persons claiming to be victims of discrimination.[26]

The Elimination of Existing Health Insurance

In creating a national health insurance program, the House bill would effectively eliminate almost all existing health insurance coverage, whether delivered by third-party payers in the public or the private sector.

Such legislation would thus impact approximately 246.5 million Americans under the age of 65 with health insurance, as well as nearly 59 million Medicare beneficiaries.[27]

According to Section 107 of Title I, it "shall be unlawful for (1) a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act; or (2) an employer to provide benefits for an employee, former employee, or the dependent of an employee of former employees that duplicate the benefits provided under this Act."[28]

Under Section 801, the bill prohibits employers from offering health insurance that provides benefits or services included in the government plan: "[N]o employee benefit plan may provide benefits that duplicate payment for any item or service for which payment may be made under the Medicare for All Act of 2019."[29]

Under Section 901, two years after the enactment of the legislation, the bill would abolish almost all major health care programs: Medicare, Medicaid, CHIP, Tricare, and the FEHBP. Under Section 701, on January 1 of the first year after the bill's enactment, the annual aggregate funding for these major government health programs would be transferred to a new federal trust fund: the Universal Medicare Trust Fund.

Under Section 902, two years after the legislation's enactment, all coverage for persons enrolled in any health plan being offered through the ACA's health insurance exchanges would also be terminated.

The Universal Medicare Trust Fund would also absorb projected funding for the maternal and child health care program created under Title V of the Social Security Act, and the vocational, and rehabilitation and mental health services programs established under the Public Health Service Act. The new trust fund would also get funding transfers from "any other program" identified by the HHS Secretary in consultation with the Secretary of the Treasury.[30]

These provisions are not only a radical and unprecedented restriction on the right of Americans to purchase their own health care coverage—they are also a dramatic departure from the practice of most other nations with "universal coverage."[31] As CBO analysts observe: "Some people might prefer to enroll in a substitutive insurance plan that suited their needs better than the public plan. Substitutive insurance might also improve the quality of care for people in both private and public plans."[32]

The Federal Standardization of Health Benefits and Services

The House bill would provide 14 categories of health care benefits and medical services, including long-term care services and supports

(LTSS). Though this is a comprehensive health benefits package, the Secretary is to review and evaluate these benefits and services at least annually, and make recommendations to Congress on proposed changes to the federal government's benefit offerings. The Secretary is to provide for medical services that are "medically necessary" and appropriate,[33] and conduct reviews and evaluations in light of emerging information related to changes in medical practice or advances in medical science and technology.

Congress, of course, would ultimately determine which medical benefits and services all Americans would receive in the government health program. The bill specifies that the House Energy and Commerce Committee and the House Ways and Means Committee would be required to receive the Secretary's benefit recommendations and hold annual hearings on these recommendations. For both major congressional committees, these procedural requirements would be enacted as a rule of the House of Representatives, and, in the event of a conflict with other rules, this health policy rule would supersede any other rule of the House of Representatives.[34]

In preparing benefit recommendations, the Secretary is to consult with the Director of the National Center for Complementary and Integrative Health of the CMS, the Commissioner of the Food and Drug Administration, as well as "research institutions," "nationally recognized" specialists in complementary and integrative medicine, and other experts. State officials could also mandate the addition of medical benefits and services for their residents, but only at the expense of their own state taxpayers.[35]

Following the practice of current Medicare law, the Secretary is required to make "national coverage determinations" for new or "experimental" medical items and services, and establish an appeals process to adjudicate the HHS coverage decisions.[36]

Likewise, the bill authorizes the Secretary to establish medical practice guidelines to govern the delivery of medical services. The language of the bill specifies, however, that in the event that a doctor or medical professional determines that it would be necessary to override these guidelines, the provider may do so, provided that the practitioner's "best judgement" is in accord with state law, is "medically necessary" and appropriate, and accords with the "best interest" of the patient or the patient's wishes. Based on these considerations, the actions of the doctor or medical professional would be deemed to be in accordance with the federal practice guidelines authorized under the government's national health insurance program.[37]

No Cost Sharing. The House bill would guarantee U.S. residents that their care would be "free" at the point of service. The legislation would thus prevent any doctor or other medical professional from levying any charge over and above the government payment for a medical benefit or service. The bill would also outlaw cost sharing in the government health insurance program. Under Section 202, the Secretary "shall ensure that no cost sharing, including deductibles, coinsurance, copayments or similar charges, is imposed on an individual for any benefits provided under this Act." This provision is not only a major departure from current federal health policy; it is also very different from the common practice of other nations with "universal" health care systems.[38]

Aside from private health insurance, major federal health programs, such as traditional Medicare, Medicare Advantage, the Medicare Part D prescription drug program, and the FEHBP, deploy cost-sharing strategies to constrain excessive use and contain health care costs. While zeroing out up-front patient costs would secure "free" care at the point of service, it would also guarantee that the total cost of health care would be much higher at the back end, thus sharply increasing the financial burden on patients as federal taxpayers. As CBO analysts observe, "[E]xisting evidence indicates that people use more care when the cost is lower, so little or no cost sharing in a single payer system would tend to increase the use of services and lead to additional health spending, as well as more government spending."[39]

Long-term Care. The House bill would provide a comprehensive set of long-term care services and supports. The Secretary would be required to issue eligibility rules for U.S. residents who suffer from medical conditions related to aging, physical or mental disabilities ("cognitive or other impairments") that result in "functional limitations" in performing the "activities of daily living," or need assistance in performing "instrumental activities of daily living."[40]

In administering the new federal long-term care benefit, the Secretary is authorized to establish standards for nine categories of care. This care, however, is to be "tailored to an individual's needs."[41] The statutory language is quite specific with respect to the standards of care. The Secretary must promulgate standards that meet the patients' "physical, mental and social needs," provide the "maximum possible autonomy," and secure the "maximum possible civic, social and economic participation."[42]

In developing long-term care regulations, the Secretary is to consult with a special advisory commission comprised of a specified set of "stakeholders," including people with disabilities, disability organizations,

TEXT BOX 1

Benefit Categories Under the Medicare for All Act of 2019

H.R. 1384, Title II, Section 201, specifies the following categories that would be covered under federal law:

- Hospital services, including inpatient and outpatient care, emergency services, and inpatient prescription drugs;
- Ambulatory patient services;
- Primary and preventive care services, including chronic disease management;
- Prescription drugs and medical devices, including outpatient prescription drugs, medical devices, and biological products;
- Mental health and substance abuse treatment, including inpatient care;
- Laboratory and diagnostic services;
- Comprehensive reproductive, maternity, and newborn care;
- Pediatrics;
- Oral health, audiology, and vision services;
- Rehabilitation and habilitation services and devices;
- Emergency services and transportation;
- Early and periodic screening, diagnostic, and treatment services;
- Necessary transportation to hospitals or clinics for persons with disabilities and low-income individuals (as determined by the HHS Secretary); and
- Long-term care services and supports.

groups that represent the "gender, racial and economic" diversity of the nation's disabled population, as well as representatives of the "provider community," organized labor, policy experts, and "relevant" academic and research institutions.[43]

Adding the long-term care services and supports to the government's health insurance program, along with three other benefit categories, would require a significantly larger budgetary commitment than previous iterations of "Medicare for All" legislation.[44] The CBO reports that in 2016 alone, the total spending—mostly government spending—for long-term care amounted to $366 billion.[45] As CBO analysts further observe:

> Public spending would increase substantially relative to current spending if everyone received LTSS benefits. Under the current system, many people receive Medicaid benefits for such services, but use their own funds to pay for LTSS before they qualify for Medicaid; state Medicaid programs currently pay about half the cost of such services. Private insurance accounts for a small portion of LTSS spending. Under a single payer system, government payments could replace payments by individuals and private insurance.[46]

CBO analysts also note that most of the financial support for persons needing assistance with activities of daily living comes from the financial contributions and the unpaid care from family, relatives, and friends of the patients. With the creation of a universal entitlement to long-term care, there would be a major cost shift from families providing "informal care," as well as existing private and insurance payment, to the public sector. This is particularly true if the government health insurance program covers both home-based and community-based care.[47] The House bill includes both home-based and community-based care categories. [48]

RAND Corporation analysts estimate that about half of the "informal" care of family and friends would shift to "formal" care, and they project that there would be a 200 percent increase in formal-home-care cost and a 10 percent increase in nursing-home cost.[49]

New Regulations for Physicians and Other Medical Professionals

Physicians and other medical professionals often complain about the imposition of administrative and paperwork burdens—the hassle factor—that accompany complex third-party payment systems in both the public and the private sector. These burdens, particularly compliance and reporting requirements, are often demoralizing and among the chief causes of widely reported American physicians' "burn-out" and the accelerated practitioner retirements contributing to the nation's physician shortages.[50] Based on the worsening conditions in Britain's National Health Service (NHS), the proposition that a single-payer system would somehow remove such burdens is unsupported by the empirical evidence.[51]

The House bill would, in fact, create a large and formidable regulatory regime. It would not only establish rigorous conditions of provider participation and reporting requirements, but also tightly control the character and scope of medical practice.

Provider Agreements. Today, state agencies and professional organizations have the primary responsibility for establishing licensing and standards of practice for physicians and specialists, as well as for the licensing and scope of practice rules for other medical professionals, such as nurses, nurse practitioners, dental assistants, and a wide variety of other health care workers. Under the House bill, doctors, nurses, and other medical professionals would also be required to meet new standards of qualification for practice in the government health insurance system, and accept and abide by the terms and conditions of medical practice, including federal practice guidelines such as new federal restrictions on their ability to provide medical services even outside the national program. The statutory text clarifies that medical professionals must not only meet the existing terms and conditions required under the current Medicare law, but that they would also have to sign a special "participation agreement" and file it with the HHS Secretary.

Under that legal arrangement, physicians and other medical professionals would have to agree to a number of conditions. They would have to acknowledge their responsibility to provide the medical benefits, items, and services available under the government program; agree to the full range of "non-discrimination" requirements specified in the legislation; levy no charge for any covered item or service above the amount reimbursed by the federal government; and submit any "such information" that the HHS Secretary may require in his or her efforts to secure the quality of care, as established under the federal government's standards. Physicians and other medical professionals must also agree to submit billing or payment records, or any statistical data being gathered by the federal government, for "such other purposes" as the Secretary may require in the course of administering the program.[52]

The bill requires doctors, hospitals, and all other medical professionals receiving government payment to submit paperwork concerning reimbursement within 30 days of providing the covered items or services.[53] On a quarterly basis, these "providers" must also comply with reporting requirements concerning conflicts of interest, as required by regulation. Giving proper notice, the Secretary can terminate a "provider participation agreement" if the physician or another medical professional fails to comply with the statutory or regulatory requirements of the Act, or due to of a violation of the Act's fraud and abuse provisions.

The bill includes language designed to protect "whistleblowers." Doctors and hospital officials would be protected from unlawful terminations, such as terminations related to their cooperation with federal or state law

enforcement officials, testifying before legislative committees concerning violations of the provisions of the Act, or refusing to violate the Act or refusing to participate in efforts to violate the provisions of the Act. Beyond doctors, hospital officials, or other medical professionals, these protections would also apply to their employees. All such persons would enjoy the "anti-retaliation" protections of the Federal False Claims Act or similar protections embodied in federal or state laws. Moreover, all such persons would also have a right of action in federal courts.

Federal Quality Standards. A "qualified" provider, according to the bill, is a doctor, nurse, specialist, or other medical professional who is qualified to deliver "items and services" provided under the act if the provider is licensed or certified in the state in which he or she practices, and fulfills the requirements of federal and state law in providing these items and services.

The House bill provides that the Secretary "shall establish and update 'minimum' standards for all providers"—doctors and other medical professionals, as well as hospitals and other "institutional" providers—to "ensure the quality of items and services" delivered under the government health insurance program. Within their jurisdiction, however, states can impose additional quality standards.[54]

The basic quality standards for the government program would be the standards of quality already required in current Medicare law. This would include standards governing the adequacy of institutions to deliver care, staffing requirements, standards governing the training and competence of health care staff, the comprehensiveness and continuity of medical services, patient waiting times, and access to services, as well as medical outcomes.[55]

The Center for Clinical Standards and Quality, an office of the CMS, would be required to develop quality measures and standards in "coordination" with the Agency for Healthcare Research and Quality, an HHS office. The Center would be the central agency to "review and evaluate" medical practice guidelines and performance measures for physicians and other medical professionals. The Center staff would undertake methodological analyses and develop criteria that regional directors of the program could employ for their own internal regional reviews of quality performance. On an annual basis, the Center would also submit reports to the Secretary on medical outcomes and practice guidelines.[56]

The Center for Clinical Standards and Quality would also be required to address the problem of health care disparities, and, in pursuit of this effort, collect relevant data on race, ethnicity, and gender, as well as

geographic and socioeconomic data. The Center would be required to prepare a report and make policy recommendations to address these disparities within 18 months of the enactment of the act. Thereafter, the center would be required to submit a report to Congress on these issues every four years.[57]

Restrictions on Private Payment. The House bill would severely restrict Americans' ability to spend their own money to pay a doctor for medical services outside the government program. A personal right to contract with a doctor would depend on whether a doctor is participating or non-participating, whether the medical service is covered or non-covered, and whether the patient is eligible to receive reimbursed services under the government program.

According to Section 303 of Title III: "An institutional or individual provider with an agreement in effect under Section 301 may *not* bill or enter into any private contract with *any* individual eligible for benefits under the Act for *any* item or service that is a benefit under this Act."[58] (Emphasis added.)

For that small number of "non-covered" benefits and services, the House bill specifies that a "participating" doctor would be able to enter into a private contract with a patient "eligible" for government benefits.

But there are crucial limiting conditions: The doctor could not get *any* payment (either "directly or indirectly") from *any* organization that also gets government payment for the government's benefits and services. Moreover, *any* doctor contracting privately with a patient for "non-covered" services must sign an affidavit to that effect and file it with the Secretary of HHS within 10 days of the contract.[59]

The House bill, however, would permit "non-participating" providers—that is, doctors and other practitioners who have *not* signed an agreement to participate in the program—to contract privately for "non-covered" services with any individual. If, however, a "non-participating" provider were to contract privately with patients enrolled in the government's "covered" medical services, the House bill prescribes detailed terms and conditions of the contract: The private contract must be in writing, signed by the parties, entered into outside an "emergency situation"; and the patient must acknowledge that the government program will not pay or cap the costs of these privately delivered services. The "non-participating" doctors must also file an affidavit that they entered into such a private contract with their patients and file it with the HHS Secretary within 10 days of the contractual agreement. Concerning this required affidavit, the text states that "the provider will not submit *any* claim for *any* covered

item or service provided to *any* individual enrolled under this Act during the 2-year period beginning on the date the affidavit is signed."[60] (Emphases added.) In short, the bill contains a "lock-out" clause.

These proposed congressional restrictions—not only on the right to purchase private health insurance, but also to secure private medical care—are far more severe than those imposed by the British socialists who created the British National Health Service in 1948. Today, not only are British citizens free to enroll in private health plans, they are also free to engage privately the services of British doctors, even though these doctors also practice in the NHS.[61] Because of significantly longer NHS waiting times, according to the *British Medical Journal*, British patients are increasingly relying on private medical services.[62]

Central Planning: How Washington Would Run the Program

The Secretary is required to develop policies, procedures, guidelines, and regulatory requirements to implement the national health law. The scope of the Secretary's administrative authority would be very broad. The Secretary's regulatory penetration into the details of care delivery would be very deep.[63]

Scope of Control. The Secretary's broad range of authority would cover the program's eligibility and enrollment; adding or modifying health benefits and services; developing or implementing standards for provider participation and standards for the quality of care; preparing the national health care budget; developing and implementing new payment methodologies; establishing processes and procedures for addressing grievances and appeals; planning for capital expenditures and professional education funding; working in coordination with state officials concerning regional planning; and issuing "any other regulation necessary to carry out the purposes of the Act."[64]

In carrying out this vast range of administrative responsibilities, the Secretary would be required to consult with a wide variety of entities and organizations, including federal officials in other agencies that have health policy responsibilities, Indian tribes, professional organizations, representatives of organized labor, and academic experts or specialists in health care policy.

National Database. As noted, the purpose of the bill is to ensure that "every person" residing in the United States has access to health care. The bill thus reads: "The Secretary shall have the obligation to ensure the timely and accessible provision of items and services that all eligible individuals are entitled to under this Act."[65]

Such a task would require comprehensive data collection. Therefore, the Secretary would establish "uniform" reporting requirements for a national database. The database would contain information on the provision of medical items and services, information on the costs and quality of these services, and the "equity of health" among various population groups.[66] In the process of gathering this large body of data, the Secretary would also be responsible for protecting the privacy of patients and collecting information without imposing an undue burden on medical professionals.

Within two years of the date of enactment, the Secretary must report to Congress on the implementation of the national health insurance program, including progress on enrollment; the provision of benefits; health costs, including per capita costs; and the financing of the program. The report must also address the issues of cost containment, quality assurance, health status of Americans, and any problem that the Secretary encountered in implementing the law, as well as recommendations for program improvement. The Comptroller General of the United States would also be required to conduct an audit of the program and submit a report to Congress every five years.[67]

Regional Administrators. The House bill would create a pyramidal system of program management. The Secretary "shall" establish regional program offices to administer the program, incorporating wherever "feasible" the existing system of regional organization established under the current Medicare program and managed by the CMS. The Secretary would appoint the regional directors, and they, in turn, would appoint deputy regional directors to represent Native American tribes, as appropriate, in any given region of the country.

The regional directors would present the Secretary with an annual report on the health needs of the region, make recommendations for the regional reimbursement of doctors and other practitioners, and establish a quality assurance program to oversee care delivery for residents of the region. The regional directors would also monitor providers to "minimize both underutilization and overutilization" of medical items and services.[68]

The Secretary would also appoint a Beneficiary Ombudsman to help enrollees who have complaints or grievances resolve them. The ombudsman would report to Congress annually and would identify for Congress any systemic problems with the program that should be resolved, including any problems with coverage of benefits or services or payment issues.

Establishing a Global Health Care Budget

Under the House bill, the HHS Secretary would establish a "national health budget" by September 1 of each year. This is commonly referred to as a "global budget," which is an arrangement whereby medical institutions, such as hospitals or clinics, and medical professionals, such as doctors, nurses, and other medical professionals, get a fixed payment, usually on an annual basis.[69]

Under the House bill, the budget would contain the Secretary's estimate of what level of federal spending would be necessary to administer the national health insurance program, including the program's operating expenses, capital expenditures, and funding for the program's "special projects." The budget would also outline the necessary expenditures for other categories, including quality assessment, professional education, administrative costs, prevention initiatives, and a "reserve fund," which would anticipate the need for public spending to cope with epidemics, pandemics, or other unforeseen national emergencies.[70]

Regional Budget Allocations. The Secretary would allocate the budget for program administration in each of the program's regional offices. These regional budget allotments would be used to cover the regular operational expenses of the program, such as payment to doctors and hospitals. The regional budgets would also cover capital expenditures for the construction and renovation of hospitals and other medical facilities, and, of course, special projects, such as the funding needed to staff medically underserved areas with the appropriate kind and level of medical personnel.

Annual payment to "institutional providers"—such as hospitals, skilled nursing facilities, and medical clinics—would be in the form of lump-sum payments for providing the program's approved medical items and services. Regional directors, however, would be responsible for reviewing the performance of these providers and determining whether their payments should be adjusted, particularly in the case of unforeseen costs or the emergence of unforeseen or complex medical challenges. Group medical practices would be paid under the regional budget directly, or through the global budget allocated to "institutional" providers, such as hospitals or other medical institutions.

Negotiated Rates. The regional directors would "negotiate" payment amounts with providers annually. The providers' negotiated rates would factor in the historical volume of services, the actual spending from the most recent costs, the levels of comparative spending and payment rates of other providers, volume projections, and wage levels. Negotiated rates

would also reflect the spending on education and prevention programs. Payments to institutional providers, such as hospitals, could not factor in capital expenditures or be used or diverted for capital expenditures.

Resurgent Fee-for-Service (FFS). For individual providers, such as physicians and medical specialists, who are not paid a salary, or are paid through a government negotiated group practice payment rate, the Secretary would be required to pay them on an FFS basis. Under the terms of the program, these payments would be payments in full; and no physician, specialist or other "individual provider" would be able to charge any amount above the government's FFS payment.

The House bill would require the Secretary to establish this new FFS system within one year of the enactment of the program. The system would be updated annually and would be operationalized with a system of electronic billing. In developing the new FFS system, the Secretary would be required to "take into account" the existing Medicare payment rates for medical items and services, the medical practitioners' "expertise" in providing the services, and the "value" of these medical items and services.[71]

In determining the "value" of services for patients, the House bill imposes certain limitations. Payments could not be made to reflect any provider's marketing expenses (such as advertising her medical services) or a provider's profits or bonuses based on "patient utilization" of medical items and services. The bill also includes a clear prohibition: "The use of Quality Adjusted Life Years, Disability Adjusted Life years, or other similar mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments."[72]

Government officials would determine "value" for all provider payments in the program. Under Section 613 of the House bill, the Secretary is to establish a process to review the "relative values of physicians' services," and provide a written description of the review process that would be used to determine the "value" of physicians' services. The House bill specifies that this review would take place annually, in consultation with the existing Medicare Payment Advisory Commission (MedPAC), the panel that advises Congress on reimbursement for Medicare physicians and participating hospitals. The Comptroller General of the United States would also be required to conduct a "periodic" audit of this exercise.

The House bill would "terminate" certain physician payment programs created under the Medicare Access and CHIP Reauthorization Act of 2015: the Merit-Based Incentive System, the alternative payment models, and the incentive program for "meaningful use" of electronic

health records. It would also eliminate key payment and delivery-reform programs created under the 2010 ACA: the "value-based" purchasing provisions for hospitals, nursing homes, and home health agencies, as well as the accountable care organizations, the hospital readmission reduction program, and the "value-based" purchasing program for ambulatory surgical centers.[73]

Capital Expenditures. The Secretary is to pay providers such "sums deemed appropriate" for the funding of capital projects. The bill would require the Secretary to give priority to capital projects in "medically underserved" areas, or to address health disparities among racial, ethnic, or socioeconomic classes that suffer from such disparities. Also, under the terms of the bill, if a "non-governmental" agent funds a capital project, and that funding would lead to a reduction in patient care, health care staffing, or the availability of primary care, there would be a consequence: Federal funds would be disallowed for that capital project.[74]

The House bill would also prohibit the use of federal funds for capital projects financed by charitable donations in any region without the specific approval of the regional director.[75] In no case would "providers" be permitted to co-mingle capital and operating funds.

Prescription Drug Payment. On a yearly basis, the Secretary must "negotiate" the prices for drugs, medical supplies, technologies, and devices. In negotiating these prices, the Secretary is to "take into account" several factors: the comparative clinical and cost effectiveness of these items, the impact of government payment on the program's budget, the treatment alternatives available, and, in the case of drugs, the manufacturers' total revenues, sales, and investment data.[76]

If the Secretary is unsuccessful in negotiating a price for a particular drug, notwithstanding all other federal laws, the Secretary must cancel the manufacturer's patent exclusivity, and "shall authorize the use of any patent, clinical trial data or other exclusivity granted by the Federal Government with respect to such drug as the Secretary determines appropriate for purposes of manufacturing such drug for sale under the Medicare for All Program."[77]

If the Secretary were to take such a strong action against a drug manufacturer, the manufacturer would be entitled to "reasonable compensation" for these losses based on the "risk-adjusted" value of any federal subsidies and the manufacturer's investment in the development of the drug. The compensation would also reflect the impact of the drug on prices and health benefits, and "other relevant factors determined as appropriate by the Secretary to provide reasonable compensation."[78] The

bill would also allow the drug manufacturer to "seek recovery" of such losses by filing suit against the United States in the United States Court of Federal Claims.

Before negotiation and until one year after drug approval by the U.S. Food and Drug Administration, the federal government would pay the average price of the drug in the 10 countries of the Organization for Economic Co-operation and Development with the largest gross domestic product and a per capita income of "not less than half the per capita income" of the United States. The bill would also authorize the Secretary to procure a drug directly from the manufacturer.[79]

Many champions of "single-payer" proposals believe that such one-sided government "negotiations" would secure significantly lower drug costs and overall health care savings without adverse consequences. As Blahous warns, however:

> There are hard limits on the potential savings that can arise from such a provision because prescription drugs account for just 10 percent of total national health expenditures, and generics already make up 85 percent of all prescription drugs sold. Nevertheless, the lower bound estimates employ aggressive assumptions for prescription drug cost savings, specifically an immediate 12 percent reduction in prescription drug expenditures, without attempting to model potential adverse effects of this reduction on the pharmaceutical industry or the pace of innovation.[80]

Commanding a Fast-Track Transition

The House bill provides for the creation of a transitional government health program, and the universal availability of health benefits and services, no more than two years after the date of enactment.[81] The Secretary must establish a Medicare Transition Buy-In program, run by the CMS Administrator. The plan would function as an alternative health plan in the ACA's health insurance exchanges nationwide. While the initial enrollments would be among those ages 55 and older, or ages 18 and younger, anyone living in the United States would be entitled to the benefits of the transitional program, assuming the person meets the Secretary's eligibility determinations.[82] During this two-year transition, the Secretary would also be required to consult with "interested parties," including groups representing "providers," beneficiaries, employers, and insurers.

The transitional program would comply with all of the ACA's existing insurance requirements, including benefit requirements. The program's

benefit offerings must also have an actuarial value of 90 percent, meaning that the plan would pay 90 percent of the total average costs for the covered benefits.[83] The actuarial value of 90 percent is the highest level of health plan coverage ("platinum" level) in the ACA's health insurance exchanges. It would be significantly "richer" than the actuarial value of the rest of the ACA plans, such as the "bronze"-level plans (60 percent), "silver"-level plans (70 percent), and "gold"-level plans (80 percent).

The transitional program would reimburse doctors, hospitals, and other medical professionals and facilities on a FFS basis, while the Secretary would negotiate the drug prices with the drug manufacturers. The bill also imposes a mandate on providers: Participating "providers" in the Medicare program must be participating providers in the Medicare Transition Buy-In program.[84] The Secretary would establish a "process" to allow other providers to participate.

The CMS Administrator would set the temporary program's beneficiary premiums, and these premiums could vary by single or family coverage and tobacco use, but not on the basis of geography. Beneficiaries in the program would also be eligible for more generous federal premium and cost-sharing subsidies.

The premium tax credits for the temporary program would be available for persons with annual incomes in excess of the ACA's cap of 400 percent of the federal poverty level, or $103,000 for a family of four.[85] For persons in states that have *not* expanded Medicaid, under the terms of the ACA, these federal subsidies would also be available to persons below 100 percent of the federal poverty level.[86]

In the meantime, the House bill would eliminate the 24-month waiting period for Medicare enrollment for persons with disabilities and ensure the continuity of coverage and care for persons with health insurance, including persons with group health insurance coverage.

A Tight Timetable. The CBO warns: "The transition toward a single-payer system could be complicated, challenging and potentially disruptive."[87] In this connection, RAND Corporation analysts note that the House bill would engineer "a massive reorientation" of American health care in an uncomfortably short period of time: "The Jayapal bill includes a two-year transition period; however a longer time may be required to enable consumers, providers and regulators to fully adjust to this substantial change."[88]

Historically, major health reform measures—highly consequential but far less ambitious—have usually provided far more generous time frames for transitions, giving employers, employees, doctors and

patients, medical institutions, and professionals ample time to adjust. The Affordable Care Act of 2010 (ACA), which effected a major shift in regulatory authority over health insurance from the states to the federal government, provides a graphic example. In 2014—the first year of full implementation—the ACA got off to a rocky start, even with almost four years of federal and state preparation. Nonetheless, the Obama Administration had to grapple with an initial failure of its enrollment website, unanticipated disruptions and losses of coverage in the insurance markets, explosive premium and deductible increases, and much narrower than anticipated provider networks in the ACA plans. Even targeting a much smaller population for health insurance coverage, the federal administrative task proved to be large and complex and was routinely plagued by serious glitches.

Conclusion

The congressional sponsors of H.R. 1384 would create a single, national health insurance program and provide "universal" coverage for every "resident" of the United States—regardless of whether that resident is in the U.S. legally or illegally.

Universal government coverage means universal government control. Two years after enactment, the legislation would virtually eliminate all existing public and private coverage alternatives, including all private health plans, employer-sponsored health insurance, health insurance exchange plans, Medicare, Medicaid, CHIP, Tricare, and the FEHBP. It would also severely restrict the ability of doctors and patients to enter into any independent relationship outside the government program, and government officials would closely monitor those external arrangements that are permissible. If enacted, the House bill would amount to another quantum leap forward in the power of the modern administrative state.

Under the House bill, any remaining independent, private transactions in American health care would largely disappear; private market profit and loss would be replaced by public program spending and program funding shortfalls.[89] The legislation would thus complete the politically driven concentration of federal power over American health care, a process of market consolidation accelerated in 2010 by Obamacare's rapid multiplication of federal government mandates.[90] The legislation would also hasten the already rapid erosion of independent medical practice and physician autonomy.

While Congress would exercise the final authority over program financing and the content of the benefits package, the key, day-to-day

decision making over most aspects of American health care would be vested in the HHS Secretary and the Secretary's many subordinates. Among numerous administrative and regulatory duties, the Secretary would be required to create a national health database and national health budget and oversee regional offices and the transition program. Though the House legislation contains no financing provisions, the sheer size of this vast enterprise, and the federal spending and taxation to sustain it, would be enormous and unprecedented.[91]

Congressional sponsors of the legislation often claim that a single government system would be more equitable and economically efficient, while generating significant cost savings and superior medical outcomes. They thus propose the adoption of a global budget to reduce health care costs. It could be done, of course, but not without shifting costs, in the form of pain and suffering, to patients. The "single-payer" experience of other countries demonstrates a clear pattern of waiting lists, delays, and denials of access to care.[92]

As of yet, there is no CBO cost analysis of the bill to justify a belief in either imagined savings or greater economic efficiency. In fact, as noted, a broad range of diverse and respected independent analysts—ranging from the liberal Urban Institute to the conservative Mercatus Center—warn that overall costs could be considerably greater than the leading congressional proponents of these House and Senate proposals have claimed.[93]

The first set of congressional hearings on the House bill in 2019 marks a turning point in the national health care debate. The proponents of the proposal promise a bright health care future. Opponents rightly point to dismal performance of countries with similar systems in place, particularly long wait times and reduced access to quality care.

Opposition to this concentrated federal power and control over American health care is not, in any sense, an endorsement of the status quo. Members of Congress have a grave responsibility to address the central problems of American health care, including distorted and uncompetitive markets, constraints on the choice of health plans and providers, artificially high health insurance costs, uneven quality, and the gaps in care and coverage. The Health Care Choices Proposal, developed by conservative health policy analysts, would directly address these problems and thus reduce costs, expand personal choice, reignite competition, and stabilize coverage in the nation's health care markets.[94]

Sound reform can address America's worst problems without destroying what is best: America's capacity for medical innovation and rapid responsiveness in the treatment and cure of deadly disease. Most

important, comprehensive reform can expand Americans' personal freedom while solving these problems, instead of eliminating it.

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CHAPTER 5

Government Monopoly: Senator Sanders' "Single-Payer" Health Care Prescription

ROBERT E. MOFFIT, PHD

Senator Bernie Sanders (I–VT), along with 16 Senate Democrats, is sponsoring the Medicare for All Act of 2017 (S. 1804).[1] The legislation would outlaw almost all private insurance and create a government health care monopoly: a single entity delivering, as well as financing, medical benefits and services. Federal officials, most notably the Secretary of the U.S. Department of Health and Human Services (HHS), would have almost total control over America's health care financing, organization, and delivery.

Senator Sanders and his Senate colleagues are not alone. Representative John Conyers (D–MI) is sponsoring broadly similar legislation in the House with the support of 120 Representatives, more than half of the entire House Democratic membership.[2]

The Sanders' bill provides for a four-year transition period. At the end of that period, the federal government would run a national health plan. The new law would also expand the already formidable power of the HHS Secretary, well beyond the broad scope of authority that the Secretary already exercises under Obamacare. Unlike previous iterations of the legislation, however, the far-reaching measure contains no provisions for its financing. Instead, Senator Sanders and his colleagues have separately provided for a set of financing "options" for the measure, including a broad-based federal payroll tax, a new "premium tax," and a series of additional taxes on private savings and investments, especially targeted at upper-income citizens.

Private monopolies exist when there are no firms producing and delivering a similar good or service. A government monopoly enjoys the same dominance, but, unlike a private firm, is armed with the coercive power of the law. In the case of the Sanders bill, the federal government would undertake a radical restructuring and consolidation of third-party payment, as well as a comprehensive control over the ways and means to reimburse and limit payment to doctors, hospitals, and other medical professionals. These payment restrictions—largely a continuation of the Medicare price-control system—are combined with practice guidelines governing how doctors and other medical professionals are to deliver medical benefits and services.

For ordinary Americans, there would be no escape. Except for a small set of benefits uncovered by the government plan, individuals and families would, ipso facto, have no health care options. Federal government officials would determine the kind of plan they get, the benefits they get, the medical procedures and treatments that would be available to them under the new government system, and under what circumstances, terms, or conditions they may receive medical services or benefits. In short, the bill would constitute a major restriction on personal and economic freedom.

If the Sanders bill becomes law, Americans can expect:

- **A prohibition of private health plans.** Today, nearly 60 percent of working-age Americans get their health insurance through private, employer-sponsored health plans. Under the bill, the government would effectively outlaw almost all private health insurance, whether offered by employers or by insurers in the individual or small-group markets. Under Title VIII, Section 801, the bill language specifies, for example, that "no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Act of 2017."[3] Employers and insurers would be able to offer *non-covered* benefits and services, but the sponsors of the bill intend these offerings to be minimal. The reason: The government health benefits program would be comprehensive, covering 10 major benefit and service categories, and, of course, there would be no private health plan legally permitted to offer Americans these benefits, regardless of their preferences in the matter, under different terms and conditions. In short, competition with the government health plan would be illegal.

It is worth noting that a recent NBC/ *Wall Street Journal* poll found that the general public favors the adoption of a "single-payer" health plan by a slim margin of 47 percent to 46 percent. When the public realizes that this would mean the elimination of employer-sponsored health insurance, however, support for the proposal falls to just 36 percent with 55 percent of the respondents opposed.[4]

- **The absorption of existing government health programs.** While the Senate legislation is popularly advertised as "Medicare for all," ordinary Americans should understand that the bill language would *not* preserve "Medicare as we know it." In fact, the bill would make major changes to the Medicare program, including the elimination of private plan options that exist today, and under Title IX of the proposed measure, Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) would, as a matter of law, be phased out during the transition period and absorbed into the new government health plan. With Medicare, for example, "no benefits shall be available under Title XVIII of the Social Security Act for any item or service furnished beginning on or after the effective date of benefits under Section 106 (a)."[5]

  Likewise, the bill specifies that "no individual is entitled to medical assistance" from a state Medicaid plan (except for long-term care) or a state CHIP plan. However, the bill would provide a continuity of coverage for persons enrolled in those programs during the transition to the new government plan.[6] Enrollment in the Obamacare health insurance exchanges would also end, and the bill would transition current enrollees into coverage under the new government health plan.

  When fully implemented, the Senate bill would also end enrollment and the provision of health benefits for over 8 million federal employees and retirees and dependents under the popular and successful Federal Employees Health Benefits Program (FEHBP), a system of competing private plans, the largest group health insurance program in the world. Historically, notably during the 1994 debate over the proposed Clinton health plan, the threat of abolishing or eliminating the private health insurance coverage for federal workers and retirees has sparked ferocious opposition among members of the federal workforce.[7] Beyond federal workers and retirees, the bill would also end enrollment and the provision of benefits in TRI-CARE, the special health care program for military dependents.[8]

There are two notable exceptions to the phasing out of existing government programs: the Veterans Administration Health Program and the Indian Health Service.[9] Both, incidentally, are classic single-payer health systems, and both have a troubled record of performance.[10]

- **Compulsory taxpayer funding of abortion.** Under most federal health programs, there is usually a statutory restriction on the use of federal taxpayer funds for abortion. In the case of the Medicaid program, for example, the Hyde Amendment only allows abortion in the case of rape, incest, or the protection of the life of the mother.

  It has long been the considered judgment of Congress that American tax dollars should not be used to pay for abortions. With the enactment of the Affordable Care Act (ACA) in 2010, the Obama Administration weakened and breached the traditional wall of separation between abortion and federal taxpayer funding. With the proposed Senate legislation, the wall would disappear entirely. Under the new government health plan, federal payments for all medical benefits and services would be drawn from a newly created federal trust fund. The proposed centralized control of health care financing effectively repeals the Hyde Amendment. Title VII, Section 701 of the bill declares, "Any other provision of law in effect on the date of enactment of this Act restricting the use of federal funds for any reproductive health service shall not apply to the monies in the Trust Fund."[11] As Ilsye Hogue, President of NARAL Pro-Choice America, declared enthusiastically, "Senator Sanders' healthcare bill ends the debate and makes clear that reproductive healthcare, including abortion services, is a fundamental right—not just a privilege of the wealthy."[12]

- **Centralization of power.** The proposed Senate bill is profoundly authoritarian. A major consequence of Obamacare was the transfer of a vast field of regulatory power over health insurance from the states to the federal government. The primary decision maker in the complex system created under the ACA was, of course, the Secretary of HHS. The bill would allow a limited right of private contracting between doctors and patients, but the language would impose a draconian restriction on physicians who engaged in such a contract: the inability to treat and receive payment for all other patients (meaning those enrolled in the government plan) for a full year.

Given that virtually the entire American population would be subject to the government plan, the bill would greatly expand the scope of the Secretary's power. The language is very broad: "The Secretary shall develop policies, procedures, guidelines and requirements to carry out the Act."[13] The specified areas for the Secretary's administrative actions include: standards for plan enrollment, health benefits, eligibility for benefits, insurance premiums and cost sharing, medical practice guidelines and rules for provider participation, levels of funding, methods for determining payment, coverage determinations, determination of medical necessity and appropriateness of procedures, planning for capital expenditures and professional education funding, actions to encourage states to develop "regional planning mechanisms" and "any other regulation necessary to carry out the purpose of this Act."[14]

Senator Sanders insists that such centralization, modeled on the traditional Medicare program, would reduce administrative costs.[15] The Senator also claims that it would simplify the American health care system.[16] In fact, such centralization is almost certain to generate even greater bureaucratic complexity, economic inefficiency, more intense politicization of health care decision making in Congress, and the same kind of organizational sluggishness that has long burdened the Medicare program. As Dana Goldman, a senior fellow at the Brookings Institution and professor of economics at the University of Southern California, observes:

> People also forget that Medicare is a hidebound system. It took Congress more than 40 years to offer a prescription drug benefit, for example. Physicians are paid using an arcane system developed decades ago and that has now ballooned to more than 140,000 procedure codes, all of which is supervised (and gamed) by physicians themselves. Standard private sector cost saving measures, like competitive bidding for routine services, are rarely used.[17]

- **Large and unknown costs.** The Senate bill provides no financing provisions, and, of course, no Congressional Budget Office (CBO) score.[18] This is a curious omission, as both health care spending and costs are the most important, if not the most urgent, issues in the nation's ongoing health care debate. Compared to current and projected future costs, it is routine for single-payer advocates to insist that the new program

would be more economically efficient and usher in an era of unprecedented health care savings. It is worth noting, however, that in the area of health care costs, the experience, beginning with Medicare itself, has been that the real costs of government health programs almost invariably exceed, often far exceed, their initial projected costs.[19]

History is likely to repeat itself. Jodi Liu, a research analyst with the Rand Corporation, doubts that the Senate bill would necessarily result in savings over the status quo, and further warns: "The spending required for a single payer system depends on the price of care and services used. When health care is free, people tend to use more health care services, some of which is beneficial and some is not. Under Sanders' Medicare for All plan, the use of health care services would almost certainly increase."[20]

Independent analyses of a 2016 version of the Sanders proposal indicated that the real costs of the proposal would far exceed the initial projections. For example, Kenneth Thorpe, a professor of health economics at Emory University, projected the 10-year costs at $24.7 trillion. Likewise, scholars at the Urban Institute, a liberal leaning think tank, estimated that the government health plan would cost $32 trillion over 10 years.

Meanwhile, as noted, neither the CBO nor independent analysts have completed the tax and spending estimates for the most recent version of Senator Sanders' bill. The costs and the taxes to sustain it are doubtless going to be very large. For perspective, consider that the federal government spent a total of $3.9 trillion in 2016. According to the Urban Institute estimates, Senator Sanders' government health plan would require a stunning $3.2 trillion in spending annually, while Professor Thorpe's analysis indicates that the yearly cost of the program would amount to $2.6 trillion.[21]

Polling on Senator Sanders' concept has been generally positive. The political viability of the proposal, however, depends on public acceptance of the necessary trade-offs, especially its additional costs to the taxpayer. In this context, it is worth noting that the T. H. Chan School of Public Health at Harvard University and *Politico* recently conducted an in-depth survey of American voters on the topic. These researchers found that Americans are generally favorable to replacing the

current insurance arrangement with a taxpayer-funded "Medicare-like" plan by a stunning margin of 66 percent, reflecting the popularity of the Medicare program itself. The Harvard–*Politico* survey, however, required respondents to consider the desirability of key policy options by clarifying the necessary or likely trade-offs that must accompany these public choices. Thus, they found that support for the "Medicare-like" plan proposal drops to 44 percent if adopting it meant that their "own taxes" would increase. When the pollsters describe the national health insurance program as a "single-payer" health plan, combined with the tax increases imposed on respondents necessary to sustain it, popular support for the proposal falls from 45 percent to 31 percent.[22]

The Next Debate. American health care is a huge sector of the economy, where roughly half of all health care spending is government spending. Senator Sanders' bill would expand that government payment to close to 100 percent. Current arrangements are governed by a diverse set of third-party payment arrangements in both the public and the private sectors, including employer-sponsored health insurance. The Sanders bill would simplify coverage by consolidating third-party payment in the federal government and by outlawing almost all private insurance, including the employment-based insurance that covers the vast majority of Americans under the age of 65.

Current government regulation and an inequitable and inefficient federal tax treatment of health insurance distort current private health insurance arrangements. Senator Sanders' bill would solve that problem by consolidating regulation in the hands of the Secretary of HHS and abolishing all private insurance—logically eliminating all of the federal and state tax breaks that offset its cost. The result would be a large influx of additional tax revenue into federal coffers to fund the new government plan, along with the fresh federal revenues from a new set of heavy federal taxes on employers, individuals, and citizens' investment income.

Current payment for doctors, hospitals, and medical professionals is based on multiple billing from private insurers and federal and state government programs. Senator Sanders would eliminate these multiple billings and establish a universal provider payment system directly based on an updated version of Medicare's complex payment formulas. Such changes would guarantee cuts to providers' revenues, and end provider cost-shifting to the private sector—because there would be no more private-sector plans. At the same time, the establishment of the federal government as the sole payer would virtually eliminate physician and hospital "market power" in negotiation with private payers because

those private payers would no longer exist as parties to any such market negotiation.

Today, consumers and patients operate in a complex and bureaucratic mixed health care economy with distorted markets variously plagued by perverse economic incentives. Senator Sanders' bill would eliminate that problem by eliminating market incentives altogether. Government would decide which plans, benefits, and medical procedures patients receive. Government would control the health care dollars, and, in so doing, would control the nature and scope of personal health care decisions. In such a world, personal choice, personal wants, or personal preferences would be ultimately irrelevant. *Personal freedom in health care would itself be irrelevant*.

Establishing the Universal System

Title I, Section 102 of the Senate bill sets out a declaration of universal entitlement: "Every individual who is a resident of the United States is entitled to benefits for health care services under this Act. The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under this Act."[23]

The provision is remarkable since it defines "residency" rather than "citizenship" as a condition for eligibility to the new federal entitlement, and reserves to the Secretary of HHS, rather than Congress, the plenary authority to define that eligibility in regulation rather than legislation. The bill further authorizes the Secretary of HHS to establish a process of automatic enrollment for all persons at "the time of birth in the United States and at the time of immigration into the United States or other acquisition of qualified resident status in the United States."[24] The federal government would provide every resident with a "Universal Medicare Card" for processing claims. Curiously, the language reads: "The card shall not include an individual's Social Security number."[25] In short, the bill would cover illegal aliens.

The Senate bill would also enact a broad non-discrimination provision: "No person shall, on the basis of race, color, national origin, age, disability, or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in, be denied the benefits of, or be subjected to discrimination by any participating provider as defined in section 301, or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act."[26]

TABLE 1

Ten Benefits Categories in Sanders' 2017 Plan

1. Hospital services, including inpatient and outpatient hospital care, including 24-hour-a-day emergency services and inpatient prescription drugs
2. Ambulatory patient services
3. Primary and preventive services, including chronic disease management
4. Prescription drugs, medical devices, biological products, including outpatient prescription drugs, medical devices, and biological products
5. Mental health and substance abuse treatment services, including inpatient care
6. Laboratory and diagnostic services
7. Comprehensive reproductive, maternity, and newborn care
8. Pediatrics
9. Oral health, audiology, and vision services
10. Short-term rehabilitative and habilitative services and devices

SOURCE: Medicare for All Act of 2017, S.1804, 115th Cong., 1st Sess., §.201(a) https://www.congress.gov/bill/115th-congress/senate-bill/1804/text#toc-id25c91cb96228483495ad9de0b47b79f8 (accessed October 24, 2017).

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The bill language is similar to that embodied in Section 1557 of the ACA, which had generated a regulatory scheme that undermines conscience protections in health care delivery.[27] The bill's language, however, is broader and more direct.[28] It provides HHS with broad authority to change or modify the national benefits package. In the absence of conscience protections—combined with a reigning assumption that federal officials' "government-approved" morality automatically trumps the moral, ethical, or religious convictions of physicians and patients—the provision invites even greater cultural and political polarization. It is reasonable to assume that the government health plan could require medical professionals to participate in a number of practices to which they would have profound moral or religious objections, including abortion, the provision of abortifacients, gender-reassignment surgeries, and even

physician-assisted suicide, which is being aggressively promoted as an appropriate approach to end-of-life care.[29] As with Section 1557, a broad interpretation of the language, either through regulation or adjudication, could expand the meaning of disability, for example, to include medical conditions and thus additional mandatory treatments.[30]

The bill also authorizes the Secretary of HHS to establish "a procedure for adjudication of administrative complaints" alleging a violation of this non-discrimination clause. It also provides a cause of action in federal courts for persons claiming discrimination based on this provision to get "compensatory and punitive damages, declaratory relief, injunctive relief, attorneys' fees and costs, or other relief as appears appropriate."[31] The provision is likely to generate a flood of litigation, particularly suits against religiously affiliated doctors and hospitals or medical institutions.

Benefits. Under the bill, the government health plan would provide medical benefits and services, effective on January 1 of the fourth calendar year after its enactment.[32] At that time, the government would literally outlaw any private health insurer or any employer that provides health insurance benefits that "duplicate" any of the benefits that are authorized in the federal government's comprehensive health plan.[33]

On a "regular basis," the Secretary of HHS can change ("improve or adjust") the government health benefits package in response to changes or developments in "health science" and make recommendations to Congress.[34] Congress, in other words, would retain the ultimate authority over which medical benefits or services are to be available to Americans, and which benefits and services will not be available to them in the government health plan.[35] States, however, may provide "additional" benefits for their own citizens, at their own citizens' expense.

Medical benefits are to be tightly controlled. In general, according to the Senate bill, "benefits" for services are not available under the act unless the services meet the standards in Section 201(a), *as defined by the Secretary*."[36] (Emphasis added.) The Secretary of HHS "shall" make coverage decisions with experimental services, and patients can appeal those coverage decisions based on a process that shall, "as much as is feasible," follow the current Medicare appeals process.[37]

Government benefit setting is political process. It is also worth noting, in this context, that government benefit setting, based on the 50 years of experience, will surely replicate the intense and frenzied lobbying that characterizes the provision of new benefits or changes in the Medicare program. Congress is often beholden to the "Medicare industrial complex"

of powerful provider and other medical groups, and Medicare today is a big arena for special interest group lobbying.[38] Meanwhile, Medicare's benefits and services often lag behind the provision of benefits and services in the private sector. Moreover, in the adjudication of claims for benefits or services coverage, the current Medicare program has a record of being more stringent than the private sector, and the appeals process in Medicare is complex, cumbersome, and painfully time consuming.[39]

No Cost Sharing. The bill provides that government plans' medical benefits and services will be "free" at the point of service. It thus forbids any "cost sharing," such as the payment of deductibles, copayments, or coinsurance.[40] Cost sharing for prescription drugs and "biological products" would be the major exception. For these categories of medical services, cost sharing would be permitted for the government plan's drug benefits as long as the use of the drug is "evidence-based," encourages generic substitution, does not apply to "preventive drugs," and the amount is limited to $200 per person annually (adjusted for inflation).[41] The government would also forbid doctors (or other medical professionals) to charge patients any amount above the set government payment for medical benefits and services.[42] In short, no "balance billing."

There is, of course, an inverse relationship between premium price and program costs and the level of cost sharing in health insurance. The higher the cost sharing, the lower the premium and program costs. In light of current practice in the traditional Medicare program, the bill's restriction on cost sharing is a radical departure from traditional Medicare, which, in fact, imposes an array of cost-sharing requirements on benefits and services in order to dampen excess utilization and control both program and beneficiary costs. Without such cost sharing, the premium costs would be higher for both patients and taxpayers. Economists generally conclude that the existing Medigap and other supplemental coverage arrangements in the Medicare program that eliminate patient cost sharing at the point of service have contributed to significant increases in both beneficiary costs and overall Medicare program costs.[43] The Sanders bill would also generate higher health care costs.

In the new government health plan, medical professionals would be subject to government medical-practice guidelines. Over the past five decades, federal law and regulation has progressively weakened the professional independence of Medicare physicians. Remarkably, the bill is a bold and explicit rejection of Medicare's original statutory prohibition of government interference in the practice of medicine: "Nothing in this Title shall be construed to authorize any federal officer or employee

to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.[44]

The guideline language includes a proviso that any deviation from a practice guideline would be considered within the guideline if the medical professional deviating from it did so with "appropriate professional discretion."[45] Because the Senate bill is silent on the topic of medical liability or tort reform, it is unclear what impact federal medical practice guidelines will have in either encouraging or discouraging litigation. In any case, attempts to adjudicate thorny disputes in such matters will entail some complex and difficult administrative and judicial proceedings.

Long-Term Care. Beyond the provision of acute care benefits and services, the bill would also provide for expanded coverage under a revamped Medicaid program for 13 long-term-care services and supports, ranging from nursing home care and intermediate care, to home-based and community services and self-directed personal assistance services.[46]

In financing long-term care, the federal government would make Medicaid payment to the states as long as the states do not adopt eligibility standards that are more restrictive than those in force as of May 5, 2017.[47] Payment to the states would be based on an "expenditure floor," and indexed annually by the Medical Consumer Price Index (M-CPI). The basic level of state spending, or the "expenditure floor," in turn would be based on the state long-term-care spending for fiscal year 2017. This level of spending would be adjusted by a growth formula that would include the percentage increase in a state's overall health care costs, long-term-care spending in the previous year, population increase, and the increase in the population aged 65 and older. In receiving the federal payment, the states cannot, in any way, restrict eligibility for long-term care services and supports, but the states may set "additional standards" for eligibility, benefits, and providers "consistent with the purposes" of the act.

Doctors and Medical Professionals. Under Title III, the Senate bill sets forth the terms and conditions of provider participation. No American doctor or other medical professional would be legally authorized to provide medical benefits or services under the act without entering into a "participation agreement" with the Secretary of HHS. In turn, the Secretary is to require any physician or professional participating in the government health plan to furnish services in accord with the aforementioned "non-discrimination" clause of the bill (Section 104), refrain from charging patients any more than the government payment specified for the service, and agree to abide by the Secretary's request for information

and reporting requirement, as well as cooperate with quality reviews and record-keeping requirements.[48]

Physicians and other medical professionals can remain in good standing with the federal government if they comply with the federal regulations and the various standards prescribed by the Secretary, and they will enjoy the government's protection if they testify in any proceeding or report to the authorities any violation of any of the provisions of the Act.[49]

Private Contracting Restrictions. The Senate bill also provides a limited right of private contracting with patients outside the government program. This right of contract is broadly similar to the right of private contracting between doctors and patients permitted in the current Medicare program. Specifically, a doctor or other medical professional may enter into a private contract with a patient if they provide advanced notice to the patient that they will not submit a claim to the government for the service, sign an affidavit that they have entered into a private contract with the patient, submit the affidavit to the Secretary of HHS within 10 days, and refrain from providing medical services for government reimbursement to all other patients eligible for government health services for a period of one year.[50]

This restriction on the right of doctors and patients to contract with each other privately is similar to the current restrictions in the Medicare program. Under the current Medicare law, doctors and patients who enter into a private agreement with each other, for reasons of patient privacy or any other reason that they deem appropriate, can do so. Under the Medicare statute, however, the doctor must "opt out" of the Medicare program and forego treating *all other* Medicare patients for a period of two full years.[51] This unusual restriction on the doctor-patient relationship does not exist, of course, in any other American government health program, such as the FEHBP or even Medicaid. Ironically, such a restriction does not even exist in the British National Health Service, the quintessential single-payer system, where doctors freely practice in both the government program and the private sector. Throughout the 1990s, the Clinton Administration, however, was persistent in its efforts to expand federal control, and succeeded in getting the current restriction enacted through the notorious Balanced Budget Act of 1997. The law secured its intended effect: Voluntary, private agreements between doctors and patients within the Medicare program barely exist. Less than 1 percent of American physicians today "opt out" and enter into private contracts with Medicare patients.[52] Under the Senate bill, the public can expect a similar outcome.

In real life, there are a number of legitimate reasons why patients would not want to submit a claim to a government agency to reimburse

their medical treatments. It may be a strong desire for personalized medical care, a concern over the sensitivity of their medical condition, the higher quality of the personal care that they have received from a physician with whom they have enjoyed a long professional relationship, or simple privacy. While Medicare law and regulation, as well as private third-party payment contracts, have attenuated the traditional doctor-patient relationship, the Senate bill would largely complete the process, and would strongly discourage the viability of independent medical practice or the pursuit of personalized medical care.

Centralizing Federal Power

Today, the American health care sector of the economy is roughly $3.2 trillion. With the elimination of almost all private insurance and the elimination, consolidation, or transformation of almost all other federal government health programs, the Secretary of HHS, as noted, would be vested with vast administrative authority to develop "policies, procedures, guidelines and requirements" to implement the many provisions of this far-reaching legislation. With the adoption of the Senate bill, federal regulatory power would pervade virtually every aspect of the financing, organization, and delivery of medical care in a sector of the American economy larger than the GDP of France.

Data Collection. The task will require a herculean effort in central economic planning. Central planning requires the collection and organization of vast amounts of information to inform and guide regulatory initiatives. Under the bill, the Secretary of HHS would be required to create a national database. This database is to contain information on the performance of medical professionals, the costs of benefits, services, and facilities, and the quality and outcomes of the medical services being delivered by the government health plan and its contractors.[53] This information is to be made available to federal officials, health care providers, analysts, economists, researchers, and scholars without "compromising patient privacy."

The Secretary of HHS is required to submit an annual report to Congress on the implementation of the act, outlining the progress and the problems that it encountered in its enforcement. The bill further requires the Secretary to report on more than a dozen specific areas, ranging from enrollment and health care spending to progress in reducing ethnic and racial disparities and quality improvements. The bill also authorizes the Secretary to consult or contract with experts and conduct empirical analyses and research on health-related topics, including health care

payment and delivery methods and the standards required for "evidence-based" policymaking.[54]

Waste and Fraud. The bill requires the HHS Secretary to appoint a "Beneficiary Ombudsman" to process complaints from beneficiaries and address patient grievances, as well as identify problems in the government health plan, particularly in relation to coverage or payment policies. The bill further provides for application of the current law's provisions to combat waste, fraud, and abuse, including the existing sanctions against guilty providers, such as the exclusion of providers from the program, the imposition of civil and monetary penalties, and the provisions that require medical professionals to disclose their ownership of medical facilities.[55]

Medicare and Medicaid are plagued annually with tens of billions of dollars in losses from waste, fraud, and abuse. In 2015 alone, Medicaid's improper payments amounted to $30 billion.[56] In Medicare, improper payments reached $43.3 billion that same year.[57] Private plans seem much better at policing and arresting these problems that are seemingly intractable in the public sector. In any event, the Sanders legislation is prescribing largely the same remedies for the same problems that have burdened Medicare and Medicaid for decades. Taxpayers can expect, given the sheer scope of the problem and the attendant costs, that under the new government health plan the losses will only substantially increase, not decrease, under the terms and conditions of the bill.

Global Budget. The HHS Secretary "shall establish" an annual "national health budget" no later than September 1 of each year. The national budget will account for the "total expenditures" for medical benefits and services provided under the government health plan. Among its categories, the budget will also outline spending for health-quality assessment, the education expenditures for health professionals, the administrative costs of the program, operating and capital expenditures related to the plan, and prevention and public health activities.[58]

For a five-year period, beginning with the first year implementation of the new law, the bill specifies that 1 percent of the national health budget is to be allocated for "worker assistance" for persons who lost employment because of the elimination or dislocation of existing commercial insurance arrangements, such as the elimination of private insurance plans in the individual market and those firms marketing or administering employer-based health insurance.[59]

With an administrative payment system, as envisioned in the bill, there are ample mechanisms to ratchet down provider payments to meet

spending targets set by a national health budget. The tougher challenge will be political. With the adoption of a national health budget—setting a fixed amount of dollars for health care—the key question is whether or not any Congress will really adhere to the budget. If the demand for medical services is higher than the government officials anticipated, they will face intense pressure to discard the budgetary constraints and simply increase the health care spending. In that case, the budget is meaningless.[60] If government officials stand firm by the budget they created, in the face of rising demand, there will be a denial of access to medical services, or a more-or-less sophisticated form of government rationing, where federal officials will determine which patients receive care, when they receive it, and under which conditions they receive it.

Provider Payment. The HHS Secretary is required to establish, through regulation, fee schedules for doctors, hospitals, and other medical professionals that are consistent with Medicare payment rules and recent rules established under the Medicare Access and CHIP Reauthorization Act of 2015 as well as those under Obamacare.[61]

The Medicare physician payment system, which sets the dollar amounts for roughly 8,000 medical services, is an administrative payment system. A complex set of formulas determine and update the annual amounts of physician payment. At the heart of this system is the resource-based relative value scale (RBRVS). With the support of the first Bush Administration, Congress enacted the Medicare RBRVS into law as part of the Omnibus Reconciliation Act of 1989. Under the RBRVS, the "value" of a physician service is equal to the resources required to deliver it. The determination of economic "value" in this case is not subject to the free-market forces of supply and demand, where consumers judge the relative value of the different commodities, goods, and services through market transactions. Instead, government officials or their agents determine, for this purpose, economic value "objectively." They accomplish this feat through a social science measurement of the various resources that go into providing a particular medical service, including the time, labor, or level of effort, as well as practice and malpractice costs that are appropriate to the service, adjusted for geographic costs. On a regular basis, special committees of medical professionals, acting on behalf of the federal government, meet to evaluate and determine the "relative values" of medical services.

The Senate bill would also require the Secretary of HHS to establish a "standardized process" to review the "relative values" of physicians' services, and to consult the "stakeholders" in this process. The Secretary

is further required to present a "written plan" to Congress each fiscal year on physician services, the "relative value" of these services, and the rationale used for the determination of the "values" of these services. The bill's sponsors evidently believe in the 19th-century economic theory that the value of goods and services is "objective," based on labor or other resource inputs, beyond the perceived benefit or value to a consumer. It is quite the opposite of modern economics, which holds that the economic value of goods or services is subjective, reflecting consumer demand. Of course, in a market, suppliers of goods and services try to satisfy the personal wants, needs, or preferences. In such a large bureaucratic system, as proposed by the bill, the personal wants, needs, or preferences of individuals are usually shortchanged if not altogether irrelevant.

For compensating medical professionals, or any other class of professionals, this is a profoundly flawed approach to reimbursement; such a top-down, supply-driven process does not, as noted, account for value or benefit to the patient.[62] The Senate bill requires that payments for drugs, medical devices, and medical equipment be "negotiated" between the manufacturers and the government annually. In the case of drugs, the Secretary would be required to establish a national drug formulary, a list of approved drugs that are to be reimbursed under the government health plan. In establishing this national formulary, the Secretary "shall promote the use of generic medications to the greatest extent possible."

New Federal Trust Fund. The bill would create a "Universal Medicare Trust Fund" for all federal monies deposited or appropriated to, or transferred from, the general fund in the Treasury, as well as any "gifts and bequests." The bill automatically appropriates monies to the Trust Fund for each fiscal year beginning on the date on which benefits first become available.[63] In other words, like the Medicare program, the funding for the new government health plan is a permanent, indefinite appropriation, meaning that it is mandatory entitlement spending, not subject to the annual appropriations process of Congress.

In the case of existing government health programs, the bill states, "Notwithstanding any other provision of law, there are hereby appropriated to the Trust Fund for each fiscal year, beginning with the first fiscal year beginning on or after the effective date of benefits under Section 106, the amounts that would have otherwise have been appropriated to carry out the following programs."[64] Included in this sweeping, automatic rechanneling of appropriated funds are amounts that would have otherwise gone to fund Medicare, Medicaid, the FEHBP, TRICARE, the federal maternal child and health program, a number of Public Health Service

programs, and "any other Federal program identified by the Secretary, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health services the payment of which may be made under this Act."[65] As noted, the bill would provide for the transfer of funds in the existing Medicare trust fund into the new Universal Medicare Trust Fund.

Transitioning Out of the Status Quo

During the four-year period between the enactment of the legislation and its full implementation, the legislation makes a number of major changes to existing federal government health programs. As a general matter, these changes would both increase the benefits offered through these temporary programs and consolidate the federal government's delivery of medical benefits and services.

Medicare. The Sanders bill would progressively lower the age of Medicare eligibility. The eligibility standard would include U.S. residency, including legal alien status and citizenship, or a person not otherwise eligible to benefits under Parts A and B of Medicare.

In the first year of the transition, the existing Medicare program would be open to all persons who have reached the age of 55; the second year, all those who reached the age of 45; and the third year, all of those who reached the age of 35. The Secretary would establish an enrollment period for these new Medicare enrollees, and the Secretary is required to determine their premiums. In determining the annual premiums for the new enrollees, the Secretary is to calculate the amount based on the "average per capita amount for benefits and administrative expenses" that would be payable under Parts A, B, and D, and, as applicable, Part C, for the newly enrolled persons.[66] Persons enrolling in Parts C and D, where private plans would offer benefits, would be responsible, as they are today, for paying any additional premium amounts for these benefits.

For the transition period, the bill makes a number of other Medicare policy changes. For Medigap coverage, the supplemental private insurance that covers benefits and costs not covered or reimbursed by traditional Medicare, the bill would require Medigap insurers to offer their policies on a guaranteed-issue basis for newly enrolled individuals, meaning that they must enroll newly insured persons without underwriting or evidence of insurability.[67]

With regard to traditional Medicare, the bill eliminates deductibles in Part A (the part of the program that pays hospitals) and Part B (the part of the program that reimburses physicians and outpatient medical services).

While eliminating the Medicare deductibles, the bill also provides for annual catastrophic coverage for Medicare beneficiaries, which is the biggest coverage gap in the traditional Medicare program. In this instance, catastrophic protection would kick in after a person's annual out-of-pocket expenses, such as coinsurance and copayment, reached $1,500.[68] This is a relatively low threshold, and would increase taxpayer obligations. The maximum out-of-pocket limit currently required in Medicare Advantage (MA) is $6,700 annually, though most competing MA plans have annual limits of between $3,000 and $4,000.[69]

Regarding the Medicare drug program, the Senate bill would reduce beneficiaries' annual out-of-pocket threshold to $305, and would eliminate all beneficiary cost sharing above that threshold.[70] The bill would also enhance the benefit package of traditional Medicare by adding coverage for dental and vision services, hearing aids, and examinations to Part B coverage.[71] Finally, the bill would eliminate the current two-year waiting period for Medicare coverage for eligible disabled persons.[72]

A Public Option. The Senate bill would create a "Medicare Transition Plan" that would compete with private health plans in the Obamacare health insurance exchanges throughout the nation.[73] This is the public option. The transitional plan would comply with all of the Obamacare insurance requirements necessary to be a "qualified health plan" under current law, benefits would have a 90 percent actuarial value, and enrollment would be open to any U.S. "resident."

Payment to doctors, hospitals, and other medical professionals would be set at Medicare fee for service rates, and payment for prescription drugs under the plan would be subject to government "negotiation." If the administrator of the Centers for Medicare and Medicaid Services (CMS) and the drug manufacturers are unable to come to an agreement, the administrator "shall" establish a payment rate that is the lesser of drug payments under the Veterans Administration program or the drug payments for the Department of Defense and state Medicaid programs.[74]

Physicians and other medical professionals participating in the Medicare or Medicaid programs would be required to participate as "providers" in the Medicare Transition Plan: "A health care provider that is a participating provider of services or supplier under the Medicare program under Title XVIII of the Social Security Act (42 U.S.C. 1395, et seq.) or under a State Medicaid plan under Title XIX of Such Act (42 U.S.C. 1396, et seq.) on the date of the enactment of this Act *shall* be a participating provider in the Medicare Transition plan."[75] (Emphasis added.) For the vast majority of American physicians, this provision would amount to government conscription.

The current income cap of 400 percent of the federal poverty level (FPL) for eligibility for Obamacare premium tax credits would be lifted for those enrolling in the transitional plan. The CMS administrator would determine the premium amounts for plan enrollees, and these amounts "may vary" based on family or individual coverage, age, and tobacco status, but not the "rating area"; the administrator must also take into consideration the cost-sharing reductions and premium tax credits available.[76]

The bill also provides for special premium tax credits for the public plan for low-income persons in states that did *not* expand their Medicaid coverage. Premium tax credits for enrollees in the public option would be available for all those below 100 percent of the FPL.[77] The premium tax credit would be re-adjusted so that those with annual incomes below 100 percent of the FPL would pay no more than 2 percent of their household income in premium, and those with an income at 150 percent of the FPL would pay no more than 5 percent.[78] The bill also authorizes the HHS Secretary to set new cost-sharing rules for these enrollees.

Senator Sanders' bill thus delivers on a major Obama Administration policy objective that was scuttled during the Obamacare debate in 2010: a "robust public option"—a government health plan—that would compete against private health plans in the national health law's insurance exchanges throughout the nation. Proponents have long argued that a "public option" would enhance market competition and, among other things, keep private insurers "honest." The initial 2009 legislative version of what would eventually emerge as the Affordable Care Act, the House Tri-Committee bill, included a public option and provided it with special advantages, such as artificially low provider payment rates based on the Medicare payment system and a shift of financial risk to the taxpayers.[79] The Sanders' bill, with special rules for the transition plan, provides that advantage. In fact, the original proponents of the public-option strategy made it quite clear that the purpose of the proposal was to undercut private health plans, drive them out of the market, and create a single-payer system in the process. The Sanders' proposal would thus accelerate the transition to the universal government health plan.

A Large and Expensive Program

As noted, the Senate bill contains no provisions for financing the new government health program. The CBO has not yet provided a tax and budget score of the legislation. Nonetheless, Senator Sanders has provided a list of "options"—new federal taxes—to finance the new government health plan along with 10-year revenue estimates.[80] The new

federal taxes would serve the dual function of funding the new government health plan and furthering a greater government redistribution of Americans' income.

Taxing the Middle Class. Senator Sanders' tax proposals, or some combination of them, would be the financial foundation of this program. They include a 7.5 percent income-based premium paid by employers (estimated to raise $3.9 trillion); a 4 percent income-based premium paid by all households (estimated to raise $3.5 trillion); new revenues from the abolition of existing federal tax breaks for insurance—tax expenditures—especially the federal tax exclusion for employment-sponsored insurance (estimated to raise $4.2 trillion).[81]

Taxing the Rich. Senator Sanders has also suggested new taxes on upper-income Americans, including a set of progressively higher marginal tax rates. For example, for Americans with annual incomes of between $250,000 and $499,000, there would be a marginal income tax rate of 40 percent. For Americans with an annual income of between $500,000 and $2 million, the rate would increase to 45 percent. For those at the very top of the income scale, making more than $10 million, the marginal income tax rate would climb to 52 percent ($1.8 trillion). There would also be a special wealth tax on approximately 160,000 households with the highest incomes ($1.3 trillion).[82]

For Americans with a household income above $250,000 annually, Senator Sanders has suggested an end to special tax breaks for capital gains and dividends, and has called for capping itemized deductions at 28 percent. He has also suggested closing certain business "loopholes" for those who run an S-Corporation—a small business.

Senator Sanders has also suggested an increase of the estate tax—replacing the existing 40 percent estate tax rate with a progressive tax rate ranging from 45 percent to 55 percent, depending on the value of the estate, with an additional 10 percent surtax on estates' value in excess of $500 million for single individuals and $1 billion for married couples.[83]

For those who run corporations, Senator Sanders has suggested a one-time tax on offshore profits ($767 billion), a new fee on large financial institutions ($117 billion), and the repeal of miscellaneous "corporate accounting gimmicks" ($112 billion).[84]

Previous Independent Estimates. In 2016, independent analysts, operating with different assumptions and models, examined an earlier version of the Medicare for All Act. The bill's financing was broadly similar to, but less robust than, the 2017 version: an employer payroll tax of 6.2 percent; an income-related premium tax of 2.2 percent for all households; the

elimination of existing tax expenditures; and a series of new taxes on wealthy citizens, including increased marginal tax rates, taxes on capital gains and dividends, increased estate taxes, and new corporate taxes. Senator Sanders estimated new spending of the proposal at $13.8 trillion from 2017 to 2026.

Dr. Kenneth Thorpe, a professor at Emory University and a former health policy advisor to President Bill Clinton, basing initial estimates on the 2016 version, found that the real cost of the Sanders proposal was indeed much higher: $24.7 trillion over the period 2016 to 2024. The annual cost of the plan, according to Professor Thorpe, would be $2.5 trillion per year, creating "an average of over $1 trillion per year financing shortfall."[85] Because the true cost of the Sanders plan would be much higher, the funding requirements would also be much steeper. In his analysis of the plan, Thorpe concluded that the combined employer payroll and income taxes would have to increase from 8.4 percent to 20 percent. Specifically, the employer-based payroll tax would have to increase from 6.2 percent to 14.3 percent, and the income-related premium tax would have to increase from 2.2 percent to 5.7 percent: "Overall," Thorpe concluded, "over 70 percent of the working privately-insured households would pay more under a fully funded single payer plan than they do for health insurance today."[86]

Thorpe noted that the 2016 Sanders plan would have some unpleasant distributional impacts on certain low-income populations, not just the "rich." For example:

> Medicare beneficiaries would no longer pay premiums and face no cost-sharing but would pay higher taxes. In general, small businesses that do not offer insurance today with 50 or fewer workers would face a 6.2 percent payroll tax increase. Low income populations living in poverty receiving Medicaid would pay more through the 2.2 percent income tax and the 6.2 percent reduction in wages.[87]

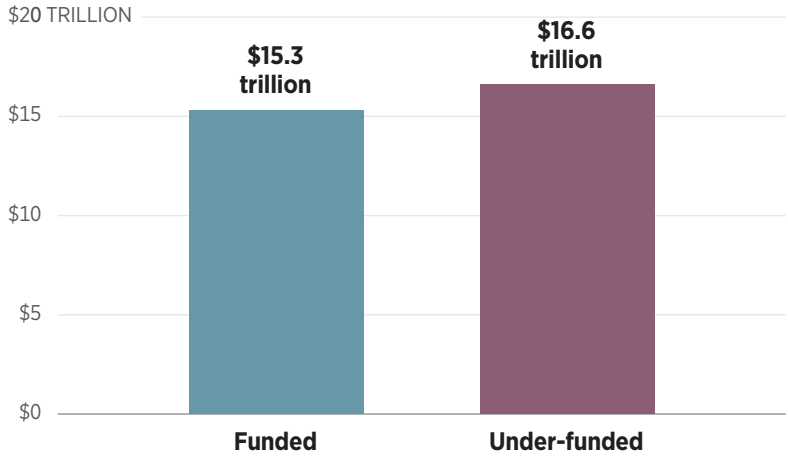
Scholars at the Urban Institute, a prominent liberal-leaning think tank based in Washington, also conducted an analysis of the 2016 Sanders plan. It estimated that the total federal cost would amount to $32 trillion from 2017 to 2026.[88] According to the Urban Institute analysts,

> The increase in federal spending is so large because the federal government would absorb a substantial amount of current spending by state and local governments, employers and households.

CHART 1

Sanders Plan Generates Trillions in Unfunded Costs

According to the Urban Institute, Senator Sanders' single-payer health care plan would raise $15.3 trillion from 2017 to 2026, which would be $16.6 trillion short of the revenues necessary for full financing.



NOTES: Figures are based on Sanders' 2016 plan. The Urban Institute projects a total 10-year cost of $32 trillion. The Urban Institute asserts that this under-financing will demand "additional sources of revenue," meaning new taxes. The taxes and shortfall may be more severe, as indicated on page 1 in the Urban Institute's report, "Response to Criticisms of Our Analysis of the Sanders Health Care Reform Plan," https://www.urban.org/research/publication/response-criticisms-our-analysis-sanders-health-care- reform-plan (accessed October 19, 2017). They now believe they may have underestimated the cost of Sanders' plan.
SOURCE: John Holahan, Matthew Buettgens, Lisa Clemans-Cope, Melissa M. Favreault, Linda J. Blumberg, and Siyabonga Ndwandwe, "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending," Urban Institute *Research Report*, May 2016, pp. 3 and 4, https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private- spending/view/full_report (accessed October 10, 2017).

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> In addition, federal spending would be needed for newly covered individuals, expanded benefits and the elimination of cost-sharing for those insured under current law, and the new long-term support and services program.[89]

Like Thorpe, the Urban Institute analysts estimated that the true costs of the Sanders proposal would outrun the projected revenues. They estimated that from 2017 to 2026, the taxes to finance the government health plan would raise $15.3 trillion in revenue. This, the Urban Institute analysts concluded, would be "approximately $16.6 trillion less than the increased federal cost of his health plan estimated here. The discrepancy suggests that to fully finance the Sanders approach, additional sources of revenue would have to be identified; that is, the proposed taxes are much too low to fully finance the plan."[90]

Conclusion

The ongoing national health care debate is not simply a dispute over health care costs, access, or quality. Virtually all Americans, as well as their elected representatives, agree that there should be a dramatic expansion of health insurance coverage. They also generally believe that government should assist, in some way, those who are poor and sick. They favor policies that would restrain the growth in health care costs, or preferably reduce them. They also support policies that would improve the quality of care that Americans get from doctors, hospitals, and health plans and programs, especially public programs.

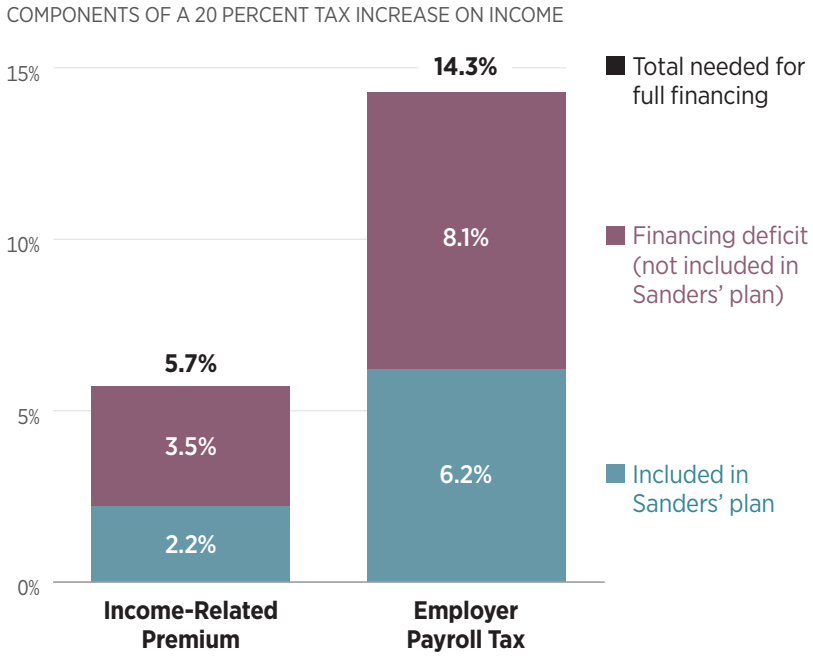
A fundamental conflict of visions is, however, at the heart of this debate. There are those for whom the provision of health care services should be a public responsibility and a federal entitlement. There are others for whom health care should be a matter of personal responsibility, and the choice of health care services should be an exercise of personal freedom. In that sense, the current debate is not just a health policy debate, but rather a quintessentially political debate over power and control. For some, government should have the power to make the key decisions in the system, and government should control the flow of health care dollars. For others, individuals and families should have the power to make the key health care decisions, and individuals and families should control the flow of health care dollars.

Americans today are struggling in a complex system that does not fully reflect either vision, though, it is clear, that the role of the federal government has greatly increased with the enactment and implementation of Obamacare, where the federal government is now exercising plenary regulatory power over the nation's individual and small-group health insurance markets. This attempt at centralized federal regulation has proven to be a costly and painful experiment for middle-class Americans trapped in these severely damaged markets without the generous

CHART 2

Taxes Needed to Pay for Sanders' Health Care Plan

An analysis of Senator Sanders' 2016 proposal for single-payer health care found that the proposal's tax increases would still fall short of the necessary funds. Full financing would require a 20 percent tax increase on income.



NOTE: Figures are based on Sanders' 2016 plan. Taxes reflect what are needed to compensate for the $1.1 trillion in federal financing that were not accounted for (under-financed) in Sanders' calculations.
SOURCE: Kenneth E. Thorpe, "An Analysis of Senator Sanders' Single Payer Plan," Emory University, January 27, 2016, pp. 1 and 5, https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal (accessed October 10, 2017).

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taxpayer subsidies that insulate low-income persons from the ugly reality of rapidly rising health care costs. Middle-class Americans in these markets face skyrocketing premiums and explosive deductibles, narrower provider networks, and fewer choices of health plans and providers.

Senator Sanders and his Senate colleagues have performed a valuable service in sponsoring their comprehensive legislation. They have outlined in detailed legislative text what a government-managed health care system would look like. They have made it clear that it would function as a monopoly, and that it would outlaw almost all private insurance options, including the employer-sponsored coverage that most Americans today enjoy. They have guaranteed a very large increase in taxes, along with the creation of a powerful bureaucracy that will exercise direct and detailed control over health benefits, levels of coverage, health care payments, reimbursements, and even medical practice. They have also made it clear that the personal rights of conscience, relating to sensitive moral and ethical issues, will be violated routinely, and that taxpayers, regardless of their ethical objections, will be forced to finance the destruction of innocent, unborn human life.

Senator Sanders and his colleagues have outlined clearly their vision of the future of American health care. It is long past time that the President and his congressional allies clearly outline their own vision of the future of American health care—and fight for it.

This paper was originally published as Heritage Foundation *Backgrounder* No. 3261 on July 27, 2018, and is available at https://www.heritage.org/health-care-reform/report/government-monopoly-senator-sanders-single-payer-health-care-prescription.

CHAPTER 6

Sacrificing Public and Private Health Insurance for "Medicare for All"

DOUGLAS HOLTZ-EAKIN, PHD, *and* ROBERT E. MOFFIT, PHD

A majority of House Democrats are co-sponsoring legislation (H.R.1384) to outlaw virtually all Americans' public and private health insurance and replace their coverage with a new government plan. In the Senate, Sen. Bernie Sanders's "Medicare for All" bill (S. 1129) would accomplish the same objective.

Americans must fully grasp the necessary trade-offs—the sacrifices—they would have to make if Congress were to create and run such a massive program.

Medicare for All poses a very big question: Is the promise of universal health insurance under a new government health program worth the deliberate destruction of all other public, private and employer-based coverage?

In today's churning insurance markets, about 30 million American residents are uninsured. Examining the data, American Enterprise Institute analysts note that about 15 million Americans are already eligible for coverage under Medicaid, the Children's Health Insurance Program and the Affordable Care Act of 2010 (ACA, or Obamacare). Mysteriously, they do not enroll.

Almost 4 million are eligible for employer-sponsored insurance, but do not enroll. Several million (at least 4 million) are here illegally and thus ineligible for taxpayer-financed coverage. Another 2 million have annual incomes that exceed 400 percent of the federal poverty level ($103,000 for a family of four) and are ineligible for ACA insurance subsidies.

Finally, there are about 2.5 million uninsured who are poor Americans who live in states that didn't expand Medicaid. This is a problem that can be solved through targeted measures—without destroying all existing health coverage.

Then there's the cost. In the initial 10 years of implementing a Medicare for All program, the aggregate price tag could range between $54.6 trillion and $60.7 trillion, according to Charles Blahous, a former Medicare Trustee. Comprehensive econometric analyses, ranging from the Urban Institute to the Rand Corporation, also show that such a program would substantially increase total costs over current law.

Most Americans would also pay more for their health care than they do today. According to a recent Heritage Foundation analysis, financing such a program would require broad-based taxation equal to 21.2 percent of all wage and salary income, and reduce the disposable income of nearly two-thirds of American households (65.5 percent), making them financially worse off than they are today.

Another big trade-off would be a decline in the timely access to quality care. For example, the Sanders Medicare for All plan would cut medical provider rates by an estimated 40 percent below projected private reimbursement. Such a sharp reduction would inevitably mean increased waiting times, longer delays and denials of care.

Medicare today sets prices for more than 8,000 physicians' services and hundreds of hospital procedures in more than 3,000 U.S. counties. Government price fixing often results in medical goods or services being reimbursed at levels that are often too high or too low. In short, either beneficiaries or taxpayers are routinely shortchanged.

Congressional champions of Medicare for All legislation often insist that a new universal Medicare-like entitlement, compared to multi-payer private insurance, would centralize all provider payment and secure significant administrative cost savings.

Comparisons between Medicare and private insurance are often apples to oranges comparisons. For example, private firms tend to concentrate more heavily (and successfully) on such items as utilization review, quality measurement and fraud detection. Medicare does not concentrate as effectively in these areas, and though it records lower administrative costs, it also loses tens of billions of dollars annually (roughly 10 percent) in waste, fraud, abuse or "improper" payments.

These are real costs, but they are rarely counted as part of Medicare's administrative costs. The Government Accountability Office (GAO) has recorded more than $50 billion annually in waste, fraud or abuse. If

today's Medicare is the model, taxpayers can expect those large annual losses to increase to scale with a universal program.

Public policy is not simply a matter of setting goals; it is also a process of making trade-offs, and Medicare for All has some very serious ones: The destruction of existing health insurance coverage, regardless of personal preferences; the abolition of alternatives to government care; higher personal and public health care costs; longer wait times and delays and denials of care; and, of course, a more thorough politicization of health care decision-making, courtesy of Congress and whatever presidential administration controls the levers of bureaucratic power.

Congress can—and should—take a different approach. It should enact policies that will give individuals and families much greater control over their health care dollars and decisions, and compel health insurers and medical professionals to compete and deliver high quality care at competitive prices.

This article was originally published in *The Washington Times* on January 20, 2020, and is available with links to sources at https://www.washingtontimes.com/news/2020/jan/20/sacrificing-public-and-private-health-insurance-fo/.

CHAPTER 7

New "Medicare for All" Bill Would Kick 181 Million Off Private Insurance

ROBERT E. MOFFIT, PHD

Independent Vermont Sen. Bernie Sanders, a self-described "socialist," is doubling down on his efforts to give federal officials total control over Americans' health care.

The senator has just unveiled the Medicare for All Act of 2019 with 13 leading Senate Democrats, including fellow contenders for the 2020 Democratic presidential nomination: Sens. Cory Booker of New Jersey, Kirsten Gillibrand of New York, Kamala Harris of California, and Elizabeth Warren of Massachusetts.

Americans should find this bill chilling. If passed, it would essentially abolish all private health coverage in America, regardless of whether Americans like their current plans.

Here are the specifics.

Outlawing Current Coverage

This bill, title by title and section by section, is almost identical in substance to the Medicare for All Act of 2017 (S. 1804) introduced in the past Congress.

Under Title I, the bill would create a new national health insurance plan to provide universal coverage to all U.S. residents, regardless of their legal status. This new program would be phased in over a four-year period.

Under Section 107, the bill would outlaw private health coverage, including employer-sponsored coverage, that "duplicates" the coverage

provided under the government health plan. Approximately 181 million Americans would lose their existing private coverage.

Like the earlier version, the new Senate bill would also abolish other federal health programs, including Medicare, Medicaid, the Children's Health Insurance Program, Tricare, and the popular and successful Federal Employees Health Benefits Program. The tens of millions of Americans currently covered by these programs would also be involuntarily absorbed into the new government health program.

Under Title II, the bill would provide 13 categories of health benefits, including a new long-term care benefit. This is a richer benefit package than that contained in the earlier Sanders bill, which listed 10 categories of benefits. Also like the earlier bill, taxpayers would be compelled to fund abortion, and the bill would override current law that ensures conscience protections for medical professionals.

The new bill would also eliminate virtually all cost sharing, except for a limited out-of-pocket obligation for prescription drugs. This provision, of course, would induce increased demand for medical services and thus increase the overall costs of the program.

Under Title II, the bill would set forth detailed terms and conditions for the participation of doctors and other medical professionals in the government system, including the limiting conditions governing private contracts.

Under Section 303 of the new Senate bill, private contracts between doctors and patients would be discouraged. Doctors who choose to take private payment from patients outside the system would face a stiff penalty.

Under Section 303, the physician would have to sign an affidavit that he engaged in such a contract, submit it to the secretary of health and human services, and then forego all reimbursement from all other patients enrolled in the new federal entitlement for a period of one year. Few doctors, of course, would be able to do such a thing.

This is essentially the same policy embodied in the previous version of the Sanders legislation, and an even more restrictive version is embodied in the House bill (H.R. 1384).

This, along with the abolition of all insurance alternatives, would come as a striking restriction on patients' personal liberty. Interactions with physicians are sometimes focused on highly sensitive matters, and patients might desire confidentiality and prefer not to submit a claim either to a government agency or even a private insurance company.

Then, of course, there is also the problem of getting access to specialized services. If the government plan, operating as a monopoly, does not

or cannot offer you what you want or need, you would have no viable alternative under this legislation.

The Likely Consequences

If the Senate bill—or some version of it, such as the House Democratic bill—were to become law, ordinary Americans could surely expect three major consequences.

1. Slower care.

With a single government health program designed as an entitlement for 327 million Americans—providing services "free" at the point of service—utilization would explode. Americans would face long waiting lists, delays, and even denials of medical care. It would be unavoidable.

The experience of "single payer" countries, like Britain and Canada, shows that waiting lists for medical treatment are common, especially for hospitalization and specialized medical services.

2. Even fewer doctors available.

Today's doctor shortage, fueled by accelerated retirements and physician burnout, would surely worsen. Beyond imposing Medicare's huge regulatory regime and its paperwork burden on the entire nation, the Senate bill would impose Medicare payment rates (rates lower than with private insurance) as the means to reduce reimbursement for all doctors, hospitals, and medical professionals. Former Medicare Trustee Charles Blahous estimates that this would translate into a stunning 40% decline in medical reimbursement.

While leftist ideologues might vigorously applaud such a radical reduction in physician payment as a major source of health care "savings," the negative impact on patient access and quality of care would be incalculable.

3. Massive new taxation.

Curiously, the new Senate bill, like its predecessor, has no financing provisions. Instead, as with the last version, Sanders has offered a list of financing options that could be used to pay for this massive enterprise, including a 4% income-based premium, a 7.5% payroll tax, the elimination of all tax breaks for existing health insurance, and a series of taxes on wealthy citizens.

Independent analysts have concluded that such "options" would fall far short of covering the true costs of such a program, meaning that

individuals and families would pay much higher taxes than the Senator's revenue proposals anticipate. Both the liberal Urban Institute and the conservative Mercatus Center projected that the earlier version of the Sanders plan would cost approximately $32 trillion over 10 years.

Those earlier projections are obsolete, because the senator has now added a costly long-term care program to the bill's mandatory benefits package.

This is not a realistic way forward. Socialism is the wrong prescription for Americans who want quality, affordable health care.

This article was originally published in The Daily Signal on April 11, 2019, and is available with links to sources at https://www.dailysignal.com/2019/04/11/new-medicare-for-all-bill-would-kick-181-million-off-private-insurance/.

SECTION 3

Framing the National Debate

Introduction

The current debate over single-payer health care is rooted in a conflict of visions: Will government officials make the key health care decisions for Americans? Or will individuals and families be able to make these decisions themselves? Section 3 presents this debate directly, looking at the arguments for and against government-run care. The adoption of a single-payer system requires major tradeoffs: a loss of personal and economic freedom, the loss of existing health coverage, the imposition of unprecedented federal taxation, major payment reductions for doctors and medical professionals, long waiting lists, and care delays and denials.

One of the reasons why this national debate is so pressing is because public opinion is still malleable. When asked, American opinions vary widely depending on how the question is framed. If you tell Americans that universal coverage will lower health care costs, 72 percent support it. However, as Whit Ayres, PhD, points out in Chapter 8, "All you have to do is tell people one thing—this proposal is going to turn health care over to the government—and you end up with a two-to-one opposition to a single-payer health plan." And, the more Americans learn about what government-run care means for their lives, the less they like it.

The debate over single-payer health care is far from over. As Robert E. Moffit, PhD, shows in Chapter 8, how the debate ends depends largely on the information, arguments, and policies advanced by the Right and the Left in coming years.

CHAPTER 8

The National Debate over Government-Controlled Health Care

ROBERT E. MOFFIT, PHD, CHRISTOPHER POPE, PHD, *and* WHIT AYRES, PHD

A Fundamental Conflict of Visions

Robert E. Moffit, PhD: Today, we are going to address proposals to replace America's current health care arrangements with a national a "single-payer" health care system. While I will confine myself to some general remarks, I am happy to introduce two outstanding colleagues.

The first is Dr. Christopher Pope, a Senior Fellow with the Manhattan Institute, a prominent public policy institution based in New York. Chris has written extensively on Medicare, the Affordable Care Act, Medicaid, and the issue of personal freedom in health care. His work has appeared in *The Wall Street Journal*, *Health Affairs*, *U.S. News and World Report*, and *Politico*. Chris earned his bachelor's degree in government from the London School of Economics and both his master's and doctorate in political science from Washington University in St. Louis, Missouri.

Dr. Whit Ayres will follow Chris with a presentation on the changing state of public opinion on single-payer health care. Whit Ayres, well known in Washington, is a leading political consultant. With over 30 years of experience in polling and survey research, he is the founder and President of the North Star Opinion Research Corporation, a public opinion research and public affairs organization. A frequent commentator on network and cable media, Whit has appeared on NBC's *Meet the Press*, *Fox News*, CNN, NPR, and the BBC. His analysis and commentary has been published in *The Wall Street Journal*, *The New York Times*, *The Washington Post*, the *Los Angeles Times*, and *USA Today*. Before starting his career

in Washington, Whit was a tenured professor in the Department of Government at the University of South Carolina. He received his doctorate in political science from the University of North Carolina at Chapel Hill.

A Conflict of Visions

A word about our topic. We are entering into another phase of America's national health care debate, regardless of whether or not Members of Congress want to engage in such a debate. The debate is unavoidable and defined by two diametrically opposed, competing visions of the future of American health care.

The first is that of a health care system powered by choice and competition. My colleagues at The Heritage Foundation, along with 90 representatives and analysts of different policy organizations, have developed the Health Care Choices Proposal as a down payment on such a system.[1] It is a major transfer of regulatory authority over the health insurance market from the federal government back to the states. It would enable state officials to tailor their statutory and regulatory initiatives and reforms to address their particular problems within the particular conditions that exist within their borders. The proposal would repurpose existing funding to better assure access to private coverage for people who have preexisting conditions and who need financial assistance because of their relatively low level of income.

The proposal would also accomplish, if enacted into law, something that no other health care reform measure being considered in Congress would do, and that is unleash an unprecedented degree of personal choice in the health insurance markets. It would enable people who enrolled in public programs to use the money allocated to them in their public coverage, such as Medicaid or the Children's Health Insurance Program (CHIP), and transfer that funding to the private health coverage of their personal choice and it would lower premiums according to independent estimates.

The second is entirely different. It is a vision of total government control over American health care. It is what we are going to talk about today. The proponents of Medicare for All or a single-payer health care program have a very ambitious agenda. The proponents claim that they want to provide all Americans, without distinction, with health care as a legal right. They promise that their program of national health insurance will provide superior care to all Americans economically and efficiently and that care will be more affordable.

The Sanders Bill

Senator Bernie Sanders, the Independent from Vermont, has introduced a comprehensive bill (S. 1804) to establish such a system.[2] You all have access to it. I strongly suggest that you all read the Senator's Medicare for All bill, as well as a similar proposal in the House of Representatives backed by more than half of all House Democrats (H.R. 676).[3] Senator Sanders is proposing a national health insurance program of universal coverage. This would be an entitlement for all U.S. residents, not necessarily citizens. He would establish a national health benefit program and eliminate nearly all cost sharing, making care free at the point of service.

Senator Sanders' bill would outlaw all private health insurance, including employer-based coverage, which covers roughly nine out of 10 people with private health insurance. The only exception would be small plans for certain noncovered benefits or services. Private health insurance, including employer-sponsored insurance, would otherwise disappear.

Given the fetching title of the bill, you will find this somewhat surprising: The bill actually eliminates Medicare. It also eliminates Medicaid and the CHIP program. It absorbs all of the beneficiaries of these programs into the national health insurance program.

In his bill, Senator Sanders does not specify how, exactly, he would fund his program. He does, however, provide a separate list of financing options, including new income and payroll taxes. Senator Sanders has been generous in describing the number of new taxes that will be required to pay for this program.

As a matter of governance, the Sanders bill centralizes virtually all decision-making power over Americans' health care in the office of the Secretary of Health and Human Services (HHS). The Senator specifies that Medicare rates would be the foundation for the payment of doctors, hospitals, medics, and home health agencies—virtually every medical professional throughout the entire United States. Moreover, and for many of us most important, the bill would sharply restrict the ability of doctors and patients to engage in a private contract for medical services outside the system. Under Section 303 of S. 1804, the bill would severely curtail such contracts between doctors and patients where patients spend their own money on medical services.

Broken Status Quo

Let me just make a couple of observations.

First, I think it is critical to know—very critical to grasp—that anyone's opposition to a single-payer system is not and should not be construed as

a backhanded endorsement of the health care status quo. American health insurance markets are concentrated; they are distorted; and they are inefficient. Premium costs in the individual markets are very high and have been soaring over the past four years. For many individuals and families, the deductibles are outrageous.

Health care quality is uneven and falls short in many areas of this country. Far too many Americans are still uninsured. Middle-class Americans, especially those who are ineligible for Obamacare subsidies because of their income, are struggling right now to hold onto the insurance coverage they've got, and those without insurance coverage are struggling to get access to plans that can deliver quality care from a system characterized by progressively narrow provider networks.

As an economic matter, the current American health care arrangements—public and private—are not generally efficient. That is the case under Obamacare. Moreover, before Congress enacted Obamacare in 2010, that was also the case. So, except for a transfer of regulatory power from the states to the federal government, there has not been a significant structural change in the insurance markets to secure either economic efficiency or personal choice.

Second, it is important to appreciate the profound emotional appeal of the single-payer proposal. It is what mainly explains much of the positive but preliminary polling on the proposal. Consider the lofty promises: Free care for all at the point of medical service; high-quality care for everyone; universal coverage; comprehensive benefits covering everything from tonsillectomies to toupees; no deductibles; no copays; no premiums; no messy managed care networks; no high administrative costs; and, finally, really serious, no-nonsense cost control. It all really sounds great. When you think about it, who could possibly be against it?

It also has an appealing simplicity. It is logically coherent. The government gives you health care, and you pay the government taxes—very big taxes, of course, but less, so they promise, than what you would pay if you were paying all of those high premiums and deductibles to private health insurance companies. Moreover, it would impose more rational payment on the rich medical professionals. Doctors and other health care providers of all sorts would be paid less and become public servants or the equivalent of public servants, and hospitals and other medical facilities would become the equivalent of public utilities. In any case, what could be simpler than that?

Promises

Single-payer proponents make many big promises. Well, I can make some big promises too. Before I turn this discussion over to Chris, here is what I promise.

First, I promise that congressional budgetary decisions and political decisions, not medical decisions or even rational economic decisions, will drive the new single-payer program. Even so, politicians cannot repeal the laws of supply and demand. If health care is a universal free good, then it is for all practical purposes what we can expect from the provision of what economists deem a free good. Free goods have certain invariable characteristics. Consumers literally act as if they are free even if they are not; and if health care is indeed a free good, then economic demand for that free good is unlimited. It is not subject to the price mechanism of the market, simply because there is no market.

However, unlimited demand at any given point in time must collide with limited supply. This means that government officials, not doctors, and certainly not the passive patients, are going to make the key decisions about who gets care, how they get care, when they get care, and under which circumstances they get care. The key decisions in such a system, in other words, are ultimately political decisions. You could say, of course, that these are budgetary decisions dictated by some impersonal bureaucratically designed formula, but budgetary decisions and the formulas by which funds are allocated are ultimately political decisions. Again, they are not largely medical or even conventionally economic decisions.

Second, I can promise you that cost control in the single-payer system will eventually reduce the supply of medical goods and services. Government officials cannot control demand. Control over popular economic demand is beyond their capacity. They can, however, control the supply of services. They can either control the supply through a global budget or impose a system of price controls on medical goods and services, as provided in the Sanders bill. In either case, supply is deliberately restricted in the face of rising demand, and the availability or quality of care necessarily declines.

Most of you have some familiarity with the British single-payer system, perhaps the most prominent and well-established single-payer program in the industrialized world. To their credit, the British media routinely report on periodic crises in the British National Health Service. Beyond periodic funding problems, Britain fares poorly among modern industrial nations when it comes to survival rates for patients with serious illnesses like heart disease and cancer. British patients are also routinely subject

to long waiting lists, a shortage of medical specialists, and substandard quality for postoperative care. Last winter, when the flu season struck, the National Health Service canceled 50,000 "non-urgent" surgeries across the board. One can only guess what particular surgery for what particular patient was either urgent or nonurgent.

Lost Liberty

Third, I can also promise that you will surrender an enormous amount of personal and economic freedom. Champions of single-payer health care always promise free care for all without exception. Your personal decisions concerning the kind of care you get or want, of course, do not count. Government officials decide what health benefits you get, when and how you get them, under what circumstances you get them, what you pay for them, and how you pay for them.

For Americans who may be subject to a single-payer regime, certain key questions are unavoidable:

- Where can I go if the government program does not provide what I want or what I need?
- Is there an exit ramp from the system?
- Can I buy an alternative health plan, a plan of my choice that will provide the coverage that I want?
- Can I privately contract outside of the government program with a medical professional or specialist of my choice to treat my medical condition?
- If I am permitted to do so, does the doctor or specialist who agrees to see me suffer a statutory, regulatory, or financial penalty?
- Do private medical consultations outside of the system incur some sort of official punishment for members of the medical profession?

All of these are critical questions, and they deserve clear and unambiguous answers. Ordinary Americans will need to know exactly how the new government-controlled system will work in practice: how, in other words, it will affect them personally.

Unprecedented Taxation and Huge Costs

Fourth, I promise unprecedented levels of federal taxation: big taxes. In his analysis of the Sanders' proposal, Professor Kenneth Thorpe from Emory University, a former adviser to President Bill Clinton, estimates that the Senator's plan, if fully funded, would consume about 20 percent of payroll.[4] Understand that this amount would be on top of current federal payroll taxes. Professor Thorpe concludes that 71 percent of all working families would pay more for health care under Senator Sanders' proposal than they do under the current system.

Professor Thorpe is only one independent analyst and the only one thus far who has attempted a detailed tax analysis of the Sanders bill. Over the next several months, there will be more such analyses. If Congress were to enact something like the Sanders bill, it would mean heavy federal taxation. It would mean very large taxes for middle-class persons and even low-income persons. Taxes on the perennially unpopular "rich" will not do the trick in a program of this magnitude.

Fifth, I promise that the actual cost of the single-payer system will be much larger than advertised. When Senator Sanders initially introduced his proposal, he billed the cost at $13.8 trillion over 10 years.

Since the Senator unveiled his bill, prominent and widely respected independent analysts, liberal and conservative, have disputed the Senator's initial cost projections. The Urban Institute, a prominent liberal think tank here in Washington, estimates the 10-year cost of the Sanders proposal at $32 trillion.[5] Dr. Charles Blahous, a former Medicare Trustee and a prominent conservative, writing for the Mercatus Center at George Mason University, estimates the cost at $32.6 trillion.[6] The Center for Health and the Economy estimates the 10-year cost at $44 trillion.[7] Beyond massive increases in federal spending, each of these estimates projects large, additional federal deficits. I note that the single-payer proposals in California, Vermont, and Colorado have all faced similar fiscal problems.

We are now entering the next phase of America's national health care debate. It is going to be a rough debate, consuming a lot of your time and energy. It makes no difference whether Members of Congress, whether Republicans or Democrats, want to have such a debate. It is unavoidable. Too much is broken; too much is at stake. In the meantime, every citizen should be fully informed and understand the consequences of the choices we as a nation are going to make.

It is my pleasure now to turn this discussion over to Chris Pope.

Robert E. Moffit, PhD, is Senior Fellow in Domestic Policy Studies, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.

The Real Trade-Offs

Christopher Pope, PhD: Thank you, Bob, and thank you, everybody, for coming today. Senator Sanders' bill presents us with a simple thesis: If we eliminated all the cost-control devices that private health insurers currently use, then the savings would pay for an enormous expansion of benefits. That does not make any sense. Eliminating cost controls would not reduce expenses; it would cause them to soar.

Insurance companies currently check to see whether the hospital claims are reasonable and necessary, proper or improper, legitimate or fraudulent. They do the same for doctors. They establish networks to get discounts and better control costs. They have a set of preferred providers whose integrity they trust and who they are able to reward for delivering care in a cost-effective way. In addition, most health care plans have substantial cost sharing. This obviously is a standard disincentive to the excessive utilization of services; and even though it may or may not be well designed in specific circumstances, it certainly keeps cost down.

Senator Sanders' theory is that if we got rid of all these various cost-control devices, we would actually end up saving money because, supposedly, such devices are so costly to administer. Well, that is not really the way it is likely to play out. In fact, experiences we have had in the past few years make it clear that it doesn't play out that way in practice.

A Controlled Experiment

We actually already have a good direct, controlled experiment for what a single-payer system looks like alongside a system of private, competing health insurance companies. This is the contrast between the initial Medicare program that was set up in 1965 and the Medicare Advantage Program, which has been developed over recent decades. Medicare Advantage is an option for Medicare beneficiaries who choose to receive their Medicare benefit from competing private insurance companies.

Amy Finkelstein of MIT, along with several coauthors from Stanford University, conducted an apples-to-apples controlled comparison of what it cost to deliver Medicare benefits by competing health insurance companies and having the government pay for each service directly.[8] In short, they found that the delivery of the Medicare benefit through private insurance was 25 percent cheaper than having the government through

traditional Medicare purchase medical services directly. Moreover, that is the savings from establishing networks, reviewing medical claims, and controlling access to high-cost specialists. Out-of-pocket costs under the government-administered Medicare program and the existing privately insured Medicare options are currently fixed at the same level: 24 percent of total expenditures.

The Medicare Payment Advisory Commission (MedPAC) commissioned a study of what happens to the cost to taxpayers when you eliminate cost sharing entirely in the traditional Medicare program, which Medigap's Plan F does, and found that this elimination increases Medicare spending by an extra 27 percent.[9] If you compounded the 25 percent cost from losing the savings generated by private insurers with the 17 percent cost from eliminating cost sharing, for the sections of the population who would be effected, it would yield a 39 percent increase in total health care costs borne by Americans. That is equivalent to $10,000 per household.

Bear in mind, all this does is get rid of health insurance claims reviews, get rid of networks, and get rid of patients' out-of-pocket medical costs. This calculation does not include the cost of extending coverage to anyone who is currently uninsured. Nor does it include the cost of adding additional health benefits, like dental care, which are currently not covered by the traditional Medicare program. Both of those types of costs would be in addition to the extra $10,000 a year per household that would be required to end networks, claims reviews, and cost sharing.

Additional Taxes

So the question, then, is this: Is the average American household willing to pay an extra $10,000 over and above what their employer is paying today for their health insurance just to get rid of claims reviews, networks, and out-of-pocket costs? $10,000 a year per household. Most Americans, when they learn the details, are likely to find that pretty hard to stomach.

The prospect of these enormous additional taxes is why states like Vermont and New York have had second thoughts about this approach. The legislatures in those states have said to their governors, "You figure out how to pay for it." Vermont's governor came back with the news that the state would have to double its tax revenue for this to be feasible. That finding killed the whole project in the bluest of blue states—and Bernie Sanders is undoubtedly aware of it.

People often ask: How are other countries able to fund everybody's care with little in out-of-pocket costs without a crippling burden for taxpayers?

The first thing to note is that the United States government currently spends more than the British government on health care. The United States government spends 8.3 percent of GDP. The British, according to World Bank data, spend about 7 percent of GDP on health care, funding its National Health Service. Therefore, if government spending is the answer, we have more than enough government spending already to purchase and deliver essentially the same health care that the British have today without touching what the private sector is doing.

A second point is that the United States has many more hospitals. The United States' Medicare program has 4,700 participating hospitals. England has 200 hospitals. Obviously, the United States is a bigger country, but that is still four times more on a per capita basis. More hospitals means higher overhead costs, more costly medical equipment, and likely lower occupancy rates. If those costs are spread over fewer patients, then the costs per procedure will be higher. The United States may need more hospitals because it is a less densely populated country, but if you want to address the cost of American health care, you have to address the costs of hospitals.

Differences in Quality

Third, the quality of care really does differ from country to country. However, most people have not undergone the same major procedure in multiple countries, so they are not able to compare the patient experience of having a heart replacement in England and then having the same operation in the United States and comparing the quality of both. No one has that experience. If you look at the statistics, however, mortality is 39 percent lower after a stroke in the United States than it is in England and 72 percent lower after a heart attack in the United States than in England. The quality of care is significantly higher in the United States.

Fourth, American health care faces a tougher task in many respects because the disease burden is much greater in the United States. The United States has twice the obesity level than the European Union. That means it has much higher levels of the most expensive diseases, like diabetes, heart disease, strokes, and many types of cancer, and so America's health care system must do much more work.

Fifth, there is also the fact that high-skilled labor is also much more expensive in the United States than it is in European countries. This, in a sense, is the offshoot of a good thing: It is much easier to start a business in the United States than it is in European countries. Therefore, the health care system has to pay more to attract high-skilled people into the medical profession.

Sixth and finally, there is the issue of waiting lists. Substantial waiting lists for access to specialist physicians and surgeries are common in single-payer systems. Waiting lists actually do save money. When some people are waiting for care, some people get better. If you wait six months for treatment, some medical conditions resolve themselves.

Waiting lists also save money because patients often give up trying to get care. The process you actually have to go through in many other countries to get treatment, to get a knee replacement or a hip replacement, can be quite formidable. Patients are not going to die from such conditions, and they just bear with the pain. That is certainly not an uncommon thing in many single-payer systems.

However, for many conditions, people actually do die while they are waiting for care—which will also "save" money. In that case, you are one less person taking up space in the hospital. You are one less person who is not going to be using expensive drugs. You are one less person who is going to be requiring skilled medical labor. There are real savings in that, but that is *not* a good thing.

A key issue is our attitude toward health care spending. Health care is a good thing, and it is good that we are able to purchase a lot of it. We have a lot of sick people, and treating more of them means spending more. If we provide higher-quality treatment, then we will also spend more. However, there is also the question of value: We are clearly doing many things in a very inefficient way, and our hospital industry is clearly bloated and inefficient.

Misleading Comparisons

People like to compare different countries' health care systems, but countries' health systems and populations vary in so many different ways that it is easy to produce misleading comparisons. A much clearer way to understand the issue is just to look at directly comparable situations within our country: traditional Medicare run by the government versus Medicare Advantage, a system of competing private health plans driven by patient choice. Here we have the same kind of patients, who have the same choice, covering the same conditions in the same locations throughout the United States. Both programs, at a minimum, deliver the same benefits, and the same people are entitled to the same things. The result: We have savings in Medicare Advantage, the quality of care for the same people is much better, and medical outcomes are also better.

We have this direct comparison of privately competing insurance companies to the government micromanaging payments and benefits. At the

end of the day, when the government micromanages everything, you have people show up here on Capitol Hill and say to you, "I want you to cover my expensive procedure" or "I want you to increase the payment for my billing code" or "I want you to prevent my facility from closing down with subsidies in this way."

When the federal government starts micromanaging these things on a much larger scale than Medicare, you will not have costs going down over time; you will have costs going up and up and up over time. The medical professionals and the administrators of hospitals and medical institutions do not want to be put out of business, and so they will come to Washington to demand higher payment and higher spending. Politicians will become responsible for the solvency of every hospital and medical practice, and so they will have no choice but to provide whatever money is needed to keep them in business.

Those are a few of the reasons why the single-payer approach is so problematic and a good reason to go exactly in the opposite direction: the path of choice and competition.

A Malleable Public Opinion

Whit Ayres, PhD: Good afternoon, and thank you for taking time out of your day to talk about one of the more challenging and complex policy issues facing America. During the 21st century, health care is going to be a major challenge, especially as the baby boomers retire and age. Our health care costs are inevitably going to increase substantially no matter how many days a week we work out. My goal is to give you a brief overview of American public opinion—and it *will* be brief—to allow plenty of time for questions.

A Persistent Priority

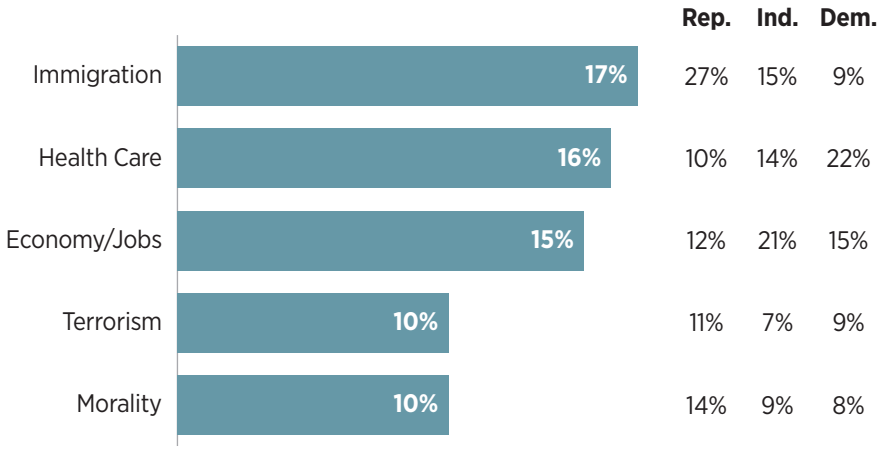
First, it is clear that as an issue, health care is not going away. It ranks as one the most important issues facing America today. Because Donald Trump has focused so heavily on the problem of illegal immigrants, Republicans think illegal immigration is the top issue. Relatively, they split it equally between health care, followed by the economy, terrorism, and morality. Independents pick the economy first, and then there is a tie for second place between immigration and health care. Democrats say health care by far is the most important issue facing the country, followed by the economy.

Therefore, it is safe to say this is one of the top issues facing the country. It is not going away, regardless of what happens in the midterms.

CHART 1

Health Care Remains One of Top Issues Facing Country

Q: In your opinion, what is the most important problem facing the U.S. today?



SOURCE: Ipsos/Reuters poll, July 13–17, 2018.

heritage.org

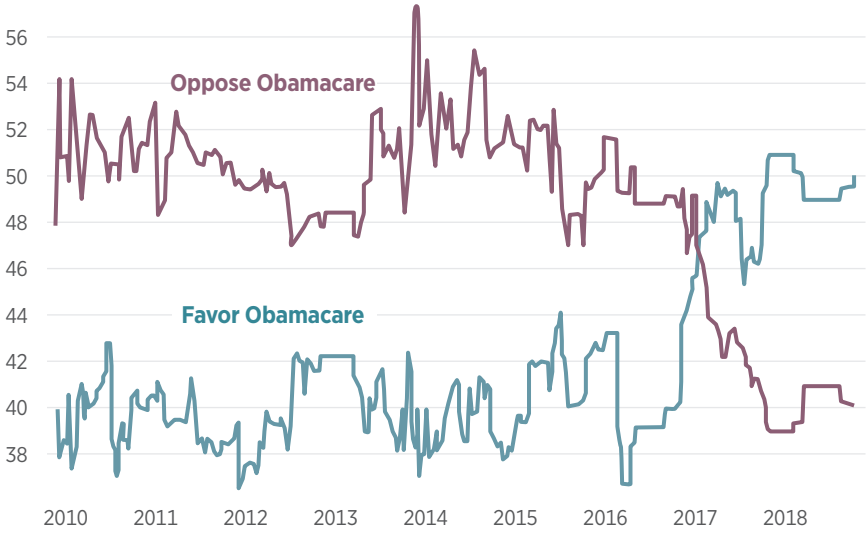
There is an interesting phenomenon with public opinion and the Affordable Care Act. We—I mean we on the Republican side—cleaned up in 2010 because the numbers in opposition to the Affordable Care Act were substantially greater than the numbers in support for the Affordable Care Act. Opposition to the Affordable Care Act continued right up until the end of 2016.

What happened at the end of 2016? Well, there was a prospect of repealing the Affordable Care Act. In addition, look what happened to public opinion: Boom! All of a sudden, the majority of Americans think the Affordable Care Act is not such a bad idea after all. Moreover, it has maintained that popular support as the Republicans have talked more and more about alternatives and repealing various provisions of the Affordable Care Act.

Now we start asking questions about something like a Sanders plan. Do you favor or oppose a national health plan? Do you favor or oppose what some call single-payer, or the "Medicare for All" plan, where all Americans get their insurance from a single government plan? Look at this poll taken last year.

CHART 2

Obamacare Support Surged with Prospect of Repeal



SOURCE: Real Clear Politics, "Public Approval of Health Care Law," https://www.realclearpolitics.com/epolls/other/obama_and_democrats_health_care_plan-1130.html (accessed December 17, 2018).

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Initial Polling

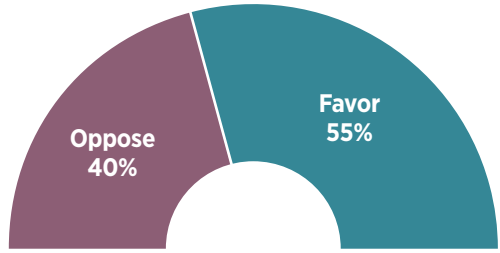
The numbers are very similar in other polls taken more recently. I am using this one because I followed it up with a number of other questions I want to share with you. However, 55 percent favor, and 40 percent oppose. *The Washington Post* teamed up with the Kaiser Family Foundation and conducted another poll this year that showed 51 percent favor. This number, expressing approval, has languished in the 40s for many years. Therefore, this is something new. You now have the majority of Americans, somewhere in the low 50s or low to mid 50s, supporting a single-payer health plan.

Think about it. Let us remember that 40 percent oppose, and 55 percent favor. Let us say we ask people who favor the single-payer proposal at 55 percent, "What if you heard that opponents say the guaranteed universal health care plan would give the government too much control over

CHART 3

Polls Show Majority Support Single-Payer Health Plan

Q: Do you favor or oppose having a national health care plan, or single-payer/ Medicare-for-all plan, in which all Americans would get their insurance from a single government plan?



SOURCE: Kaiser Family Foundation Health Tracking Poll, June 14–19, 2017. heritage.org

health care?" Bingo! Only 33 percent favor; the 55 percent in favor goes down to 33 percent. In addition, the 40 percent opposed goes up to 62 percent. All you have to do is tell people one thing—this proposal is going to turn health care over to the government—and you end up with a two-to-one opposition to a single-payer health plan.

What if they hear that will require many Americans to pay much more in taxes? You just heard about *how* much more in taxes. You have almost a two-to-one opposition to the proposal if the respondents hear just that one thing. Therefore, you go from 40 percent opposition to 60 percent opposition when the American people find out they might have to pay more taxes.

How does the public feel about eliminating or replacing the Affordable Care Act? Well, you have a majority opposing this single-payer health plan. That is a lot of change in public opinion when just a couple of points are made that will inevitably be made in the course of the national debate.

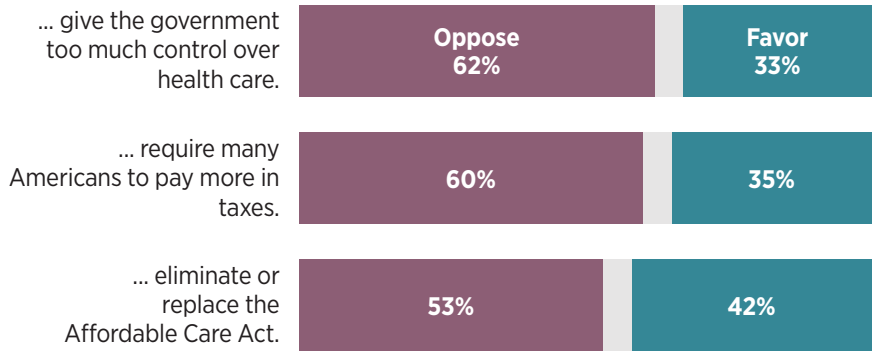
Let us look at this the other way, though. Let us ask that 40 percent who *oppose* the plan: "What if you heard supporters say with guaranteed universal coverage, under such a plan, we'd reduce health insurance administrative costs?" Wow! The 55 percent in favor goes up to 72 percent in favor, and the 40 percent of folks who oppose goes down to 23 percent.

Let's ask this question: "How would you feel about the plan if you knew that it would ensure that all Americans have health insurance as a basic right?" Then the favorable to unfavorable numbers are 71 to 24 percent. Further, "How would you feel if the proposal would reduce the role of all

CHART 4

Arguments Against Single-Payer Health Plan Increase Opposition

Q: What if you heard guaranteed universal coverage through a single-payer plan would ...



SOURCE: Kaiser Family Foundation Health Tracking Poll, June 14–19, 2017. heritage.org

private health insurance companies in health care?" You end up with a two-to-one margin favoring the single-payer plan.

Unstable Numbers

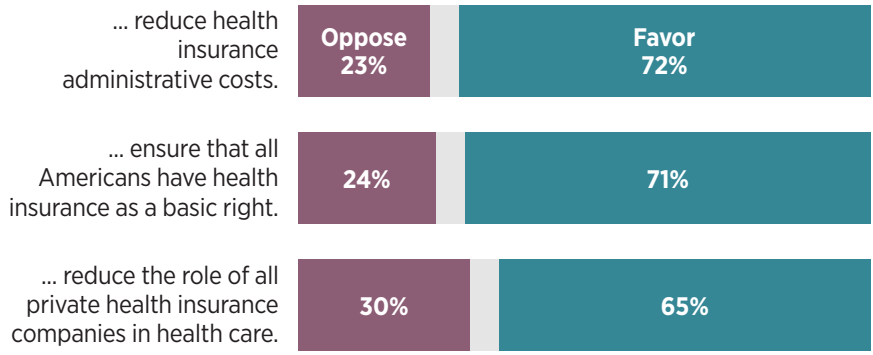
What do these two slides tell you? These two slides tell you that whether it is 51 or 55 percent who say they *favor* a single-payer plan, that number is very malleable. It is very unstable. It is open to substantial movement depending on how the debate unfolds and which side is able to make the key points that can win that debate.

The key message I want you to take away from this short briefing is that the numbers that you are going to see in numerous polls are not in any way cut in stone. They are just a starting point for talking about health care, and they will move all over the place depending on which side is more persuasive in getting its points across. Just to drive that point home, it is interesting to see the numbers go positive or negative in reaction to each of the following terms.

CHART 5

Arguments in Favor of Single-Payer Health Plan Decrease Opposition

Q: What if you heard guaranteed universal coverage through a single-payer plan would...



SOURCE: Kaiser Family Foundation Health Tracking Poll, June 14–19, 2017. heritage.org

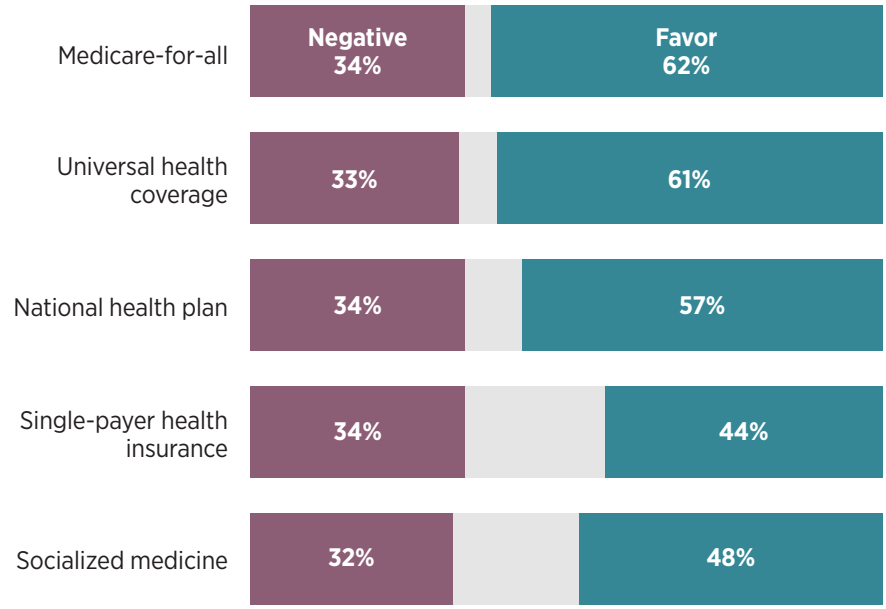
- "Medicare for All." Wow! That is a two-to-one positive reaction, as is "Universal Health Coverage." Who could be opposed to that, letting everyone have health coverage?
- "National Health Plan." That is a 57 percent positive to 34 percent negative.
- "Single-Payer Health Care." That starts to get under 50 percent positive.
- And "Socialized Medicine" is all of a sudden an even-up positive or negative.

Is it any wonder that Democrats have been talking recently about "Medicare for All" while Republicans like to talk about "Socialized Medicine"? This is not an accident. It is perfectly logical and perfectly consistent with this chart.

CHART 6

Support for Single-Payer Plan Varies Dramatically Depending on How It Is Phrased

Q: Do you have a positive or negative reaction to the following terms?



SOURCE: Kaiser Family Foundation Health Tracking Poll, June 14–19, 2017. ☎ heritage.org

This yet again shows that public opinion is malleable and dependent upon which phrases you use to describe the proposal you are talking about.

So let me conclude. Health care will remain an important issue regardless of who wins the midterm elections. It is not going away. It is not going away as a political issue, especially for you folks who work up here on Capitol Hill. The attempted dismantling of Obamacare, coupled with the absence of a viable Republican alternative replacing it, will increase pressure for a new government initiative of some sort.

Senator Lamar Alexander, the Tennessee Republican, desperately tried to build some sort of bridge with Senator Patty Murray, the Washington

State Democrat, enabling the country to pass from what we have now to something better in the future. It was a good-faith effort; it was a bipartisan effort. For some reason, Senator Murray blew it up. Nonetheless, something like that will at least help us to bridge from the current problems to better solutions. Trust me. There will be pressure on those of you who work on Capitol Hill to produce something as Obamacare continues to decline without any other alternative in place.

Finally, if conservatives in Congress leave the field without concrete health policy alternatives, forfeiting that game only hands victory to those who are campaigning for a single-payer plan. I am convinced of that. If folks on my side of the aisle just throw up their hands and say, "We're not into health care. We do not know anything about it," the pressure will build for some form of a single-payer plan not unlike the proposals we've been talking about here today.

Questions & Answers

Dr. Moffit: Thank you. Ladies and gentlemen, please ask questions of any one of us.

Question: Looking at the Affordable Care Act, it appears that it was designed to create increased frustration. Doesn't that contribute to the sense of desperation on the part of the American people that they needed to cheat us so badly that we need the government to figure this all out? Did you look at that or have any thoughts?

Dr. Ayres: We have not asked any question exactly that way. There is no question that the increasing frustration with the health care system increases the demand for something different. I do not know if it is a single-payer plan, but for something different. Keep in mind, most Americans, even those covered by employers, are very satisfied with their health care coverage. However, if you ask people systematically, "Do you think the American health care system is working well? Are you satisfied with the overall health care system?" they are not as satisfied.

Question: One of the ironies of single-payer or government-dominated health care systems overseas that I've observed, whether it's the U.K. or other systems, is how quick people are to sign up and pay for private insurance on top of the taxes that they're already paying. As soon as people have the means, they tend to sign up for the private insurance that the single-payer was supposed to replace. There is some work to be done to highlight that point.

Dr. Pope: I think that is a very good point. What does it mean to have health insurance? In countries like Britain, obviously, only 20 percent

actually have health insurance that delivers a quality of care that is comparable to the United States. You can go privately and see a specialist and have a surgery done in a timely manner. Therefore, insurance is not a generic product; insurance is coverage of a spectrum. The question is: How much are you covered and at what cost?

I frequently encounter the question: Is health care a right? Well, in a sense, it does not really matter whether it is or not. The question is: *Who* pays for it, and how much will they pay? If it is a right, then you still have to pay for it. If it is a right and you pay nothing, someone else is paying for it. Whether or not it is a right, the answer to that question does not practically resolve anything important. These necessary trade-offs are the essence of the single-payer issue.

Question: Chris, a question for you. You said that Medicare Advantage today saves 25 percent over Medicare. Does that include the costs of the government or the costs of the individual? That is part one. Part two: When you make the comparison, does it encompass the Medicare supplement or Medicaid?

Dr. Pope: That comparison is really just the cost of the Medicare package: the physician services and the hospital benefits. Many Medicare Advantage plans have dental and drug coverage, vision coverage; the traditional Medicare benefit package does not. The traditional Medicare benefits package actually does not have an out-of-pocket cap. Therefore, you will have to buy a Medicare supplemental plan on the side. Medicare Advantage has a requirement to protect enrollees from catastrophic costs.

Question: So, then, for the senior citizen the savings are greater because they would have to buy the Medicare supplemental plan on top of the traditional Medicare plan? The Medicare Advantage plan often has no additional premiums, includes all A and B benefits and often drug coverage plus an out-of-pocket cap.

Dr. Pope: Yes, the savings could be substantial.

Question: I think I heard one of you jump in and mention that, given the absence of a Republican replacement for Obamacare, you believe that there will be a continued outcry for single-payer. What about what is happening right now with the alternatives that have been offered like association health plans and short-term plans? They exist; they are options for people.

I tend to agree with you: Without a legislation at the federal level, there will continue to be pressure for single-payer. I think part of it, however, is that people do not know these options exist. So are we going to have to pass something on the Republican side? Alternatively, can we do better just by messaging that there are options?

Dr. Moffit: I think you have no choice. The American people need legislation that is competently crafted and consequential, meaning a bill that will lower their health insurance costs and increase affordable health plan choices for millions of Americans. We cannot think small on such a big subject.

The Secretary of HHS and the Secretary of Labor are to be commended; they have given people, primarily middle-class people, options to get affordable health insurance with the association health plans and the short-term plans. They are what they are: stopgap measures. They do not and cannot change the fundamental structure of the health insurance markets nor remove the provisions of the Affordable Care Act that are damaging these markets, killing choice and competition, and contributing to the dramatic cost increases in the individual and small-group markets.

You can only go so far using administrative authority under current law to create these kinds of patchwork options. What can be done by administration can be undone by administration. Ultimately, Congress is going to have to deal with the problems directly and reform the health insurance markets. That is why I mentioned the Health Care Choices Proposal, which is at this point the most comprehensive way to stabilize the health insurance markets and give people options that they need.

We have to reduce the high premium costs for middle-income Americans right now. They are actually paying the equivalent of a second mortgage in the premiums they are forking over for health insurance.

Dr. Pope: I actually think that the Trump Administration's initiatives would be significant. The reason: It really does make available health plans that are more like the plans that individuals had before the enactment of the Affordable Care Act. If you think about the most unpopular thing about the ACA, it was the broken promise that if you liked your health care plan, you could keep it. These affordable plans would be only a third or half the price of plans on the ACA's health insurance exchanges.

The short-term plans are really going to make affordable coverage a viable alternative. With regard to the new regulations, you would have to sign up for them, and you would have a renewal for up to three years. That is substantial coverage. Then, after three years, you can sign up afresh with the guarantee that you can have coverage for another three years. That can go a long way to restoring the kind of full life coverage for people in the individual market. The short-term plans can help people between jobs who would otherwise be covered in the employer market. The individual market has always mostly been a matter of filling in the gaps.

Dr. Moffit: Let me also comment on that. When the Trump Administration unveiled this option, it did not present it as a long-term solution to the problems in the individual market. They offered these plans as a stopgap measure, primarily to help people who found the health plans in the ACA exchanges so expensive that they could not afford them. These short-term plans were also offered for people between jobs who lost their job-based coverage or people who felt the Affordable Care Act plans did not meet their specific health care needs. They are what they are.

Remember, too, another key legal point: Congress authorized the short-term health plans under the Health Insurance Portability and Accountability Act of 1996. Under that law, Congress gave the states the authority to regulate these plans, and thus, the states will have an awful lot of say about whether or not these plans prosper. I can assure you that many states, particularly liberal or "blue" states, will hinder or close off these coverage options.

In principle, progressive or liberal legislators are often opposed to these plans, and they can be expected to block an individual's access to them because they do not have the full range of benefits or regulatory restrictions required of ACA-compliant plans. This may not be what individuals may want; it is what state *legislators* want that counts. They describe the Trump Administration's efforts to expand personal options as a form of "sabotage" rather than a rescue plan for workers between jobs or middle-class Americans who find their current health insurance too expensive.

Question: Just a follow-up on alternative plans. As you know, plans like Liberty Healthcare and other Christian organizations offer options where premiums or payments are sometimes half those of regular health insurance plans that are "qualified" under Obamacare. Have there been any studies of the financial stability of those organizations?

Dr. Moffit: I am not aware of any. Thus far, however, they seem to be doing all right.

This this will conclude our session. Do not hesitate to contact any one of us if you have further questions. You can reach us at The Heritage Foundation: that is, *heritage.org*. Again, ladies and gentlemen, thank you very much.

This lecture was delivered on September 26, 2018, and originally published as Heritage Foundation *Lecture* No. 1305 on February 19, 2019. It is available at https://www.heritage.org/health-care-reform/report/the-national-debate-over-government-controlled-health-care.

CHAPTER 9

No Choice, No Exit: The Truth About "Medicare for All" Proposals

ROBERT E. MOFFIT, PHD

Polls from the Kaiser Family Foundation and the Harvard School of Public Health with *Politico* show a majority of Americans favor "Medicare for All" proposals—at least in concept, which is simple enough: a single, government-controlled health insurance program that would cover every person residing in the United States.

The Harvard–*Politico* poll found that 68 percent of respondents say that adopting a national health plan like "Medicare for All" should be an "extremely important" priority for the new Congress. The Kaiser Family Foundation reports that 56 percent of Americans favor the proposal, and just 42 percent oppose it.

But do Americans really understand what such a project would entail? Based on the available survey evidence, the answer is no.

For example, the Kaiser survey found that 55 percent of respondents erroneously think that they would be able to keep their current health insurance. Only 35 percent realize (correctly) that they would lose it. Likewise, a national survey conducted by the National Opinion Research Center at the University of Chicago found that 55 percent of respondents think (incorrectly) that participation in such a plan would be voluntary.

In fact, any American can easily learn "what's in" the leading "Medicare for All" proposals. The legislative language of the leading Democratic bills (H.R. 676 and S. 1804) is clear.

The House bill prohibits any private health insurer from offering any of the 10 statutorily designated categories of health benefits or specialized

services authorized by Congress. According to Title I, Section 104 of the House bill, "It is unlawful for a private health insurer to sell health coverage that duplicates the benefits provided under this Act."

The House bill, in other words, would prohibit ordinary Americans from purchasing any alternative health coverage, except for items such as "cosmetic surgery" or health services that government officials decide are not "medically necessary."

Not surprisingly, the Kaiser Family Foundation survey found that if the "Medicare for All" plan would "eliminate private insurance companies," respondents would oppose it by a margin of 58 to 37 percent.

The Senate bill, sponsored by Sen. Bernie Sanders (I-Vt.), also prohibits any private health plan that "duplicates" the benefit coverage of the government's national health insurance program. Under Section 801, the bill outlaws employer-sponsored health insurance: "No employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Act of 2017."

Ironically, the House and Senate "Medicare for All" bills abolish Medicare. Yet the Kaiser Family Foundation survey finds that a majority of Americans would oppose the "Medicare-for-All" plan by a margin of 60 to 32 percent if it "threatens the current Medicare program."

The House and Senate bills would also abolish Medicaid, the Children's Health Insurance Program (CHIP) and Obamacare health plans. Under Section 212 of the House bill, federal funds are to be "transferred and appropriated" from the Treasury in "such amounts" that the Secretary of HHS estimates would have been "appropriated and expended" for Medicare, Medicaid, CHIP and other "federal public health programs."

Under Section 901 of the Senate bill, Medicare, Medicaid and CHIP programs would be phased-out, as would the Federal Health Benefits Program (FEHBP) and the Department of Defense's Tricare program, providing health coverage for military families.

During the 2009-2010 debate on the Affordable Care Act, former President Barack Obama promised Americans, repeatedly, that if they liked their health plan, they would be able to keep their health plan. This proved false: millions of Americans, the vast majority of whom were satisfied with their plans, subsequently lost access to them.

In sponsoring House and Senate "Medicare for All" bills, liberals in Congress are making no such promises to Americans who want to keep their current health coverage. In fact, they are declaring, in black-and-white legislative language, exactly the opposite.

Rep. Pramila Jayapal (D-Wash.) is rewriting the House bill to align the statutory text more closely with Sen. Sanders' comprehensive legislation, and House Speaker Nancy Pelosi has promised House "progressives" hearings on the measure.

Whether you like your health plan or not, whether it is a good plan or not, your preferences would be utterly irrelevant. The bills now under consideration would take your existing coverage away, while outlawing any alternative for you and your family.

There would be no choice, and no exit ramp from the progressives' new health care order.

This article was originally published in the *Sacramento Bee* in January 2019. It is available with links to sources at https://www.heritage.org/medicare/commentary/no-choice-no-exit-the-truth-about-medicare-all-proposals.

SECTION 4

Britain and Canada: Lessons from Their Experiences

Introduction

Health care reform affects many aspects of a nation: social, economic, scientific, and cultural. Prior to implementing a new health care system, it can be difficult to predict what its effects will be. One of the best ways to envision life with government-run health care system in the U.S. is to look at Britain and Canada. Both countries are similar to the U.S. in many ways. And they rely on government-run health care systems: Britain created the National Health Service (NHS) in 1948, and Canada began implementing a single-payer system in 1966. In this section, scholars examine the systems in both countries and explain the negative consequences their citizens have experienced. Americans would be wise to look at their neighbors before implementing an irreversible single-payer system.

Though Britons are proud of the NHS, they are also aware of its shortcomings. British patients suffer from long waiting lists and difficulty scheduling an appointment. In 2011, there were 2.6 million patients waiting for treatment; by 2019 that number had ballooned to more than 4 million, including patients in pain or with life-threatening conditions. The NHS is below average internationally when it comes to preventing deaths from heart attacks, strokes, cancer, and lung diseases. The system has also stifled innovation and delayed the adoption of new drugs. For example, Herceptin, a breast cancer drug that was available in the U.S. in 1998 was not available in Britain until 2002. Meanwhile, the improvement that the NHS has seen comes largely from cooperation with private

sector. Unfortunately, even a government system riddled with problems is not cheap—the NHS is projected to receive 38 percent of all government spending by 2024.

Likewise, the Canadian single-payer system should serve as a warning to the American public. International comparisons indicate that Canada achieves only mediocre, and even poor, performance scores for access to, and timeliness of, health care. Like the British, Canadians suffer from long waiting lists, outdated drugs, and understaffed hospitals. While it claims to be universal, Canada's government-run health care fails to cover many medical needs, and a third of health care spending ends up being covered privately. Of course, Canada's public health system is not cheap, either: Canadians pay up to 51 percent more in taxes than Americans, yet out-of-pocket health costs are close to what Americans pay, even though Canada covers only marginally more than the U.S. Ultimately, the Canadian system should serve as a lesson in over-bureaucratization at a very high cost.

In Section 4, scholars residing in Britain and Canada examine the problems and tradeoffs of their health systems. Close examination of Britain's and Canada's health care approaches is warranted given that some leading American politicians and analysts who favor single-payer health care point to them as models. A realistic look at the systems of their Canadian neighbors and British friends will cause Americans to pause before adopting such a sweeping government takeover of health care.

CHAPTER 10

London Calling: Don't Commit to Nationalized Health Care

TIM EVANS, PHD

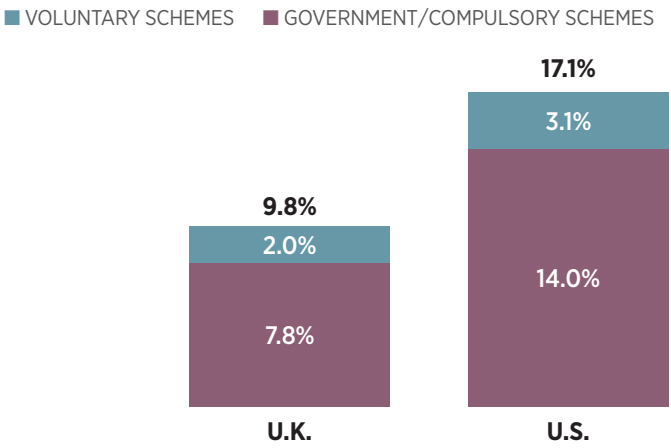
All modern health care systems are the products of history, politics, and culture, and require sound foundations of science, education, and economics. That is why reform of any health care system is as much a matter of social and cultural consideration as it is of organisational, business, or change management. While it would be foolish to attempt to transfer any health care system from one country to another, this does not mean that countries cannot learn from each other. Comparative analyses and the sharing of experience offer powerful aids to learning, reflection, and improvement.

It is in this spirit that this *Backgrounder* presents its overview of Britain's experience with its National Health Service (NHS). Ever in search of the best health care system, the author not only acknowledges the failings of the current British and U.S. models, but, in so doing, also hopes to overcome a distracting and unhelpful "dialogue of the deaf" between these two great nations. For, just as many Britons incorrectly believe that all U.S. health care is private, many Americans no doubt assume that all British health care, not just that provided by the NHS, is socialized.

Both countries have much more mixed economies in health care than is popularly acknowledged. In fact, the U.S. spends a greater proportion of its gross domestic product (GDP) on its state health systems (Medicare, Medicaid, the Children's Health Insurance Program, and the Veterans Health Administration) than the U.K. does on the NHS. (See Chart 1.)

CHART 1

Health Spending as a Share of GDP



SOURCE: Organisation for Economic Co-operation and Development, "Health Spending," https://data.oecd.org/healthres/health-spending.htm (accessed April 15, 2019).

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Around the world, people and electorates often take great pride in their own nation's health arrangements, which are not always justified by performance or comparison. When it comes to practitioners and policy experts, many privately admit that if they could start over again, few would want to do it the same way.[1]

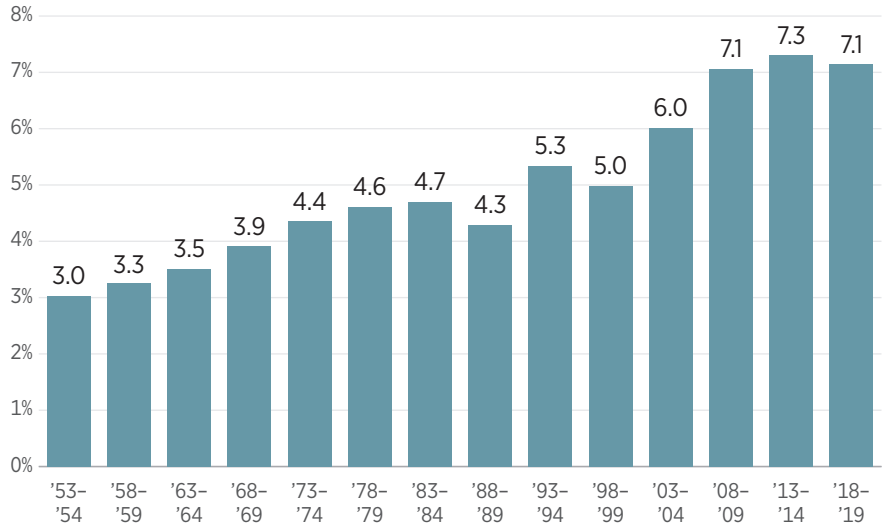
Britain's National Health Service and the Promise of "All"

In 1948, the British government delivered a leaflet to every home in the United Kingdom. In plain English, it announced the promise of the country's new National Health Service, the NHS. Building on German Chancellor Otto von Bismarck's official health insurance system of 1883, and Britain's National Insurance Act of 1911,[2] the leaflet heralded a new age of universal health care, funded by national insurance and general taxation, in which all health care services would be provided "free" at the point of delivery. Specifically, the leaflet promised that the NHS "will

CHART 2

U.K. Health Care Spending Has More than Doubled Since 1953

PUBLIC SPENDING ON HEALTH CARE AS PERCENTAGE OF GDP



SOURCES: B.R. Mitchell, *British Historical Statistics* (Cambridge, Cambridge University Press, reissue 2011) Gov.uk, "HMT Public Expenditure Statistical Analyses (PESA)," https://www.gov.uk/government/collections/public-expenditure-statistical-analyses-pesa (accessed April 15, 2019), and Ukpublicspending.co.uk, "United Kingdom Central Government and Local Authority Spending Sources of Spending Data," https://ukpublicspending.blogspot.com/2009/04/sources-for-public-spending-data-series.html (accessed April 15, 2019).

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provide you with *all* medical, dental and nursing care. Everyone—rich or poor, man, woman or child—can use it."[3] (Emphasis added.)

The key word is "all." The NHS promised to provide *all* medical, dental, and nursing care—to everyone. Now 71 years on, Britain's NHS offers an unrivalled prism into the experience of socialized medicine and the practical reality of such a national insurance and health scheme.

On the upside, medicine and health care have evolved hugely since 1948. In Britain, people now live, on average, more than 10 years longer than they did when the NHS was created.[4]

In 1948, women spent an average of 14 days in the hospital after giving birth.[5] In recent years the figure is less than 1.7 days. Back in 1900, 160 babies out of in every 1,000 died before the age of one.[6] Now, the figure is 3.9.[7]

In 1948, there were more than 16,000 general practitioners (GPs). By 2017, this figure had risen to more than 33,000.[8] In 1949, Great Britain employed 5,000 consultants and more than 125,000 nurses and midwives. Today, there are more than 45,000 consultants[9] and roughly 300,000 nurses and midwives.[10]

In 1958, the NHS launched a polio and diphtheria vaccinations program, which led to dramatic reductions in these diseases. In 1988, the NHS launched a comprehensive breast-cancer and cervical-cancer screening program for women that went on to save thousands of lives.[11]

Despite a gradual resurgence of private health care and increased partnerships across the public and private sectors, the founding principles of the NHS remain popular with a majority of Britons. Significantly, the polling company Ipsos MORI ranked the NHS "first" as the institution that made people "most proud to be British."[12] As a result, under electoral pressure, the NHS's budget has grown significantly over the years. (See Chart 2.)

By 2024, the NHS is projected to account for 38 percent of all U.K. government spending, making it the largest item of state expenditure. (See Chart 3.)

While it remains to be seen whether such a trajectory is politically sustainable over the longer term, public affection for the NHS cannot disguise the service's ongoing problems and challenges.

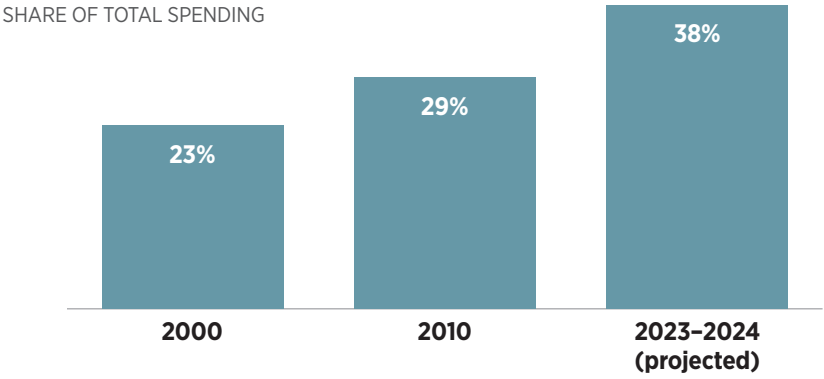
Reality and Experience

Despite the promises of 1948, one downside of the NHS experience has been that checks on demand have always involved the rationing of supply, not through price, but scarcity. It was not long before the imposition of cash limits turned doctors into allocators of scarce resources and for a long time "more than minimal care was denied to cases where there was little chance of successful recovery, particularly to young children or the elderly with serious conditions."[13] The supply of NHS health care is also rationed through wait times. Crowded waiting rooms in many general practices and hospital outpatient departments are common. Lengthy waiting times are also a reality for many inpatients, who often wait several days even for those procedures deemed a priority.[14]

Against the popular view that the NHS provides free and unlimited health care, history demonstrates that the supply of NHS services has

CHART 3

National Health Service Spending on Public Services



SOURCE: George Martin, "NHS Spending to Rocket to 38p in Every £1 of Public Service Spending After Cash Injection in Hammond's Budget," DailyMail.com, October 30, 2018, https://www.dailymail.co.uk/news/article-6335675/NHS-spending-rocket-38p-1-public-service-spending-Hammonds-budget.html (accessed April 25, 2019).

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always been limited in significant ways. Experience shows that people have never had an absolute right to free and equal treatment on demand:

> What they have had instead is an unlimited right of access to a waiting list from which (with a few exceptions) they will not be excluded. This right of access is not equivalent to a right to treatment, as any notional right to treatment has little value in practice if it is available only at the end of a two-year waiting time. The right to healthcare is unlimited in the long term but is strictly limited in the short term when healthcare is actually required, at the very least, to relieve pain or discomfort.[15]

Today, many hundreds of thousands of people are on NHS waiting lists, and countless tens of thousands are trying to get *on* a list. After decades of reforms and extra tens of billions of pounds invested, out of four million patients admitted to NHS hospitals for routine treatment in 2007, more than half still had to wait at home more than 18 weeks before receiving

that treatment.[16] While government ministers frequently shy away from talking about the parlous realities of waiting times, figures indicate that 12 percent—almost half a million people—waited more than a year for their treatment and care during 2006 and 2007.[17] Nationally, while 6.4 percent of NHS patients pick up infections and illnesses that they did not have prior to being admitted to the hospital, in some hospitals, this figure is above 10 percent.[18] Similarly, it was not that long ago when, according to the Malnutrition Advisory Group, more than 50 percent of NHS hospital patients were under-nourished during inpatient stays.[19]

While the number of people on NHS waiting lists dropped between 2008 and 2011, not least because greater collaboration with private hospitals enabled greater responsiveness, the waiting list for NHS treatment has grown since 2012. In summer 2018, the figure stood at 4.12 million people on waiting lists, up 3 percent from the year before, and up 59 percent from 2.42 million at the end of March 2010. According to research by the House of Commons Library, "Once estimates for missing data are included the waiting list is currently thought to be at 4.31 million—up 7% year-on-year and 42% over five years."[20]

It is increasingly difficult for people to get a timely appointment with an NHS GP or even find an NHS dentist. As a consequence, many are turning to private GP services,[21] with a majority of dentists offering private treatment alongside the NHS.[22]

Theoretically, the NHS exists to treat people of all social classes in an equitable manner according to need. In reality, this has never been practiced.[23] Analyses of GP consultations have repeatedly shown that patients from higher social classes invariably receive more and better explanations and details of their treatment than lower-class patients, and that middle-class patients spend more time on average with their GP than those from working-class backgrounds.

Julian Le Grand of the London School of Economics demonstrated that, relative to need, patients in professional and managerial jobs have long received at least 40 percent more NHS spending per illness episode than those with semi-skilled or unskilled jobs.

The NHS at 71

At 71, the NHS is internationally below average when it comes to preventing deaths from heart attacks, strokes, and cancer.[24] NHS waiting lists for patients in excruciating pain or with life-threatening conditions, including lung cancer and bowel disease, have reportedly doubled since 2010.[25] Waiting lists for patients awaiting treatment from a specialist

for lung diseases (the U.K.'s third-largest killer) have risen by more than 120 percent since 2011 to almost 100,000 patients.[26] Again, since 2011, NHS waiting lists have ballooned from 2.6 million to more than 4 million people.[27]

To mark the NHS's 70th birthday in 2018, the British Broadcasting Corporation (BBC) commissioned independent analyses from several think tanks to identify the service's performance by international comparison across the developed world.[28] The think tanks analyzed the NHS's performance on 12 of the most common causes of death. The analysts found that the NHS performed worse than average for eight diseases or health emergencies: (1) breast cancer, (2) colorectal cancer, (3) lung cancer, (4) pancreatic cancer, (5) lung disease, (6) respiratory infections (such as pneumonia), (7) stroke, and (8) heart attacks.[29]

At its seven-decade anniversary, the NHS has one of the lowest numbers of practicing doctors per population (including GPs and hospital doctors) in the European Union.[30] Although the number of nurses is around the EU average, it is lower than comparable countries, such as France, Germany, and The Netherlands.[31] Significantly, the NHS has fewer CT scanners (eight scanners per million of population, compared to the EU average of 21.4 scanners), and fewer MRI scanners (6.1 scanners per million compared to an EU average of 15.4 scanners) than most other European countries.[32]

Despite huge improvements in medicine, technology, and the NHS budget, approximately 6.8 million people (10.6 percent of the British population) are now covered by private medical insurance; 3.7 million people (5.8 percent of the population) have private health cash plans[33]; and a further 3.3 million people (5.2 percent of the population) have private dental coverage.[34] More than an additional million people are covered by private discretionary health care plans, such as Benenden Healthcare,[35] and hundreds of thousands more pay out of pocket for acute surgery and treatment annually.[36]

These figures demonstrate that U.K. health care is already a world away from 1948, when, in order to establish the NHS, the government took into public ownership more than 3,100 private, charitable, or local-authority hospitals, clinics, and nursing homes. Today, not only do varying types of private health care annually touch the lives of many millions of people, there are, once again, hundreds of private hospitals, thousands of private nursing and assisted-living homes, and a growing plethora of private-sector providers that cover everything from eye glasses, dentistry, and acute mental health care to complex surgery, brain injury rehabilitation, and

a broad range of general practice services. There are also many independent charities dedicated to supporting patients—as well as their families and friends—with specific progressive conditions, such as Parkinson's, Alzheimer's, or multiple sclerosis.

The re-emergence of a mixed economy in health care becomes even clearer when considering that more than 50 percent of the Trades Union Congress's 6 million-plus members also benefit from a range of private health plans.[37] According to the web site of one of the U.K.'s largest public-sector trades unions, Unison, its collective muscle enables it to offer its members private health coverage from as little as 80 pence per day.[38]

It is against the backdrop of these developments, and under the rubric of public–private partnerships, that in the year 2000 the government signed an agreement with the representative body of the country's independent health care sector (the Independent Healthcare Association) to enable NHS-funded patients to receive care and treatment in more than 200 private hospitals nationally.[39] By the beginning of the millennium, much of the estate that had been removed from the private and charitable sector to create the NHS in 1948 still retained features of its pre-nationalized past. With a significant proportion of the estate predating World Wars I and II, change was required in the form of increasing private-sector capital and investment.[40]

In 2001, following several years of greater private capital investment in the NHS's stock, the government allowed the private sector to design, build, and operate a network of Independent Sector Treatment Centres (ISTCs) for NHS-funded patients.[41] With the subsequent establishment of more independent and flexible NHS trusts and foundation trusts, the NHS remains the dominant funder of U.K. health care but is no longer the monopoly provider or owner of the facilities in which its services are increasingly delivered.

However, as measured by Bloomberg,[42] despite years of modernization and significant increases in resources, British health care still fell 14 places and is now behind Chile, Algeria, and the Czech Republic. British health care dropped from 21st place (of 56 countries measured) in 2014 to 35th in 2015.[43] This shift means it has fallen to the bottom half of the Bloomberg tables and is currently behind Mexico—with Slovakia and Peru as its peers.[44]

Bloomberg's annual analysis compares countries on the basis of life expectancy versus the percentage of spending on health care. In the U.K., the absolute cost amounts to £3,327 a year ($4,356) per head of population.[45] While the U.K.'s life expectancy has remained largely unchanged in recent years, other countries have witnessed significant improvements.

Overall, Hong Kong remains at the top of the tables with life expectancy at 84.3 and just 5.7 percent of GDP spent on health care. Second is Singapore with a life expectancy of 82.7 and 4.3 percent of GDP spent on health care. By contrast, Spain and Italy have similar life expectancy rates but both spend more of their GDP on health care. While Spain spends 9.2 percent on health care, Italy spends 9.0 percent.[46]

The Challenge of Bureaucratic Displacement

While such research does not account for people's lifestyle choices and the pressures they in turn place on demand, the theory of bureaucratic displacement (Gammon's Law) suggests that in any highly bureaucratized system, such as the NHS, "increases in expenditure will be matched by a fall in production."[47] At their worst, such systems act "rather like 'black holes' in the economic universe, simultaneously sucking in resources, and shrinking in terms of 'emitted' production.'"[48]

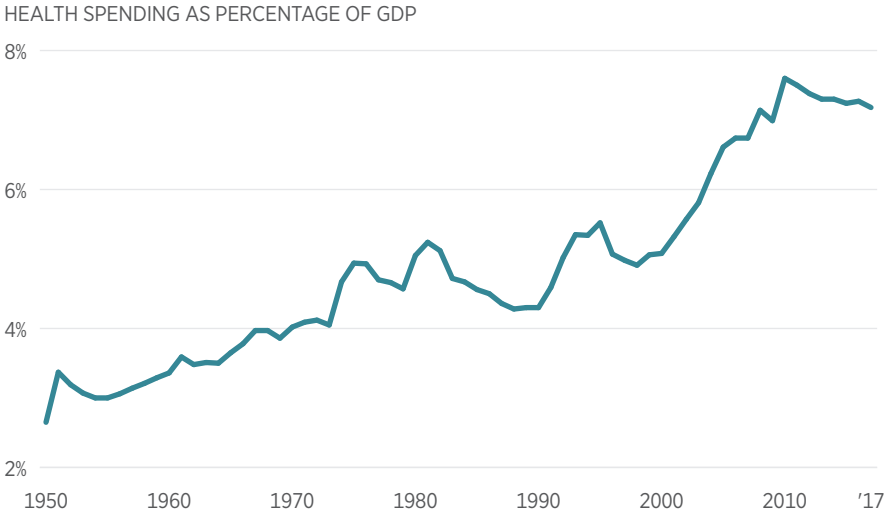
The idea that additional resources will deliver efficiency, greater productivity, and better outcomes has long been problematic for the NHS. For example, Prime Minister Tony Blair announced in January 2000 an "unprecedented 5 per cent annual increase in NHS spending for the next five years" between 1998 and 2005, and the NHS hired an additional 307,000 people, including doctors, nurses, and administrators.[49] At the time, this was the largest growth by a single employer in any country. Four years later, the NHS had taken on 52,000 more administrators, increasing its managerial payroll by more than 30 percent. Yet the additional staff did not make the NHS any more efficient or effective. Research by the Office for National Statistics revealed that staff productivity actually declined between 2001 and 2005.[50]

A 2004 study by the Office for National Statistics confirmed that money was being wasted on a sizeable scale. Just £35 of every additional £100 spent had produced real improvements in the previous two years. Of the remainder, £56 had fuelled inflation within the NHS, and £9 was lost through falling productivity.[51]

As extra sums poured into the NHS (see Chart 4), many hospital administrators and doctors were sticking to outdated practices. Even worse, half of the annual increase in the budget was spent on ever greater recruitment and higher wages. Within three years, GPs' annual pay had doubled to more than £105,000, yet they were working fewer hours. By 2006, there were reports that some GPs were earning £250,000. As for consultants' salaries, they went up by 27 percent to an average of more than £109,000.[52]

CHART 4

U.K. Health Care Spending Rising Rapidly



SOURCES: B.R. Mitchell, *British Historical Statistics* (Cambridge, Cambridge University Press, reissue 2011) Gov.uk, "HMT Public Expenditure Statistical Analyses (PESA)," https://www.gov.uk/government/collections/public-expenditure-statistical-analyses-pesa (accessed April 15, 2019), and Ukpublicspending.co.uk, "United Kingdom Central Government and Local Authority Spending Sources of Spending Data," https://ukpublicspending.blogspot.com/2009/04/sources-for-public-spending-data-series.html (accessed April 15, 2019).

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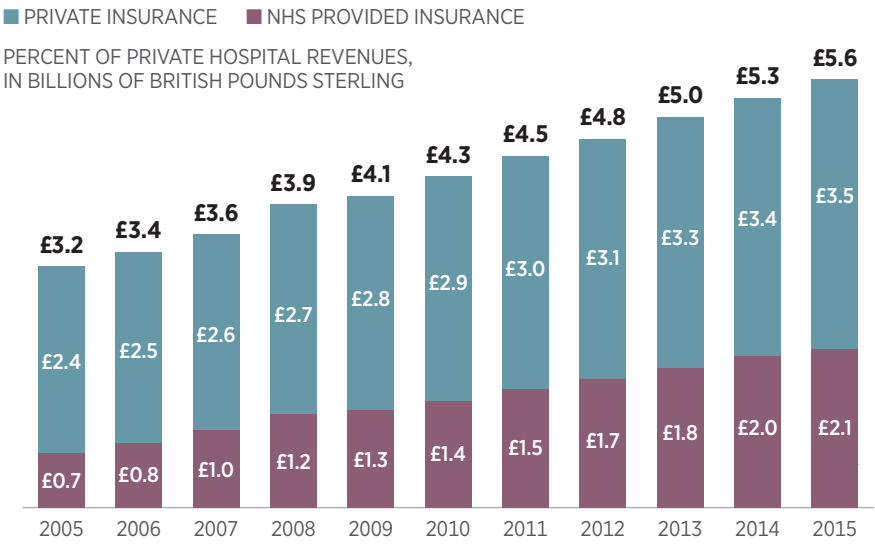
Most of the additional £3.6 billion pledged to the NHS in 2005 was earmarked for pay increases, drugs, buildings and negligence payments. Just £475 million was actually directed towards improving the treatment and care of patients. Throughout all of this, there were reports of a 200 percent difference between the cost of the most and the least efficient NHS hospitals. Some GP surgeries were giving patients an appointment within a day, while others expected them to wait for five days or longer.[53]

As Prime Minister Blair announced an NHS budget of £108 billion for 2007, deficits in many parts of the NHS were increasing. Moreover, health inequalities among the population had remained the same and in some instances were even increasing. A third more people were going

CHART 5

Private Hospital Revenues in the United Kingdom



SOURCE: Victor Chua, "London Private Healthcare in 2025," *Private Practice Digest*, September 13, 2017, https://www.privatehealth.co.uk/industry/articles/london-private-healthcare-2025-1159005/ (accessed April 25, 2019).

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to Accident and Emergency (A&E) "because 40 per cent of GPs were no longer working full-time."[54] And without proper competition, there had been no narrowing between the best-performing and worst-performing hospitals. In the best, for example, operating rooms were being used 75 percent of the time, while in the worst, the figure was as low as 35 percent.[55]

Yet, ever greater amounts of money were being consumed. When Blair became Prime Minister in 1997, the NHS's budget had been £34 billion. By 2012, it had grown to more than £120 billion.

In recent years, NHS performance has been deteriorating on a broad front: "The 18-week-to-treatment standard for planned care has not been met since February 2016, the A&E four-hour standard since July 2015 and the 62-day cancer standard for more than three years."[56]

Since 2012, the national target for elective care stated that more than 92 percent of NHS patients should start their treatment within 18 weeks from referral. While the number of patients receiving elective treatment has grown approximately from 14.2 million in 2012 to 15.7 million in 2017[57] (an 11 percent increase), the total elective waiting list in April 2012 was 2.5 million. By 2017, this list had increased to an extraordinary 4.1 million people.[58] Despite changes in clinical practice, including the inexorable rise of outpatient surgery, ever-mounting pressures on the service meant that its national leaders had to openly accept that it could no longer meet its targeted standards.[59] While the official A&E standard is for no less than 95 percent of patients attending A&E to be admitted, transferred, or discharged within four hours, this target has been missed for the past three years.[60]

When it comes to accessing cancer treatment, the most important target is that more than 85 percent of NHS patients should begin their care within 62 days of an urgent referral from their GP. While this standard was ushered in from 2009 to 2014, it has been missed every year since.[61] The NHS is treating more patients every year, and key performance measures for hospital services are now being missed all year, not simply during the winter months.

Not only do ambitions to hold waiting lists steady for 2019 reportedly look to be "doomed,"[62] but the slide is having serious socioeconomic effects. For example, while 2017 saw private-sector self-pay revenue increase by 9 percent to £1.1 billion, the independent market analysts LaingBuission recently concluded that "dissatisfaction with the NHS is now the primary driver of self-pay demand...for people seeking...diagnosis and treatment."[63]

From the viewpoint of 2019, the NHS is travelling ever further away from the political promise of 1948. Experience shows that despite huge increases in funding, countless reforms, and increased partnerships with the private and charitable sectors, fundamental problems associated with rationing and bureaucratic displacement continue to abound.

Important Lessons for U.S. Policy

Overall, Britain's experience with the NHS portends a number of lessons that American policymakers can apply as they consider the future of the U.S. health care system. Even with widespread electoral support and ever-increasing amounts of government expenditure, those who require medical treatment often end up suffering because of perpetual access problems. Although medicine and technology have advanced hugely around the world in recent decades, the British experience with socialized medicine is that it leads to comparatively poor outcomes in key

areas, such as heart attacks, cancer, and stroke. Moreover, as pressures associated with bureaucratic displacement mount over time, ordinary people revert to using more-open, diverse, and market-based solutions for their health needs. The saving grace is that in an open and free society, the unintended consequence of socialized medicine is that it often helps a thriving private alternative to re-emerge.

Conclusion: London Calling

Experientially, no health system is perfect. Most have strengths and weaknesses. While all systems globally are underpinned by statutorily defined, monopoly suppliers of labor (the national equivalents of the U.K.'s General Medical Council for doctors, and the Nursing and Midwifery Council for nurses and midwives),[64] most systems are riven with complex problems rooted in politics, history, and law.

The underlying institutional architecture of much of U.S. health care is a classic case in point. Dogged by an employer-based, geographically restrictive, and highly corporatist health insurance market, America's public and private health sectors are not only costly, but the systems increasingly disport the worst elements of overly politicized monopoly markets and poorly directed government interventionism.

Seventy-one years on from its inception, the British experience with the NHS is similarly clear. The NHS remains popular with voters because it has made a clear contribution to health improvements and relieves people of the burden of having to worry about money.[65] However, it also performs less well than systems in similar countries when it comes to the overall rates at which people die when more effective medical care could have saved their lives.

The NHS relies heavily on rationing, long wait times, and currently suffers poor health outputs in key areas including cancer, heart health, and stroke. Bureaucratic, inefficient, and riddled with poor productivity, it does not come close to providing the medical, dental, and nursing care that was promised in 1948.

It is these failings that have encouraged a resurgence of independent (private and charitable) medical, health, and social care in recent decades. With millions of people now using private hospitals, clinics, nursing homes, dentists, and other market-oriented health care services, a much more mixed-economy approach is becoming the norm.

This paper was originally published as Heritage Foundation *Backgrounder* No. 3405 on May 3, 2019, and is available at https://www.heritage.org/health-care-reform/report/london-calling-dont-commit-nationalized-health-care.

CHAPTER 11

How Socialized Medicine Hurts Canadians and Leaves Them Worse Off Financially

PETER ST. ONGE, PHD

Every American should have access to low-cost, high-quality health care. The Canadian experience demonstrates that government-run health care is not the answer.

Canadians pay up to 51 percent more in taxes, yet out-of-pocket health costs are close to Americans', even though Canada covers only marginally more than the U.S.

Government rationing has left Canadians with months-long waiting lists for urgent care, endemic staff shortages, substandard equipment, and outdated drugs.

The Canadian health care system is frequently used as a model by Americans who advocate putting the government in charge of health care. As Senator Bernie Sanders (I–VT) put it: "In Canada, for a number of decades, they have provided quality care to all people without out-of-pocket expenses. You go in for cancer therapy, you don't take out your wallet."[1] In reality, Canadians suffer similar out-of-pocket burdens as Americans, while paying far higher taxes and receiving lower quality of care. Months-long waiting lists for urgent care, substandard equipment that would embarrass Turkey,[2] years of delay on life-saving drugs, and widespread capacity shortages have all become hallmarks of the Canadian health care system.

One major reform proposal endorsed by a majority of Democrats in the House of Representatives, known as Medicare for All, would outlaw[3] private coverage except for elective procedures like plastic surgery, and in its place would establish a government-run program to provide all

U.S. residents with coverage across the board, including for hospitalization and doctor visits; dental, vision, and hearing care; and long-term care.[4] The plan would require no co-payments or fees, as all care would be funded by the government through taxes or public debt. The plan would specifically ban private insurance plans from providing the same benefits as public coverage, forcing all Americans onto the public plan.[5]

As proposed, Medicare for All is far more extensive, and far more distortionary, than even Canada's current system. It is worthwhile, then, to explore the problems that Canadian patients and Canadian taxpayers have come to face.

Who Pays for Health Care in Canada?

Like the U.S., Canada's health care system is funded by a mixture of public and private insurers. These insurers pay for care that occurs at a mixture of private and public providers. Canada's mandatory public insurance covers most of two types of medical cost—hospitals and physicians' offices—which together make up about half of all medical expenses in Canada. For these categories, public spending covers 90 percent of hospital costs and 98 percent of doctors' offices costs.

For the remaining half of health costs, private spending makes up the majority of spending, paid either by private insurance or paid out of pocket by the patient. This includes pharmaceuticals (16 percent of total spending in Canada); "other institutions," including nursing homes and long-term care (11 percent of total spending); and "other professionals," including most vision and dental care, physical therapy, hearing aids, physiotherapy, and psychological treatment (11 percent of total spending).[6] Spending in the U.S. is distributed similarly, with hospitals and physicians totaling 53 percent of health care spending, while 10 percent of spending goes to prescription drugs, 5 percent to nursing home care, 3 percent to home health care, 4 percent to dental care, and 27 percent to "other" health care.[7]

For that half of health spending that occurs outside hospitals and physicians' offices, public spending in Canada covers just 36 percent of pharmaceutical spending, 70 percent of spending on "other institutions," and only 11 percent of spending on "other professionals."[8] So, for that half of medical spending, Canadians must find another way to pay for most care. As a result, 63 percent of Canadians have private insurance, similar to the 56 percent of Americans with private insurance,[9] while 35 percent of Canadians and 36 percent of Americans are covered by comprehensive government plans.[10] In both countries, publicly funded comprehensive

TABLE 1

Composition of Health Insurance Plans in Canada, U.S.

Category	Canada	U.S.
Private insurance plans	63%	56%
Government comprehensive insurance	35%	36%
No private plan, no government comprehensive insurance	2%	8%

SOURCES: Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, "Health Insurance Coverage in the United States: 2018," U.S. Census Bureau, November 8, 2019, https://www.census.gov/library/publications/2019/demo/p60-267.html (accessed January 7, 2020); and Canadian Life and Health Insurance Association, "Canadian Life and Health Insurance Facts, 2015 Edition," http://clhia.uberflip.com/i/563156-canadian-life-and-health-insurance-facts/15 (accessed January 16, 2020).

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coverage goes mainly to the elderly and the poor, and in both countries, the government has various programs to proactively seek out and cover both groups. Finally, in both countries, many of these vulnerable populations nonetheless fail to claim benefits, leaving roughly 2 percent of Canadians and 8 percent of Americans uninsured.[11]

Because half of Canadian health care costs are for categories primarily paid privately, private spending makes up 31 percent of total Canadian health care costs (see Table 1), compared to about half in the U.S. Of that Canadian private spending, roughly half is paid by patients out of pocket, and half is paid by private insurers. Equivalent numbers for the United States vary between private spending making up 44 percent[12] and 51 percent[13] of health care costs, of which about one-quarter is paid out of pocket and the remaining three-quarters is paid by private insurers.[14]

Like all "universal" systems, the Canadian health system is only universal in the sense that everybody is forced to join. It is emphatically not universal in terms of what is covered. Proposals like Medicare for All, therefore, are promoting something far larger, in both taxes and in distortions, than what exists in Canada or, indeed, in any developed country including Europe.

Out-of-Pocket Costs in Canada

There are several ways to estimate the differences between Canadian and American out-of-pocket health care costs. The Peterson–Kaiser

TABLE 2

Canadian Health Care Spending per Capita, 2018

Category	Total Spending per Capita	Private Spending per Capita	% Private Spending
Hospitals	$1,933	$194	10%
Physician Services	$1,032	$16	2%
Other Professionals (includes dental, vision, other)	$758	$676	89%
Other Institutions (includes nursing home, long-term care)	$768	$240	31%
Pharmaceuticals	$1,075	$686	64%
Other (includes capital budget, public health)	$1,275	$311	24%
Total	**$6,840**	**$2,124**	**31%**

SOURCE: Canadian Institute for Health Information, "How Canada Compares: Results from the Commonwealth Fund's 2017 International Health Policy Survey of Older Adults in 11 Countries—Data Tables," https://www.cihi.ca/sites/default/files/document/cmwf-2017-data-tables-en-web.xlsx (accessed January 7, 2020).

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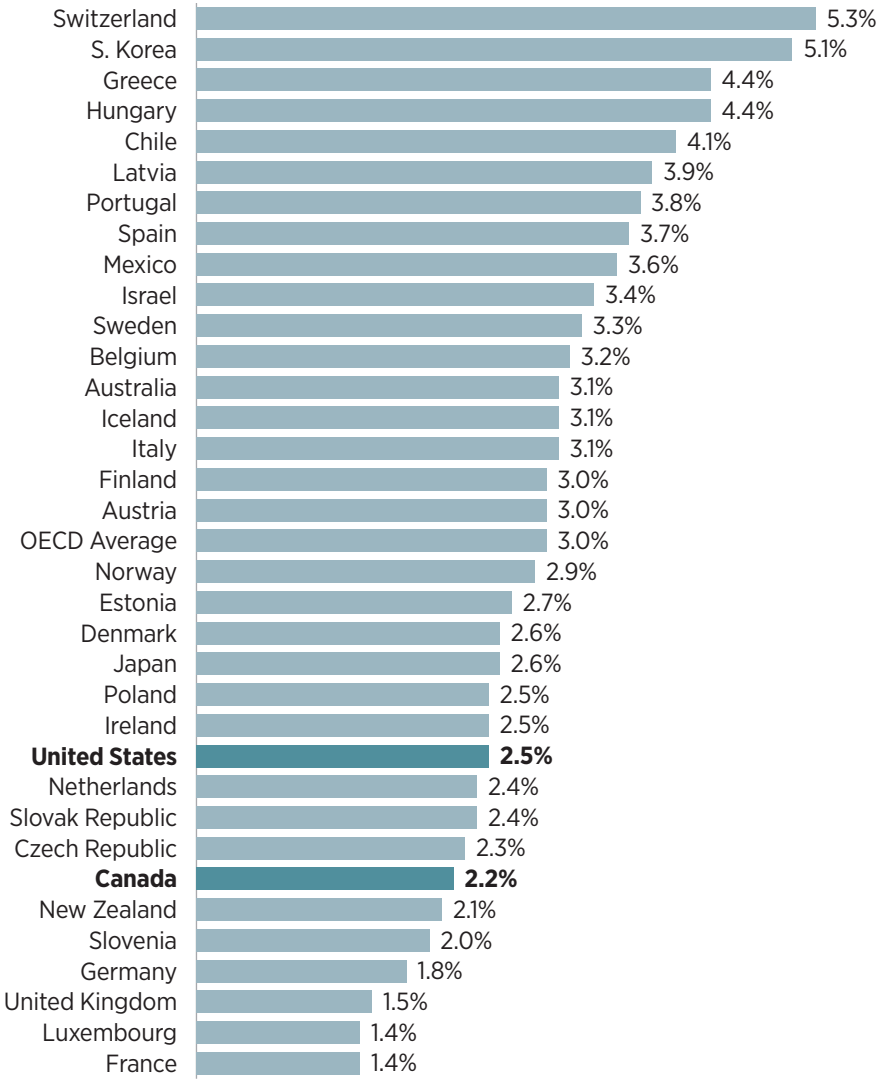
Family Foundation Health System Tracker estimates that, in purchasing-power-adjusted current U.S. dollars, the average Canadian pays US$690 per year in out-of-pocket medical costs, while the average American pays $1,103—about $34 more per month.[15] However, this difference drops by about two-thirds when measured by household income or by gross domestic product (GDP). The Organization for Economic Development and Cooperation (OECD) estimates that Canadians pay 2.2 percent of final household consumption in out-of-pocket medical costs, while Americans pay 2.5 percent—a difference of roughly $15 per month for the median American household. (See Chart 1.)[16]

Using GDP instead of household income yields similar results; the OECD calculates that Canadians spend 1.6 percent of GDP on out-of-pocket health spending, compared to 1.9 percent in the U.S. The World Bank[17] and the Peterson–Kaiser Family Foundation Health System

CHART 1

OECD Out-of-Pocket Medical Spending

AS A SHARE OF FINAL HOUSEHOLD CONSUMPTION



NOTE: OECD figures exclude long-term care expenditures.
SOURCE: Organisation for Economic Cooperation and Development, "Health at a Glance 2017," https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017_health_glance-2017-en (accessed January 7, 2019).

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Tracker[18] make similar estimates, agreeing that Canadians spend 1.5 percent of GDP on out-of-pocket medical costs, while Americans spend 1.9 percent of GDP.

While these numbers are very close, they are actually getting closer. Since 1970, U.S. out-of-pocket spending as a percentage of total medical spending has been falling steadily, from 33 percent in 1970 to about 10 percent in 2017.[19] Meanwhile, Canadian out-of-pocket spending has been falling much slower, so that by 2016 it totaled 15 percent of total medical spending—a higher proportion than in the U.S.[20] As a result, Statistics Canada warned in early 2020 that the percentage of Canadians experiencing large out-of-pocket burdens is growing, writing that "[b]etween 1998 and 2009...the percentage of households spending more than 10% of their total after-tax income on health care rose by 56%."[21]

Out-of-pocket spending in Canada disproportionately hits the poor. In a 2009 report, Statistics Canada[22] estimated that out-of-pocket spending as a percentage of household income is more than twice as high among the lowest-income quintile as among the highest, at 5.7 percent of after-tax income for the poorest one-fifth of Canadian households, and only 2.6 percent for the richest quintile.

Beyond out-of-pocket burdens, Canadians experience other health-care-related stresses familiar to Americans. In a 2015 survey commissioned by the Ontario Securities Commission,[23] 16 percent of Canadians over 50 reported that unexpected medical expenses used up a significant part of their retirement savings, while nearly two-thirds of early retirements in Canada were related to health expenses. The same report found that, despite public coverage, Canadians ages 75 and above have median out-of-pocket costs of $2,000 per year, including supplementary health insurance premiums and out-of-pocket medications. Of this 75+ population, 69 percent report having to pay rising medical costs by selling off assets, cutting spending on necessities, getting a job, or borrowing money. More broadly, among Canadians ages 50 and above, fully 39 percent report out-of-pocket health costs as a "top concern," making out-of-pocket costs the third-highest concern after inflation and declining health itself. Specific to drugs, one study in 2018 estimated that 731,000 Canadians per year—between 2.2 percent and 2.8 percent of the population—borrow money to pay for their prescription drugs.[24]

Finally, one key topic in the U.S. health care financial debate has been medical bankruptcy. As one Canadian research study concluded: "It is incorrect to assume that adopting [Canada's medical] insurance system in the US will have a significant impact on bankruptcy rates. Bankruptcy and

a lack of health insurance coverage are both caused by the same thing—a lack of income, which in turn is usually a result of unemployment."[25] Indeed, a 2006 report commissioned by the Canadian government[26] found that medical reasons were cited as the primary cause of bankruptcy for approximately 15 percent of bankrupt Canadian seniors ages 55 and above, higher than some estimates for U.S. bankruptcy.[27]

Taxes in Canada

Taxes in Canada are much higher than in the U.S., and this is largely because of government health care spending. In addition to combined sales taxes ranging from 11 percent to 15 percent for all but one province, personal income tax rates are also much higher. The OECD calculates that a married Canadian couple with two children and one earner making the median wage pays 27 percent of its income to the government, of which 10 percent is paid in income taxes and 17 percent in social security taxes. The comparable American couple pays just 4 percent of its earnings in income taxes and 15 percent in Social Security taxes. Moreover, Canadian taxes rise faster with income; if that same family earns 168 percent of the median wage—about $90,000 in each country's currency—it will pay 18 percent of earnings in income taxes in Canada, and only 9 percent in the U.S.[28]

On a national level, according to the OECD, Canadian taxation sums to 33 percent of GDP, compared to 24 percent in the U.S., meaning it is 36 percent higher. Even so, nearly a quarter of what Americans pay in taxes consists of Social Security payments, while the far-less-generous Canadian social security makes up just 14 percent of taxation. This is because Canadian social security averages just $984, compared to $1,470 in the U.S.[29] Taxation excluding social security contributions, then, comes to 28 percent of GDP in Canada, compared to just 19 percent in the U.S.—meaning 51 percent more.[30]

This excess taxation is largely a result of health spending, which has bloated provincial budgets to nearly three times the taxes of U.S. states.[31] Provincial taxes have grown to nearly the same level as federal taxation. Meanwhile, provincial health costs have risen to fully 37 percent of provincial budgets in 2016—up from 33 percent in 1993[32]—and range as high as 42 percent.[33] Canada's Fraser Institute has estimated this excess tax burden from public health costs at roughly $9,000 for a household of two adults with or without children,[34] or $750 per month in additional taxes.

Beyond the financial stress of paying higher taxes, tax differences of this magnitude are large enough to materially affect national wealth. In

a 2007 paper, economists Christina and David Romer estimated that an increase in taxes leads to a fall in GDP roughly two to three times larger than the amount raised.[35] This implies that Canada's excess tax burden could reduce GDP by between 16 percent and 24 percent. In fact, the World Bank estimates Canadian GDP as 26 percent lower than in the U.S.[36] There may be other reasons why Canada is so much poorer than the U.S., but the Romers' estimate suggests excess taxation is a serious problem.

This last point is important for discussions about net savings from socialized medicine. Democratic presidential candidates Senator Elizabeth Warren (D–MA) and Senator Bernie Sanders (I–VT) have claimed that their health care plans would cut total health spending, for example, by dictating lower hospital reimbursement rates or insurance payments.[37] Charles Blahous recently estimated that[38] Medicare for All would raise federal taxes by $32 trillion over 10 years, and would likely raise total health care costs. Even under the most generous assumptions, health care costs could fall by, at most, $2 trillion during that period—leaving $30 trillion in tax damage.[39]

Quality of Health Care in Canada: Waiting Lists

Medical waiting times have become a national crisis in Canada, and continue to worsen. The average wait time for medically necessary treatment between referral from a general practitioner and a consultation with a specialist was 8.7 weeks in 2018, 136 percent longer than in 1993. Patients then have to wait again between seeing the specialist and the actual treatment, another 11 weeks on average, 97 percent longer than in 1993.

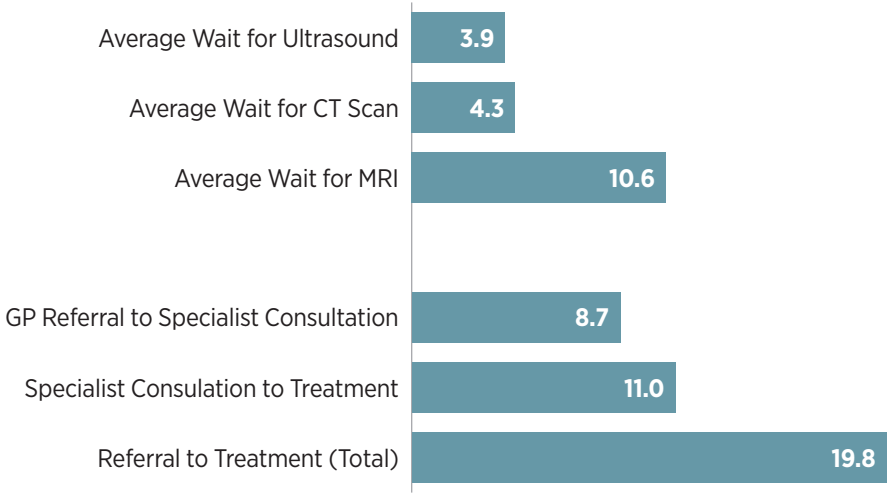
From referral to treatment, then, it takes an average of 19.8 weeks (see Chart 2) to be treated, in addition to the original wait to see the family doctor in the first place—this for "medically necessary" treatment, not cosmetic surgery. In less-populated areas, wait times can stretch dramatically longer. In New Brunswick, for example, patients have to wait an average of *six and a half months* just to see a specialist, then another four months for the actual treatment—45.1 weeks on average, again, for "medically necessary" treatment.[40]

In contrast, nearly 77 percent of Americans are treated within four weeks of referral, and only 6 percent of Americans report waiting more than two months to see a specialist.[41] As for appointments, a 2017 survey of American physicians in the 15 largest U.S. cities found that it took just 24 days on average to schedule a new-patient physician appointment, including 11 days for an orthopedic surgeon and 21 days for a cardiologist.[42]

CHART 2

Average Wait Times for Treatment and Tests in Canada

WAIT TIME IN WEEKS, 2018



SOURCE: Bacchus Barua and David Jacques, "Waiting Your Turn: Wait Times for Health Care in Canada 2018 Report," Fraser Institute, December 2018, https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2018.pdf (accessed January 7, 2020).

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As a result of these long waits, by one recent estimate, at any given moment, over one million Canadians—3 percent of the entire population—are waiting for a medical treatment.[43] These lists can average six months, and often much longer in rural areas, which tend to suffer from doctor shortages so severe that many do not even have a family doctor.[44] The shortages ripple through the system; one doctor in Ontario called in a referral to the local hospital, only to be told there was a *four-and-a-half year* wait to see a neurologist.[45] A Montreal man was finally called for his long-delayed urgent surgery two months after he had died.[46] One 16-year-old boy in British Columbia waited *three years* for an "urgent" surgery, during which time his condition deteriorated so much that he became a paraplegic.[47]

These cases are, unfortunately, not isolated; a survey of specialists found that average wait times exceed what is deemed clinically

"reasonable" for fully 72 percent of conditions in Canada. The situation continues to worsen every year: In 1994, the average gap between clinically reasonable delay and actual delay was only four days, and by 2018 had grown to 23 days. The worst gap was in orthopedic surgery, where some 150,000 Canadians per year suffered for 11 weeks longer than specialists determined as clinically reasonable. Neurosurgery wait times were nearly a month longer than clinically reasonable, cataract surgeries nearly two months longer, hip and knee replacements three months longer, and so on.[48]

With one million waiting, many Canadians turn in desperation to U.S. health care—the very system some U.S. policymakers propose to transform. In 2017 alone, Canadians made 217,500 trips to other countries for health care, of which 52,500 were to the U.S.,[49] paying out of pocket to skip the waiting.[50] Medical trips abroad included 9,500 general surgeries, 6,400 urology treatments, and 5,000 diagnostic tests, including colonoscopies and angiographies of the veins.[51] One happy Albertan summed up the trade-off after her hip replacement in the Cayman Islands: "The total cost was $25,000 Canadian to regain at least one year of my life."[52] These desperate patients spent $1.9 million per day to escape Canadian health care, up 54 percent in just the past four years.[53] Of course, those costs are not included in the Canadian health spending numbers, but can show up in U.S. health care spending when the dollars were spent in the U.S.

A major cause of Canada's waiting lists is the use of so-called global budgets while effectively banning private clinics and private insurance for medically necessary treatment. Global budgets, in which health providers get a fixed budget each year rather than being paid per treatment, are a form of rationing that strongly tends to lead to long wait times.[54] Meanwhile, rules hobbling private provision in Canada mean that nearly half of existing doctors would like to work more hours, but are effectively banned from doing so.[55] Both Senator Warren's plan[56] and Senator Sanders' plan[57] explicitly propose global budgets, and both effectively ban private insurance.

When it comes to global budgets, a 2014 report from the University of British Columbia concluded:

> One weakness of global budgets is that, under the impetus to meet budget targets, providers might restrict access to services or limit the number of admissions to facilities. Moreover, global budgets provide little incentive for innovation or to improve efficiency of care.... Global budgets do not promote coordination across service

> providers in acute and post-acute settings, creating a fragmented healthcare system that is often associated with inefficiencies and reduced quality of care.[58]

Indeed, the report noted, "Most of the countries that had previously used global budgets have since transitioned to other funding mechanisms, such as activity-based funding."[59]

The prospect of importing Canadian-style medical wait lists is not merely hypothetical: The Veterans Health Administration, for example, recently admitted to off-books waiting lists running to four to six months.[60] This suggests that the tendency to cut corners and ration care is not some uniquely Canadian flaw, but rather a characteristic of government management of health care.

Skimping on Care in Canada: Lack of Equipment, Outdated Drugs, Staff Shortages

Beyond rationing care by using waiting lists, the other key to Canada's government cost controls is underinvesting in equipment, using cheaper and outdated medicines, and staff shortages. While the average employer-sponsored private insurance plan in Canada covers between 10,000 and 12,000 drugs, most public plans in Canada only cover 4,000.[61] Canada has 35 percent fewer acute care beds than the U.S.,[62] and only one-fourth as many magnetic resonance imaging (MRI) units per capita—indeed, it has fewer MRI units per capita than Turkey, Chile, or Latvia.[63] As a result, Canadian waits for MRIs average almost 11 weeks, adding months of diagnostic delays on top of the months of treatment delays. Even routine diagnostic equipment like ultrasound machines has four-week waiting lists. In some provinces, the waits are much longer. In British Columbia, for example, patients wait nearly five months for an MRI, while in Quebec, New Brunswick, and Nova Scotia, patients wait eight weeks for a simple ultrasound.[64] Canada skimps on equipment even more than European countries: compared to the average OECD country, Canada has one-third fewer computerized tomography (CT) scanners, positron emission tomography (PET) scanners, and MRI units; half as many angiography units; and eight times fewer lithotriptors (machines that shatter kidney stones and gallstones).[65]

Some common treatments are simply unavailable to Canadians. For new pharmaceuticals, for example, Canada's policy of forcing down prices so that American consumers essentially pay for Canada's research and development[66] has led to years-long delays for Canadian patients. In

addition to a 630-day average wait before new drugs are approved, Canadians must wait for the drugs to actually be listed on their plan, averaging 152 days for private plans and 473 days for public plans. Comparing to the U.S., for drugs submitted for regulatory approval in both jurisdictions Canada takes five times longer—434 days of additional delay.[67]

Cutting corners on facilities and using outdated drugs show up in Canadian mortality rates. Thirty-day in-hospital mortality rates in Canada are 20 percent higher than in the U.S. for heart attacks, and nearly three times the U.S. level for strokes.[68] Cancer age-standardized mortality is 10 percent higher in Canada than in the U.S.—despite far healthier lifestyles, with both obesity and diabetes rates a full third lower in Canada than in the U.S.

When it comes to personnel, Canada underspends on medical staff and doctors, ranking 29th out of 33 among high-income countries for doctors per 1,000 population, accounting for a large part of those wait times.[69] Canada has half as many specialist physicians per capita as the U.S.,[70] and, while the number of general practitioners per capita is similar to the U.S., rules banning doctors from mixing public and private practice discourage doctors from working beyond the minimum hours. Despite these rules that have contributed to a doctor shortage in Canada termed "critical" for nearly 20 years,[71] nearly half of doctors would actually like to work overtime or see private patients, but are prevented from doing so by government rules that require doctors to resign completely from public patients if they see any private patients at all[72]—a daunting prospect for a doctor considering opening a private clinic. Meanwhile, Canada's physician lobby actively limits the number of specialists.[73] The problem is proportionately worse in rural areas, where physician density is nearly two-thirds below the OECD-16 average for rural areas.[74] The doctor shortage, particularly in rural areas, is widely reported in the Canadian press.[75]

With such shortages and waiting lists, Canadian emergency rooms are packed. So packed that Canadians sometimes just give up and go home. Of Canadian ER visitors who are seen, 29 percent report wait times of over four hours, three times the U.S. level.[76] In Quebec, more than half of ER visits are longer than four hours.[77] Canadian seniors are 65 percent more likely to have visited the emergency room (ER) four or more times in the past year than American seniors.[78] Ultimately, nearly 5 percent of Canadian ER visitors end up leaving without ever being treated, giving up on a medical system that is perennially "free" but out of stock at the moment. In one study at two ERs in Alberta, 14 of the 498 walkaways were subsequently hospitalized, and one died within the week.[79]

Facing these widespread staff shortages, Canadian medical providers frequently do poorly on patient assessments. Canada scores 15th out of 20 OECD countries on "[d]octors spending enough time with patients,"[80] and one study on patient satisfaction found that the patients interviewed reported "feeling dehumanized in [the] current health care culture,"[81] as if the patient is a burden to the doctor instead of a client to serve. One recent trend in Canada is for medical providers to initiate "[o]ne issue per visit" rules that force patients to make multiple appointments, not only inconveniencing them but extending wait times yet again as patients work through their medical issues appointment by appointment, each with its own waiting list. As one doctor commented, such tactics raise an "ethical question about rationing health care in a public system and whether patients are being denied treatment as a result."[82]

Beyond making patients feel dehumanized, overworked doctors risk compromising treatment. According to OECD numbers, Canada's doctors leave foreign bodies in patients at a rate 53 percent higher than U.S. doctors, and rates of postoperative sepsis are nearly 36 percent higher.[83]

The Canadian health care system has become a part of Canadian national identity, a treasured point of difference with Americans. Alas, in surveys, Canadians actually do not love their health care all that much. A 2017 survey found that while 74 percent of Americans are "completely" or "very" satisfied with the quality of health care they have received during the past 12 months, among Canadians it is only 66 percent. Meanwhile, only 25 percent of Americans rate their care as either "somewhat" or "not at all" satisfactory, with the comparable proportion of dissatisfied Canadians one-third higher, at 33 percent.[84]

Polling suggests that Americans' health care satisfaction would plunge if they were forced into the high taxes and waiting lists endemic to Canadian health care. A Kaiser Family Foundation poll found that net favorability to health care reform proposals "is negative 23% when participants hear it would require increases to taxes, and a staggering negative 44% when people hear it would cause delays in getting tests and procedures."[85] Higher taxes and delays of even "medically necessary" treatment are precisely what the Canadian health care model offers.

Conclusion

Canadians bear similar medical out-of-pocket burdens as Americans, while paying far higher taxes. Lower overall health spending in Canada is largely achieved by rationing care with waiting lists, using cheaper drugs, skimping on equipment, and underinvesting in medical facilities and staff

to the point of nationwide shortages. Far from the feel-good "we're all in this together" rhetoric, Canadian health care hides costs by throwing burdens on already suffering patients.

Sound proposals exist for reforming American health care, including price transparency, enabling patients to shop around and choose from a variety of insurance options, and eliminating anti-competitive rules. One could make a strong case for proactive policies to help those who cannot afford health care. But Canada's top-down, government-run model is one of the worst possible options. Copying, even extending, a failing and outdated Canadian monopoly rife with unintended consequences and suffering patients is not what Americans deserve.

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CHAPTER 12

Lessons from the Canadian Health Care System

BACCHUS BARUA *and* STEVEN GLOBERMAN, PHD

International comparisons indicate that Canada achieves only mediocre, and even poor, performance scores for access to, and timeliness of, health care.

Canada effectively prohibits patients from pursuing private treatment as an alternative to the government-run health program.

U.S. policymakers should be wary of enacting any health care reforms based on the Canadian system.

Americans across the political spectrum are concerned about the high cost of health care, and some policymakers are turning to other countries for insights into how to reduce costs and expand coverage in the United States. One of those countries is Canada.

Some U.S. politicians, such as Senator Bernie Sanders (I–VT), laud Canada as a posterchild for universal health care.[1] Critics decry Canada's long wait times for medical services, and other drawbacks, as an expected outcome of "socialized medicine."[2] In fact, participants on both sides of the debate often misunderstand Canada's health care system or fail to offer a complete description.

Comprehensive international comparisons of universal health care systems indicate that Canada is a relatively high spender that achieves only mediocre, and sometimes poor, performance, particularly with regard to the availability of medical resources and the timeliness of care. Canada's health care system is also particularly restrictive in a number of ways with which Americans may be unfamiliar. It is important for

U.S. policymakers and the public to understand the underlying policies, and practical reality, of the Canadian system as they seek to reform the U.S. system.

An Overview of the Canadian Health Care System

According to the Canadian constitution, the provision of health care is the responsibility of each province. However, the federal government exercises significant control over the policies that characterize provincial health care systems through its funding. The guiding principles of this financial relationship—and the basis of Canada's universal health care framework—are enshrined in the Canada Health Act (CHA), enacted in 1984.

One of the key features of Canada's system is the significant restriction on private-sector financing and delivery of core medical services. The CHA significantly restricts private activity on both fronts. Specifically, the CHA states that the insurance plan of a province must be administered on a not-for-profit basis by a public authority and must cover medically necessary services provided by hospitals and medical practitioners for every resident on uniform terms and conditions. Provincial plans must not directly or indirectly (through charges or otherwise) impede reasonable access to health services and must not impose any minimum residency requirement in excess of three months before providing coverage. In addition, the CHA also prohibits private insurance for medically necessary services that share the cost with the public system. As a result, Canada is a rare example of a country that effectively prohibits private insurers from providing coverage for services outside the government program. Meaning that, while private coverage exists, it is only available for those medical goods and services that do not require coverage by the CHA.

Another key feature of the Canadian system is that there are no cost-sharing requirements for patients under provincial plans—no deductibles, co-pays, or extra-billing.[3] By contrast, co-payments and other cost-sharing requirements are the norm in most other developed countries (with the exception of Britain, which has the public National Health Service) as a way to make patients better understand the scarcity of health care resources so that they will use the health care system responsibly.[4]

Perhaps as a direct consequence of Canada's single-payer (government-funded) system, hospitals are funded using prospective "global budgets." Under this method of remuneration, hospitals receive a set amount of funding to treat patients, thus incentivizing hospital managers to limit patient

admissions and treatments.[5] While perhaps useful for containing costs, global budgets may also disincentivize hospital administrators from treating patients who have conditions that are costly to treat.[6] More generally, global budgeting typically leads to rationed care, as only a limited amount of activity can be paid for before hospitals exhaust their budgets.

The legal status of health care providers who work entirely outside the public system is ambiguous, and only 1 percent of hospitals were classified as for-profit institutions in 2016.[7] Furthermore, and unlike most other countries, provinces in Canada heavily discourage (or outright prohibit) physicians from practicing in both the public and the (almost non-existent) private sector. As a practical matter, provincial governments also discourage private clinics from operating entirely independently of the public system, even if the suppliers do not bill the government for services provided. Canadians also have no legal right to buy private health care services that are covered by the government program, unless they go outside Canada for those services.[8]

The resulting system is one in which Canadians are effectively prohibited from pursuing private treatment for medically necessary services in their own country. Although patients can, in principle, pay the full costs of their treatment out of pocket, government restrictions on physicians' ability to receive out-of-pocket payments, as well as regulations surrounding shared costs or capital equipment with the public system, and the vague wording of the CHA (particularly section 12) have created an environment wherein provincial governments, fearing the loss of federal government funding, have implemented legislation to effectively prohibit private payment options.

While some individual legal cases have challenged prohibitions on private payment (notably the *Chaoulli* case in Quebec in 2005), Canadian patients effectively do not have the option of buying basic medical services privately. They have only the option of seeking treatment in a different country. A recent study estimated that approximately 217,500 Canadians traveled abroad to receive health care in 2017.[9] There is no other developed country, to the authors' knowledge, that places similar restrictions on patient choice.

With its restrictions as described above, the CHA severely constrains the ability of provinces to try different approaches to health care coverage and delivery, as well as the provinces' freedom to adopt new technologies and improve efficiency.

The Canada Health Act. It is important to understand the relationship between Canada's federal and provincial governments. A constitutional

monarchy, Canada is a federation with 10 provinces and three territories. The division of powers between the federal government and provincial governments is described in the Constitution Act of 1867.

Specifically, section 92(7) states that "[i]n each Province the Legislature may exclusively make Laws in relation to...[t]he Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals."[10] In other words, the provision of medical services is a provincial responsibility. As a result, Canada is often described as a pastiche of 10 health care systems—one for each province.

However, while matters related to the provision of health care services is clearly a provincial responsibility, this is not necessarily the case for the financing of (or payment for) those services. In fact, the federal government exercises a significant amount of control over provincial health care systems through its funding. While the nature and magnitude of federal government influence has evolved over time,[11] the guiding principles for the current federal–provincial government relationship are determined by the CHA.[12]

The CHA states that the primary objective of Canadian health care policy is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[13]

However, the CHA does not directly set health care policy. Rather, it is a financial act that establishes the "criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made" by the federal government.[14] Specifically, the CHA outlines the conditions that provinces must meet in order to receive a full cash contribution from the federal government through the Canada Health Transfer program, which amounted to C$38.6 billion (U.S. $29.2 billion) from April 2018 to 2019 (the Canadian fiscal year).[15]

The aspects of the CHA most relevant for setting out the framework within which provincial health care systems must function are outlined in sections 8 to 12. Commonly referred to as the five principles of the CHA, the salient points of these sections are:

1. **Section 8 (Public Administration):** "[T]the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province."

2. **Section 9 (Comprehensiveness):** "[T]he health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners."

3. **Section 10 (Universality):** "[T]he health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions."

4. **Section 11 (Portability):** The health care insurance plan of a province may not "impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services"; must pay "the cost of insured health services provided to insured persons while temporarily absent from the province"; and "provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province."

5. **Section 12 (Accessibility):** The health care insurance plan of a province "must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons," and must provide reasonable compensation to health care providers.

The compliance of these five principles, or lack thereof, is completely at the discretion of the sitting federal government, which can withhold partial (or complete) cash transfers for perceived violations by provincial governments. Further, sections 18 to 21 state that the federal government is required to make non-discretionary deductions to the cash transfers equal in amount to any extra-billing and user charges.

When it was enacted in 1984, the CHA represented the natural evolution and amalgamation of decades of provincial and federal initiatives toward universal health care—not a top-down dictate imposed by the federal government. In fact, every province already had some form of a universal health care system prior to the enactment of the CHA, in addition to existing funding relationships with the federal government.[16]

That said, two Fraser Institute analysts argue that the CHA presents a significant obstacle to provincial experimentation with successful health care policies practiced elsewhere.[17] For example, the CHA does not provide a clear definition of medically necessary services that are required to be insured by the provinces' plans. Nor does it define the term "reasonable access" or provide clear guidelines for the magnitude of penalties the federal government can impose on provinces for deemed violations of the five principles.

The two analysts conclude that "the CHA's vagueness leaves determinations of permissibility for a range of policies up to the federal government of the day, creating not only a lack of clarity for provincial policy makers, but also questions about what policies might be disallowed in future by governments with different views of a particular policy."[18] As a result, Canada's health care system has been characterized by policy inertia—with provinces afraid to experiment with private provision (either contracted or parallel to the public system),[19] dual-practice for physicians, or more narrowly defining the services that are considered medically necessary. In many cases, provinces impose restrictions on private delivery well beyond what is required by the CHA.[20]

The Cost of Canadian Health Care

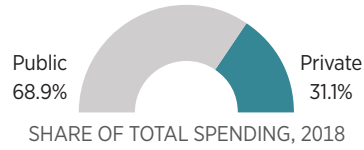
Notwithstanding the popular perception that it provides "free" health care, Canada spent approximately C$253 billion (U.S. $196 billion)[21] on health care in 2018.[22] Of this amount, approximately C$175 billion (U.S. $135 billion) is spent by various levels of government through the country's public health care system, the majority of which—C$163 billion (U.S. $126 billion)—was spent by provincial and territorial governments. The public sector accounts for 68.9 percent of total health care spending.[23] (See Chart 1). Approximately 37 percent of public-sector spending is directed toward hospitals, 22 percent toward physicians, and 8 percent toward pharmaceuticals.[24]

Health care is the single largest budget item for every provincial government in Canada. In 2018, health care accounted for between 37.5 percent (Quebec) to 45.1 percent (Nova Scotia) of provincial program spending.[25] As a result, any change in health care spending has huge implications for other provincial government program spending, as well as for taxes and the overall fiscal sustainability of the provincial economy.

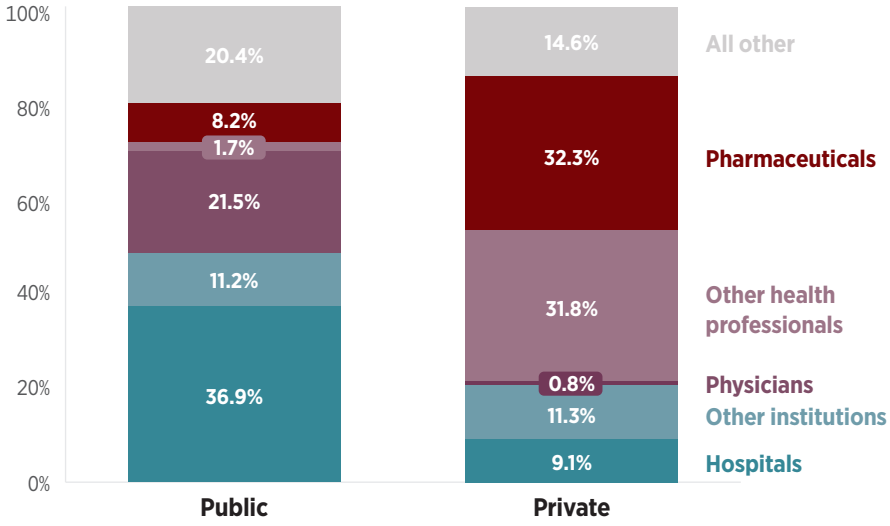
Although often referred to as a government or single-payer system, private-sector health care spending for services that are not covered by the government accounts for roughly 31 percent of the C$253 billion total.

CHART 1

Canadian Health Care Spending, by Sector



COMPOSITION OF SPENDING BY SECTOR, 2018



SOURCES: Canadian Institute of Health Information, National Health Expenditure Trends, 1975–2018, Tables A.3.3.1 and A.3.2.1, https://www.cihi.ca/en/health-spending/2018/national-health-expenditure-trends (accessed June 3, 2019), and authors' calculations.

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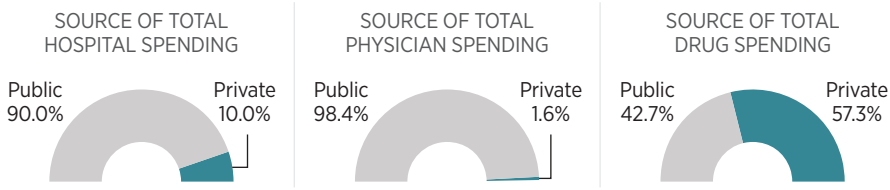
As can be seen in Chart 1, pharmaceuticals account for the largest share of private spending (32.3 percent), followed closely by spending on "other professionals" (31.8 percent).[26] By contrast, hospitals account for 9 percent and physicians only 1 percent of private-sector spending.[27]

The primary reason for the different distribution of spending between the public and private sectors is the CHA. As noted, the CHA requires the insurance plan of a province to be publicly administered and to cover medically necessary services provided in hospitals and by physicians on uniform terms and conditions. It also severely restricts the ability of the private sector to provide these services if it shares any costs with the

CHART 2

Sources of Major Health Care Spending in Canada



SOURCES: Canadian Institute of Health Information, National Health Expenditure Trends, 1975–2018, Tables A.3.3.1 and A.3.2.1, https://www.cihi.ca/en/health-spending/2018/national-health-expenditure-trends (accessed June 3, 2019), and authors' calculations.

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public sector. Furthermore, the vague wording of the CHA has led several provinces either to outright prohibit or to severely discourage physicians from practicing in both the public and private sectors.[28]

However, the CHA only requires the insurance plan of a province to cover pharmaceuticals (without extra-billing or user fees) when administered in a hospital. As a result, approximately 70.5 percent of Canadians have private drug insurance coverage,[29] and "approximately 21 percent of Canadians obtain public drug coverage through provincial and territorial plans."[30]

It is therefore no surprise that public-sector funding accounts for 90 percent of hospital spending (Chart 2) and 98.4 percent of physician payments. Conversely, private spending accounts for about 57 percent of expenditures on prescription pharmaceuticals and 100 percent of non-prescription drugs.

While Canadians are acutely aware of the private costs they bear for pharmaceutical insurance (a current topic of national debate) and medical services that do not require coverage by the CHA (such as vision and dental services provided outside the hospital setting), there is a general lack of public understanding about their full financial contributions to the public health care system. The public system is financed by general government revenues collected through a variety of taxes—including on income, sales, employment insurance, and "sin." As a result, it is

difficult for Canadian families to estimate how much they pay for public health care.

Annual estimates by the Fraser Institute provide some insight into the average family's tax contribution to the public health care system. For example, in 2018, the Fraser Institute analysts estimated that the average family of four (two parents, two children), with a household income of C$138,008 (U.S. $106,512) paid approximately C$12,935 (U.S. $9,983) for public health care through the country's tax system. The same study also estimated that the 10 percent of families with the lowest incomes paid approximately C$496 (U.S. $383) for public health care in the same year, while the top 10 percent paid C$38,903 (U.S. $30,025).[31] Whether one considers these figures astronomically high or a great bargain, one thing is clear: Canadian health care is *not* free.

The Performance of Canada's Health Care System: An International Perspective

A recent study by the Fraser Institute compared the performance of 28 countries,[32] categorized by the Organization for Economic Co-operation and Development (OECD) as having "universal" or near-universal health coverage.[33] Using a "value for money" approach, the Fraser Institute analysts examined 47 indicators in the areas of spending, availability of resources, utilization of services, timely access to care, clinical quality, and health status. The analysts concluded that despite ranking amongst the most expensive "universal" health care systems, Canada's performance was only mediocre, and in some cases notably poor. In particular, Canada had substantially fewer medical resources than the average OECD country, with a mixed record in terms of use of resources and clinical performance. It also consistently ranked at the bottom of the pack in terms of patient wait times.[34] The results of the Fraser Institute study are summarized as follows:

Health Care Spending. In 2016, Canada ranked sixth-highest for health care expenditure as a percentage of gross domestic product (GDP), and 11th-highest for health care expenditure per capita, out of the 28 countries included for comparison.[35] After adjustment for age, Canada ranked fourth-highest for health care expenditure as a percentage of GDP and 10th-highest for health care expenditure per capita.[36]

Of course, high spending by itself is not necessarily a bad thing, if it is accompanied by commensurate high performance that is, in turn, demanded by the citizenry. Hence, while comparisons often highlight the higher level of spending, a singular focus on relative spending is, at best, inadequate and, at worst, misleading.

Availability of Resources. Good performance is unlikely without having adequate resources to provide care. Out of 28 countries, on a per-thousand-population basis, Canada ranks 26th for physicians, 16th for nurses, 26th for curative (acute) care beds (of 26),[37] and 25th for psychiatric care beds per thousand population.[38] As shown in Table 1, after adjustment for age, Canada ranks 26th for physicians. Canada ranks 14th for nurses, 25th for curative (acute) care beds (of 26), and 25th for psychiatric care beds per one thousand people.[39]

Similarly, Canada has fewer diagnostic technologies than the average OECD country. Per million population, Canada ranks 22nd (of 27) for magnetic resonance imaging (MRI) units, 22nd (of 27) for computed tomography (CT) scanners, 17th (of 24) for positron emission tomography (PET) scanners, and 11th (of 22) for mammography machines.[40] After adjustment for age, Canada ranks 22nd (of 27) for MRI units (Table 2), 21st (of 27) for CT scanners, 19th (of 24) for PET scanners, and 12th (of 22) for mammography machines.[41]

Use of Resources. Medical resources are of little value if they are not used. Furthermore, the number of services provided can help explain the relative costs of different health care systems. The study examined four key indicators: the number of (1) consultations with physicians, (2) hospital activity, (3) MRI scans, and (4) CT scans.

Canada ranks seventh (of 28) for doctor consultations per capita, last (of 28) for hospital discharge rates per 100,000 population, 13th (of 25) for MRI exams per thousand population, and 12th (of 25) for CT scans per thousand population.[42] After adjustment for age, Canada ranks eighth (of 28) for doctor consultations per capita and last (of 28) for hospital discharge rates per 100,000 population. (See Table 3). For MRI examinations, Canada ranks 11th (of 25) per thousand population and 12th (of 25) for CT scans per thousand population.[43]

Timeliness of Care. The availability of resources is an important factor conditioning the performance of a national health care system. Since resources can be used more or less efficiently, it is also important to compare measures of service delivery and treatment outcomes when creating "league tables" of health care systems.

In this regard, timeliness of health care delivery is an important characteristic of the performance of health care systems. Canada is tied for last place (of 10) for the percentage of patients able to make a same-day appointment when sick (43 percent), and ranks fourth (of 10) for the percentage of patients who report that it is very easy, or somewhat easy, to find care after hours (63 percent).

TABLE 1

Availability of Physicians in OECD Nations

Country	Physicians*	Rank
Austria	5.0	1
Norway	4.7	2
Portugal	4.4	3
Iceland	4.4	4
Switzerland	4.2	5
Sweden	4.0	6
Australia	3.9	7
Germany	3.8	8
Israel	3.8	9
Spain	3.7	10
Czech Republic	3.6	11
Denmark	3.6	12
Average	3.5	
Netherlands	3.5	13
Italy	3.5	14
Ireland	3.4	15
Estonia	3.3	16
New Zealand	3.3	17
Luxembourg	3.2	18
Hungary	3.2	19
France	3.0	20
Belgium	3.0	21
Latvia	3.0	22
Finland	3.0	23
Slovenia	3.0	24
United Kingdom	2.8	25
Canada	2.7	26
Korea	2.6	27
Japan	1.8	28

* Age-adjusted per thousand population

NOTE: Countries with the same figures will have different ranks because figures have been rounded.

SOURCES: Bacchus Barua and David Jacques, "Comparing Performance of Universal Health Care Countries, 2018," Fraser Institute, 2018, https://www.fraserinstitute.org/sites/default/files/comparing-performance-of-universal-health-care-countries-2018.pdf (accessed November 12, 2019), using data from Organisation for Economic Co-operation and Development, OECD Health Statistics 2018.

TABLE 2

Availability of MRIs in OECD Nations

Country	MRIs*	Rank
Japan	38.7	1
Korea	32.0	2
Germany	31.3	3
Italy	24.8	4
Iceland	23.7	5
Finland	23.6	6
Switzerland	22.3	7
Austria	22.1	8
Ireland	17.0	9
Average	16.4	
Spain	15.5	10
Australia	15.5	11
New Zealand	15.2	12
Denmark	14.9	13
Sweden	14.9	14
Luxembourg	13.5	15
Estonia	13.2	16
France	13.1	17
Latvia	13.0	18
Netherlands	12.7	19
Belgium	11.5	20
Slovenia	11.0	21
Canada	9.9	22
Czech Republic	8.4	23
United Kingdom	7.2	24
Portugal	7.2	25
Israel	6.0	26
Hungary	3.9	27

* Age-adjusted per million population

NOTES: Countries with the same figures will have different ranks because figures have been rounded. Data for Norway were unavailable.

SOURCES: Bacchus Barua and David Jacques, "Comparing Performance of Universal Health Care Countries, 2018," Fraser Institute, 2018, https://www.fraserinstitute.org/sites/default/files/comparing-performance-of-universal-health-care-countries-2018.pdf (accessed November 12, 2019), using data from Organisation for Economic Co-operation and Development, OECD Health Statistics 2018.

Canada placed last among the 18 countries for which data was available on the percentage of patients (56.3 percent) who reported waiting more than four weeks for an appointment with a specialist. As shown in Table 4, Canada also ranked worst (10th of 10) for the percentage of patients who reported waiting two months or more for a specialist appointment (30 percent), and worst (10th out of 10) for the percentage of patients who reported waiting four months or more for elective surgery (18 percent).[44]

Long wait times for medically necessary care are, perhaps, a defining feature of Canada's health care system. But wait times have been getting worse. In 1993, the Fraser Institute estimated that the median wait time for elective surgery across 12 specialties was 9.3 weeks. In 2018, the most recent estimate, that wait time had jumped to 19.8 weeks.[45]

It is important to remember that wait times are not benign inconveniences. They can, and do, have real health consequences for patients—who may be in pain, whose conditions may worsen over time, and in the worst cases, may die—while they wait for treatment.[46]

There is also an economic cost—the value of time lost while waiting for treatment, either directly through lost wages, or indirectly through lower productivity. Conservative estimates based on only the wait between specialist to treatment (not including the prior wait to see a specialist) put the cost (based on estimated lost wages) during the work week at C$2.1 billion (U.S.$1.6 billion)—C$1,924 (U.S. $1,485) per patient. The costs climb to C$6.3 billion (U.S. $4.9 billion)—C$5,860 (U.S. $4,523) per patient—when valuing (at the same hourly rate) evenings and weekends for the 1,082,541 patients who waited for treatment in 2018.[47]

Outcomes and Quality. An often-cited indicator of outcomes is life expectancy. Perhaps the most commonly used measure of health status is life expectancy at birth, that is, the average number of years a person can be expected to live assuming age-specific mortality levels remain constant. Canada ranks 13th (of 28) for its performance on the indicator measuring life expectancy at birth (calculated by the OECD).[48]

Because this (and other such indicators) can be problematic for a number of reasons, it is often more informative to examine indicators of clinical performance and quality. Canada ranks 17th (of 24) for performance on the indicator measuring the rate of diabetes-related lower extremity amputation, which is statistically worse than the average range for the OECD countries included for comparison, but ranks well—fourth of 22—for the rate of hip-fracture surgery initiated within 48 hours after admission to the hospital.[49]

TABLE 3

Doctor Consultations and Discharge Rates in OECD Nations

Country	Doctor Consultations per Capita	Rank
Korea	19.6	1
Czech Rep.	10.9	2
Hungary	10.9	2
Japan	9.6	4
Germany	9.1	5
Netherlands	8.7	6
Australia	8.2	7
Canada	8.0	8
Israel	7.6	9
Spain	7.4	10
Average	7.0	
Belgium	6.8	11
Ireland	6.7	12
Iceland	6.7	13
Luxembourg	6.6	14
Slovenia	6.6	15
Austria	6.5	16
Estonia	6.1	17
Italy	6.0	18
France	5.9	19
Latvia	5.6	20
U.K.	5.0	21
Norway	4.6	22
Denmark	4.2	23
New Zealand	4.0	24
Finland	4.0	25
Switzerland	3.9	26
Portugal	3.8	27
Sweden	2.7	28

Country	Discharge Rates per 100,000	Rank
Austria	24,886.1	1
Germany	23,329.4	2
Korea	20,411.4	3
Czech Rep.	19,719.8	4
Hungary	19,626.1	5
Australia	19,323.9	6
Israel	19,122.1	7
Latvia	18,011.2	8
Slovenia	17,952.6	9
France	17,670.6	10
Switzerland	17,338.6	11
Norway	17,194.8	12
Belgium	16,434.2	13
Estonia	16,065.6	14
Luxembourg	15,965.3	15
Average	15,917.8	
Ireland	15,742.8	16
Finland	15,710.0	17
New Zealand	15,640.9	18
Denmark	14,076.1	19
Sweden	13,960.7	20
Iceland	13,234.2	21
U.K.	13,080.8	22
Netherlands	11,556.0	23
Spain	11,202.2	24
Italy	10,250.2	25
Portugal	10,015.6	26
Japan	9,471.7	27
Canada	8,704.1	28

NOTE: Countries with the same figures will have different ranks because figures have been rounded.
SOURCES: Bacchus Barua and David Jacques, "Comparing Performance of Universal Health Care Countries, 2018," Fraser Institute, 2018, https://www.fraserinstitute.org/sites/default/files/comparing-performance-of-universal-health-care-countries-2018.pdf (accessed November 12, 2019), using data from Organisation for Economic Co-operation and Development, OECD Health Statistics 2018.

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TABLE 4

Health Care Wait Times in OECD Nations

Country	Waited 2 Months or Longer for Specialist Appointment	Rank
Germany	3%	1
France	4%	2
Netherlands	7%	3
Switzerland	9%	4
Australia	13%	5
Average	15%	
Sweden	19%	t-6
U.K.	19%	t-6
New Zealand	20%	8
Norway	28%	9
Canada	30%	10

Country	Waited 4 Months or Longer for Elective Surgery	Rank
Germany	0%	1
France	2%	2
Netherlands	4%	3
Switzerland	7%	4
Australia	8%	5
Average	9%	
Sweden	12%	t-6
U.K.	12%	t-6
New Zealand	15%	8
Norway	15%	9
Canada	18%	10

NOTE: Figures are for those OECD countries with available data.
SOURCE: Commonwealth Fund, "International Profiles of Health Care Systems," May 2017, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2017_may_mossialos_intl_profiles_v5.pdf (accessed November 12, 2019).

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Canada ranks sixth (of 28) for performance on the indicator measuring 30-day mortality after admission to the hospital for acute myocardial infarction, statistically better than average, 18th (of 28) for performance on the indicator measuring 30-day mortality after admission to the hospital for a hemorrhagic stroke (not statistically different from the average), and 18th (of 28) for performance on the indicator measuring 30-day mortality after admission to the hospital for an ischemic stroke (not statistically different from the average).[50]

Canada ranks sixth (of 26) on the indicator measuring the rate of five-year survival after treatment for breast cancer (statistically better than average), 12th (of 26) for five-year survival after treatment for cervical

cancer (not statistically different from the average), sixth (of 26) for five-year survival after treatment for colon cancer (statistically better than average), and sixth (of 26) for the rate of five-year survival after treatment for rectal cancer (statistically better than average).[51]

While the indicators presented in this section are only a sample of indicators examined by Fraser Institute analysts, they confirm the analysts' overall conclusion—that, compared to other health care systems, Canada is a high spender, with a mixed record on usage and clinical performance, and a poor record in terms of the availability of medical resources and timely access to care.

Conclusion

Much of the debate in the U.S. surrounding the advantages and disadvantages of the Canadian health care system often oversimplifies the Canadian system. The Canadian system's approach to universal health care is unique in many key respects, and particularly restrictive in a number of ways with which Americans may be unfamiliar.

Canada significantly limits private-sector financing and delivery of core medical services. Canadians can only purchase private insurance for services that are not considered medically necessary and do not share costs with the public system. Patient cost sharing (such as co-pays and deductibles) and extra-billing are prohibited in Canada's public system, leaving patients insulated from the cost of care or understanding of the scarcity of resources, and care is often rationed as a result of the global budgeting for hospitals.

Finally, Canada is perhaps the only developed country that effectively prohibits patients from pursuing private treatment in their own country. While some individual legal cases have challenged restrictions on private payment, patients effectively have no options for buying basic medical services through the private sector within Canada's borders.

Canada is also a relatively high spender, achieving only mediocre, and sometimes poor, performance compared to many other developed countries.

One notable outcome measure on which Canada is distinctly inferior is timeliness of treatment. Canadians suffer long wait times for accessing services of physicians. The long wait times arguably reflect particular features of Canada's health care system, including first-dollar coverage for medically necessary services, the lack of a private alternative (for the financing and delivery of care), and the use of prospective global budgets for hospitals. Moreover, wait times impose costs on Canadians that are not reflected in traditional measures of health care costs.

These caveats reinforce the point that policymakers in the U.S. should exercise caution in proposing and implementing any major reforms to the country's health care system that are based on the type of policies that characterize Canada's health care system.

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CHAPTER 13

What Bernie Sanders Isn't Telling You About Canadian Health Care

PETER ST. ONGE, PHD

All Americans, regardless of political party, want access to timely, high-quality health care. The question is how to get there. Do we harness the power and innovation of the private sector, or do we hand it to the government and hope for the best?

Canada has chosen the latter route, and at one of the most recent debates among Democratic presidential candidates, Bernie Sanders once again touted its government-run health care system as a model for America.

Alas, Sanders' sanitized version of Canadian health care doesn't remotely fit the facts.

No more out-of-pocket expenses? In reality, Canadians' out-of-pocket health costs are nearly identical to what Americans pay—a difference of roughly $15 per month. In return, Canadians pay up to 50% more in taxes than Americans, with government health costs alone accounting for $9,000 in additional taxes per year. This comes to roughly $50 in additional taxes per dollar saved in out-of-pocket costs.

Keep in mind these are only the beginning of the financial hits from "Medicare for All." Canada's public system does not cover many large health costs, from pharmaceuticals to nursing homes to dental and vision.

As a result, public health spending in Canada accounts for only 70% of total health spending. In contrast, Medicare for All proposals promise 100% coverage. This suggests the financial burdens on Americans, and distortions to care, would be far greater than what Canadians already suffer.

Canada's limited coverage may surprise Americans, but the key is understanding what "universal" means in "universal care."

Universal systems mean everybody is forced to join the public system. It emphatically does not mean everything is free. Indeed, out-of-pocket costs are actually significantly higher in Sweden, Denmark, and Norway than they are in America.

More serious than the financial burdens is what happens to quality of care in a government-run system.

Canada's total health costs are about one-third cheaper than the U.S. as a percent of gross domestic product, but this is achieved by undesirable cost-control practices. For example, care is ruthlessly rationed, with waiting lists running into months or years.

The system also cuts corners by using older and cheaper drugs and skimping on modern equipment. Canada today has fewer MRI units per capita than Turkey or Latvia. Moreover, underinvestment in facilities and staff has reached the point where Canadians are being treated in hospital hallways.

Predictably, Canada's emergency rooms are packed. In the province of Quebec, wait times average over four hours, leading many patients to just give up, go home, and hope for the best.

Seeing a specialist can take a shockingly long time. One doctor in Ontario called in a referral for a neurologist and was told there was a four-and-a-half year waiting list.

A 16-year-old boy in British Columbia waited three years for an urgent surgery, during which his condition worsened and he was left paraplegic. One Montreal man finally got the call for his long-delayed urgent surgery—but it came two months after he had died.

Canadians have found a way to escape the rationing, the long waits, and substandard equipment. They go to the U.S.

Every year, more than 50,000 Canadians fly to get their surgeries here because they can get high-quality care and fast treatment at a reasonable price. They willingly pay cash for care that, for the vast majority of Americans, is covered by insurance, private or public.

Far from being a model of government-run health care, Canada serves as a warning of the unintended consequences of socialized medicine: high taxes, long waits, staff shortages, and substandard drugs and equipment. Those suffering the most are the poor, who cannot afford to fly abroad for timely treatment.

Far from the feel-good rhetoric, socialized medicine in Canada has proved a bait-and-switch that has never lived up to the promise.

In Washington today, there are very sound proposals on the table to reduce U.S. health care costs. They include reforms to assure price transparency, increase competition, and repeal price-hiking mandates. That is the best way forward.

Canada's system of socialized medicine has created high taxes and suffering patients. That's not what Americans want or deserve.

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CHAPTER 14

Why "Medicare for All" Isn't the Right Prescription for a Pandemic

ROBERT E. MOFFIT, PHD

Is a pandemic, like other crises, a terrible thing to waste? For progressives, it looks like a golden opportunity to outlaw Americans' private health insurance and create a single-payer system of national health insurance for every legal or illegal resident in every nook and cranny of the country.

Take it from the irrepressible Rep. Alexandria Ocasio-Cortez, D-N.Y., who says the United States should quickly extend "Medicare/Medicaid coverage to all."

Not a moment to lose.

For Sen. Bernie Sanders, I-Vt., enacting his comprehensive "Medicare for All" legislation (S. 1129) is taking on a new urgency.

"Health care is a human right, period," Sanders said. "So let me be clear: It has never been more important to finally guarantee health care as a human right by passing Medicare for All."

Dr. Adam Gaffney, president of Physicians for a National Health Program, says: "Only Medicare for All would eliminate the financial barriers to care and ensure that everyone in America can get the care they need when they need it."

Although the progressive faith in government central planning is unshakeable, particularly among the majority of House Democrats sponsoring Medicare for All, the faithful should take a moment, catch a breath, and get a little peek at the empirical evidence.

Exhibit A: Canada. The oft-cited "single payer" model for America's medical future, Canada currently has 78 known cases of the new

coronavirus disease, or COVID-19, including six passengers from the infected Grand Princess cruise ship.

Researchers at the University of Toronto, however, estimate that the Canadian coronavirus infections could spread rapidly, reaching anywhere from 35% to 70% of the nation's population.

With a long-established single-payer health system, the question is this: Is Canada ready to cope? No.

According to *The National Post*, Canadian doctors in Alberta already are complaining of a "lack of forward thinking" and "poor communication" in Canada's emergency planning. This includes a critical shortage of crucial medical supplies to cope with a large-scale pandemic.

And Canadian hospitals, which already have some of the worst waiting times in the developed world, are operating at capacity.

Exhibit B: Canada. Great Britain. The U.K. is the home of the National Health Service, the most well-established (since 1948) single-payer health care system in the developed world.

A large administrative system, the NHS provides all of the goodies on the progressive wish list: government-controlled universal coverage, "free care" at the point of service, global budgeting for hospitals and other medical services, and an agency (the National Institute for Clinical Effectiveness or NICE, no kidding) to permit or deny patients drugs and medical technologies on the basis of their "cost-effectiveness."

So, is Britain ready for the COVID-19 pandemic? Well, not according to British doctors. *The Guardian*, a left-leaning U.K. newspaper, reported that in a survey of 1,600 British doctors, only *eight* said that the National Health Service is ready to cope with the pandemic.

Of course, that's no surprise to anyone familiar with British health policy trends in recent years. The NHS suffers from a shortage of 10,000 doctors and has 43,000 nurse vacancies. The system already is understaffed and struggling to meet current demands for medical services, even for British patients who are critically ill.

Thus, *The Guardian* reported: "The NHS is already struggling to meet the existing need for care and so would not be able to cope with a sudden large increase in demand linked to COVID-19."

The problem, of course, is that a fair number of those infected with COVID-19 are bound to get very sick and require hospitalization. Britain already has more than 4.5 million citizens awaiting hospitalization—a long waiting list for an entire population where access to care is a legal right.

And among those who require hospitalization, it is estimated that about 1 in 5 patients may need to be admitted to an intensive care unit to

be treated for their condition. That poses yet another problem: Britain ranks 24th out of 31 nations in ICU capacity.

Concerning an upsurge in British viral infections, the problems that may confront the National Health Service are hardly new. They seem to be a recurrent feature of the British single-payer system.

During the 2018 flu season, the inability of the NHS to meet patient demand for medical services once again caught the attention of the civilized world. Overwhelmed by the additional demand for medical services, it cancelled an astonishing 50,000 "non-urgent" surgeries for the general population.

American health care has well-known flaws. However, the progressives' faith that total government control (congressional control) over health care financing and delivery should be chastened by the British and Canadian experience, where single payer is the law of both lands.

Devout adherents to the Party of Science might take some time to check out the facts.

This article was originally published in The Daily Signal on March 13, 2019, and is available with links to sources at https://www.dailysignal.com/2020/03/13/why-medicare-for-all-isnt-the-right-prescription-for-a-pandemic/.

SECTION 5

Are You Better Off Financially Under Government-Controlled Health Care?

Introduction

Medicare for All offers an alluring promise—"free" health care at the point of service. Hiding behind this claim are higher taxes for almost every American. When politicians say that Medicare for All will consolidate and lower health care costs, they are ignoring economic realities and promising more than they can deliver. In Section 5, scholars examine the two largest financial components of Medicare for All: higher taxes for Americans, and an increase in federal spending.

Some politicians claim that most Americans will end up paying less for health care under government-run health care, once private care is abolished. The reality: Roughly three-quarters of Americans would be worse off financially under Medicare for All. Median-income married couples would be worse off, unmarried median-income workers without dependents would be worse off, even low-income unmarried mothers would be worse off. Worst off: people who get health coverage from their employer today. Medicare for All would cost some working families more than their budget for electricity, others, their gasoline budget, and others even more than their food budget.

One reason for this situation: Federal spending would increase dramatically under Medicare for All, by more than $30 trillion in 10 years. And higher taxes pay for this new spending. Under the new system, most working Americans would see nearly half their paychecks going to the government. If American legislators and citizens are going to consider a government-controlled health care system, they should be aware of its

fiscal and political costs. Medicare for All is necessarily all-encompassing and expensive; once adopted, there would be no simple way to reverse course. Section 5 demonstrates this reality through original research and illustrations of how Medicare for All will affect individuals and families.

CHAPTER 15

In Charts, How Medicare for All Would Make Most Families Poorer

MARIE FISHPAW *and* JAMIE BRYAN HALL

Under Medicare for All, three quarters of Americans would be worse off financially, according to new research from The Heritage Foundation.

Here's the bottom line: Most Americans, even many of those not making much right now, would pay more in new taxes than they would save from no longer paying for private health care.

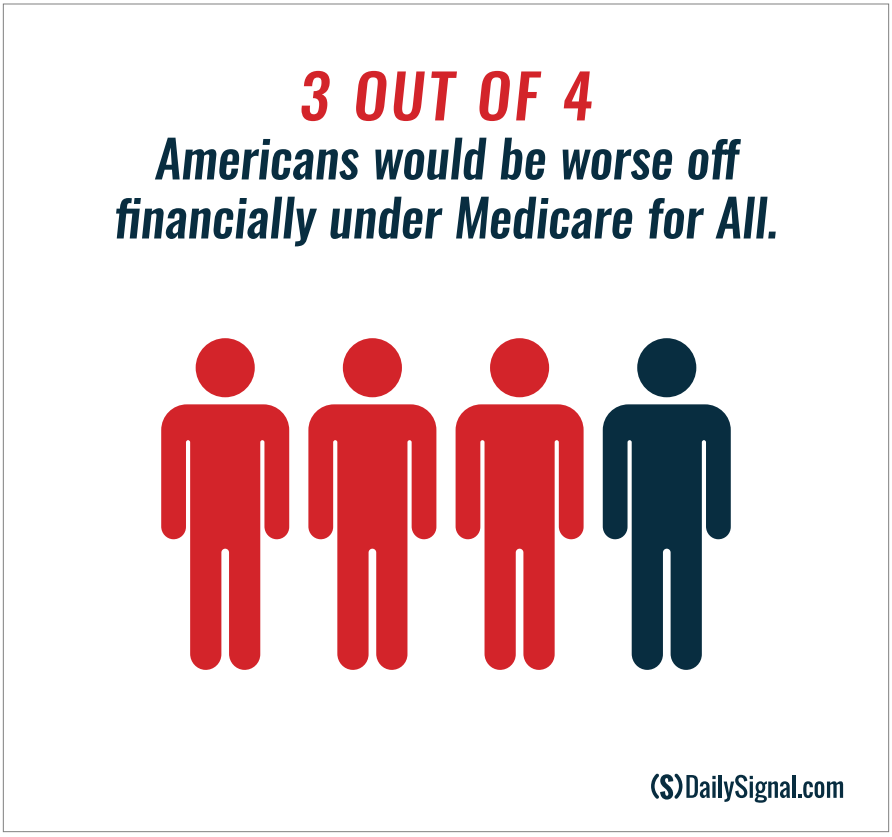
That is the reality—but it's not the story for Medicare for All advocates are telling. Sen. Bernie Sanders promises most people will be better off with Medicare for All, and that's why it's worth it to make such a massive change to our health care system. The plan would abolish private coverage and force everyone onto a government-run plan.

"Are people going to pay more in taxes?" Sanders asked at a Fox News town hall in April. "Yes. But at the end of the day, the overwhelming majority of people are going to end up paying less for health care because they aren't paying premiums, co-payments, or deductibles."

Heritage Foundation scholars Ed Haislmaier and one of us, Jamie Hall, took a hard look at this claim, and found that the politicians are promising more than they can deliver.

In fact, it turns out Medicare for All would cost some working families more than their budget for electricity; others, their gasoline budget; and others, even more than their food budget.

As a result, 73.5% of Americans will have less money in their pockets under Medicare for All. The cost of the new taxes they have to pay will be more than what they save on health care costs.

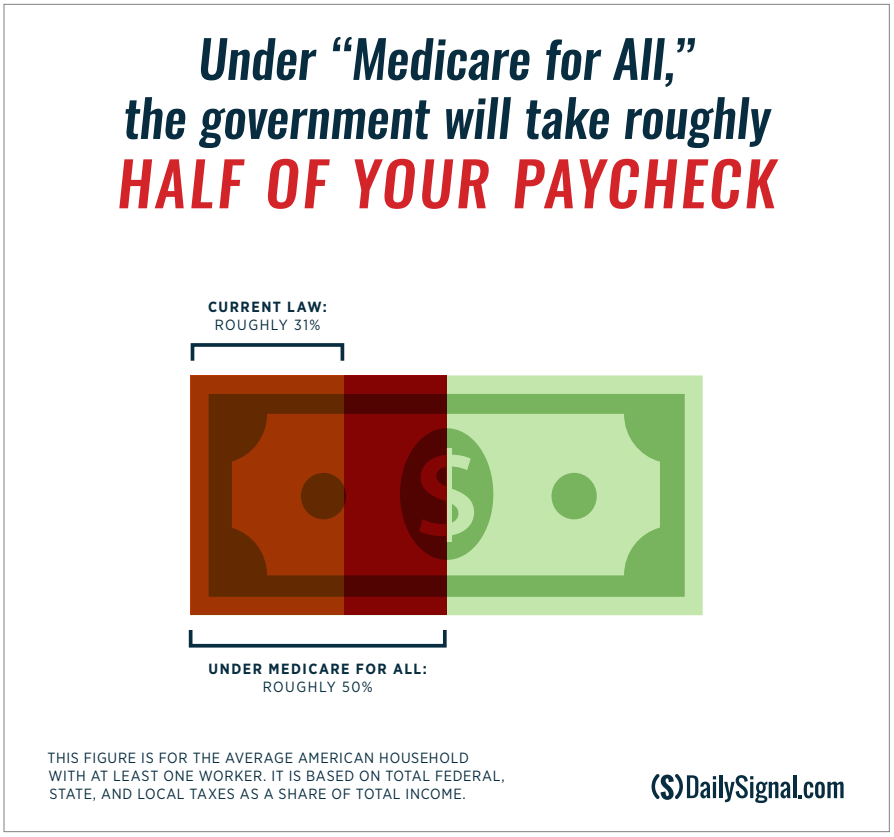


Households that receive employer-sponsored coverage would be particularly hard hit. Their income after taxes would shrink by an average of $10,554, and 87% of them would be financially worse off.

Even lower-income working families, which currently get health care through government programs like Medicaid and the Children's Health Insurance Program, would be worse off. Their average household income after taxes would decline by $5,592 per year.

That's because fully paying for these programs requires taxes to go up—a lot.

Those pushing for Medicare for All have left out some essential details. No legislative sponsor of this plan has offered a way to fully pay for its promises. Instead, Sanders and Sen. Elizabeth Warren, D-Mass., and have put out plans that don't fully pay for what they've promised to provide, and they dramatically overestimate the revenue that new taxes on the rich could raise.



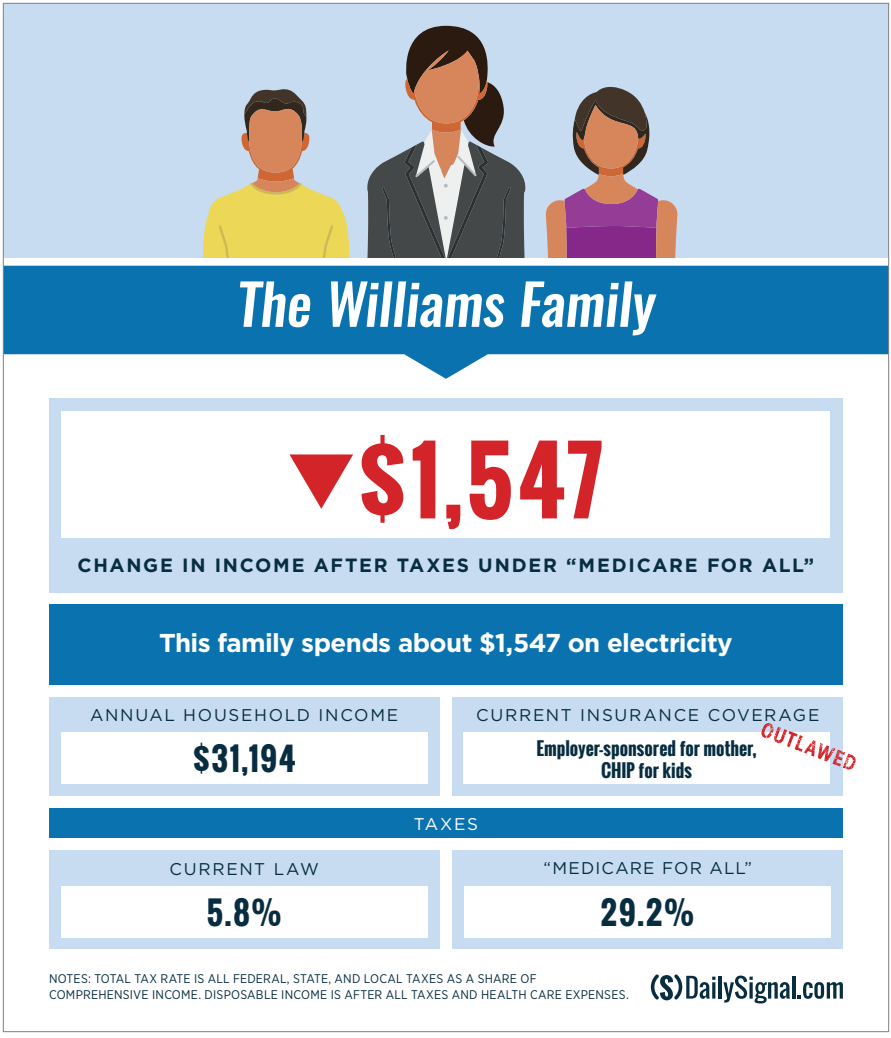
Our study uses the same means to pay for government health care as basically every other developed country uses: payroll taxes.

We ran the numbers and found that Medicare for All would require an additional tax of 21.2 cents on every dollar that every American earns. (Right now, most workers and their employers pay 15.3 cents on the dollar in payroll taxes.)

Adding that on top of other existing taxes would mean the average American would see almost half their income taken by the government.

In real life, we know that if Americans faced that kind of tax increase, some would cut back on work hours or quit working altogether. But we decided not to include that speculation in our study.

Instead, we assumed that all Americans would continue to work just as much as beforehand, while their employers convert current health insurance spending into additional taxable wages.

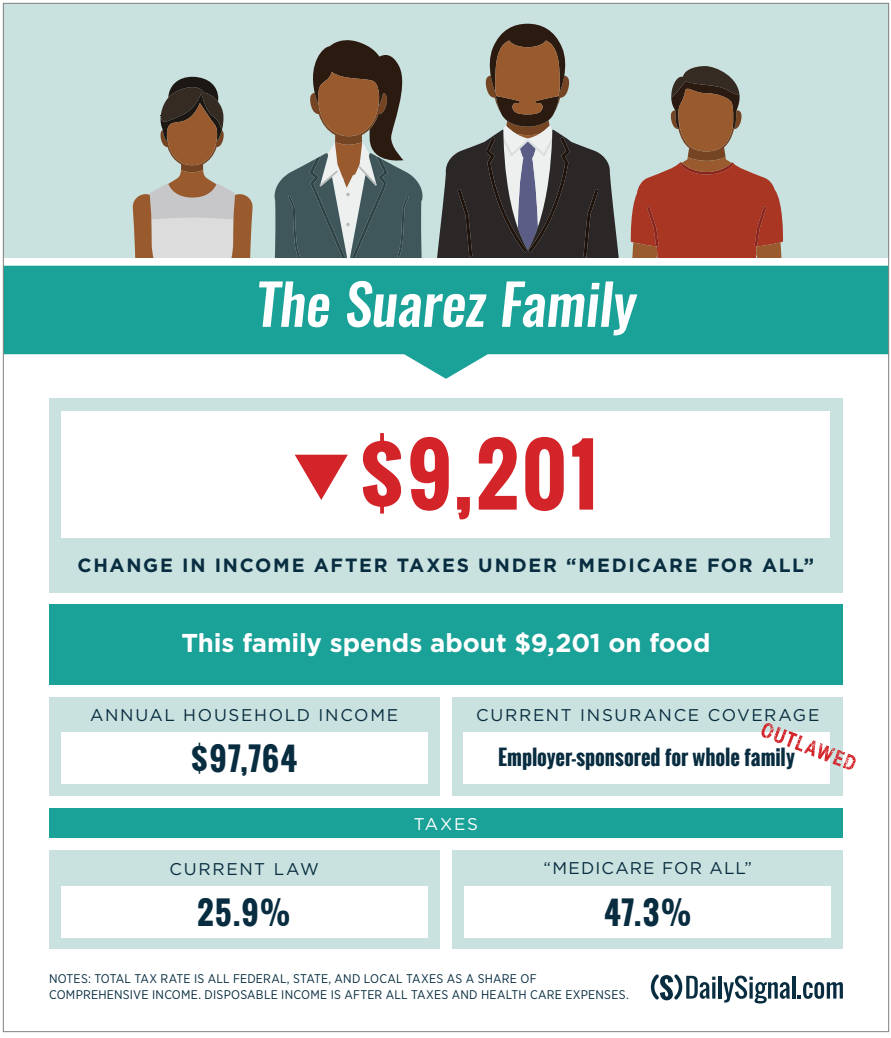


Under these conditions, here's how several sample families would fare with Medicare for All.

Olivia Williams: an unmarried mother of two earning $31,000 a year. She would be worse off by $1,547.

Under Medicare for All, Olivia would lose almost exactly the amount she spends on electricity every year.

Today, she gets her health coverage through her job, and her children get their coverage through the Child Health Insurance Program. Under Medicare for All, her current health costs go away—but she'll still lose $1,547, or 5.3% of her disposable income.

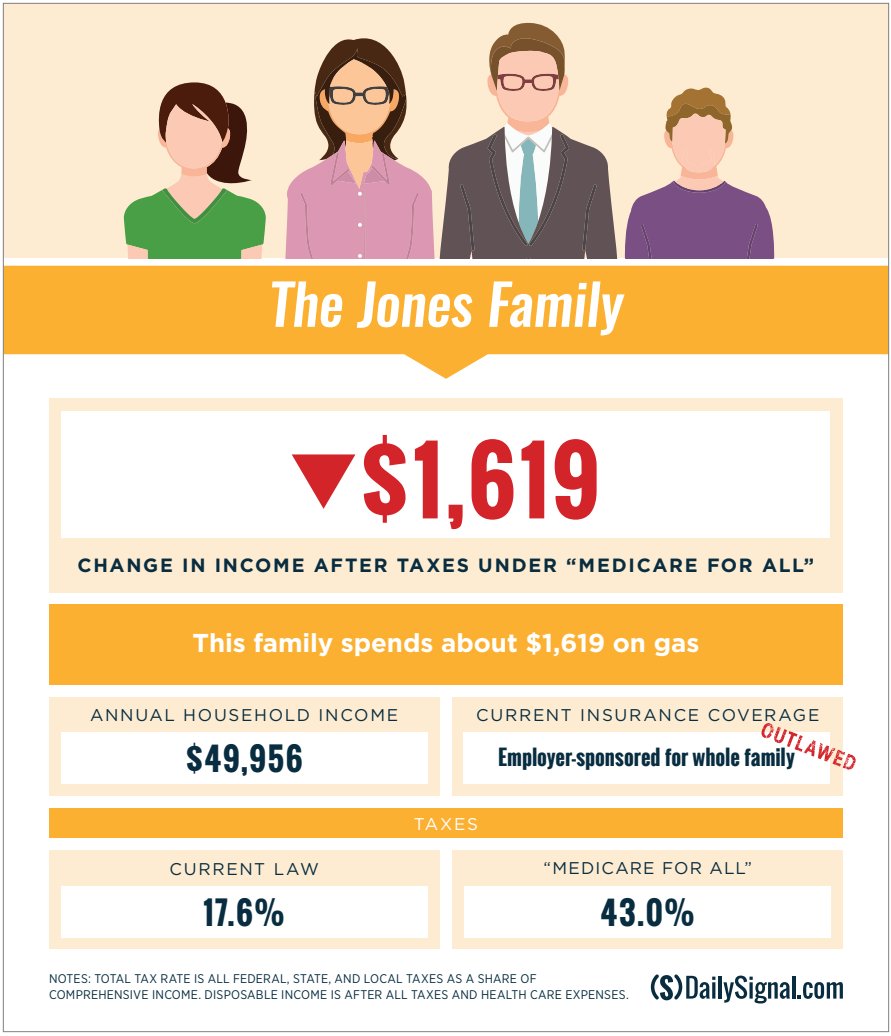


The Suarezes: a median-income married couple earning about $98,000, with two kids and employer health benefits. They would be worse off by $9,201.

Today, the Suarez's get their health coverage from dad's employer. Under Medicare for All, their health costs go away, but they'd still lose $9,021 or 13.3% of their disposable income—about as much as they spend on food today.

The Joneses: a lower-middle-income married couple earning near $50,000 a year, with two children and employer health benefits. They would be $1,619 worse off.

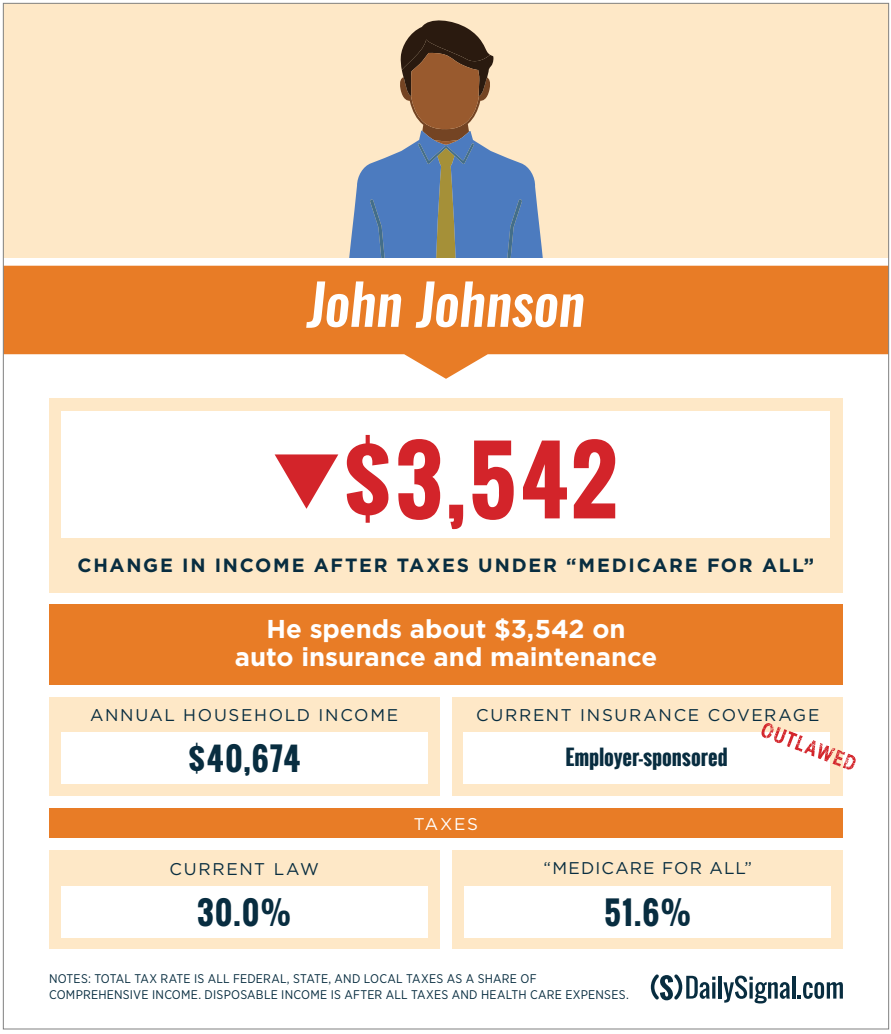
Today, the Joneses get health coverage through mom's job. Under Medicare for All, their health costs would go away, but they would still



lose $1,619, or 4.4%, in disposable income. That's about as much as they spend today on gasoline.

John Johnson: a median-income single man without dependents. He would be $3,542 worse off.

Today, John earns about $41,000 and gets health coverage through this job. Under Medicare for All, his health costs would go away, but he'll still lose $3,542, or 13% of his disposable income. That's about as much as he spends today on car insurance and maintenance.



Less Money for Most People

Medicare for All would make most Americans worse off financially, not better.

What's more, Americans would be getting a lower quality product, based on what we've seen in other countries with government-run health care. For example, wait times to receive care in Canada are longer than those in the U.S., and in Britain, morale among doctors is often low, since they face bureaucratic hurdles and larger workloads.

However, the status quo in America is not the solution, either. Costs here are too high and choices are too few—and too many Americans feel

that special interests and big government benefit from the current system, rather than them.

Congress should work toward real solutions that address these concerns at their root causes. But Medicare for All won't do accomplish that, no matter what its advocates say. It needs to come off the table.

This article was originally published in The Daily Signal on November 19, 2019, and is available with links to sources at https://www.dailysignal.com/2019/11/19/in-charts-how-medicare-for-all-would-make-most-families-poorer/.

CHAPTER 16

How "Medicare for All" Harms Working Americans

EDMUND F. HAISLMAIER *and* JAMIE BRYAN HALL

Over half of the Democrats in the House and 14 Democrats in the Senate are calling for enactment of a new government-run health coverage program to replace all existing private health insurance, including employer-sponsored health benefits, as well as the current publicly funded coverage for Americans enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The proposed new program would be operated and funded solely by the federal government, and private insurers and employers would be prohibited from offering coverage that duplicated any of the program's benefits.[1] While the terminology (such as single-payer and Medicare for All) and the details may vary, any such proposal would significantly increase federal government spending and require major tax increases.

Advocates of this idea suggest that Americans currently covered by private health plans would be financially better off, even after their taxes are raised to fund the proposed new government program. For example, Senator Bernie Sanders (I–VT) has said: "Are people going to pay more in taxes? Yes. But at the end of the day, the overwhelming majority of people are going to end up paying less for health care because they aren't paying premiums, co-payments or deductibles."[2]

That assertion is incorrect. Our analysis finds that in order to fund such a program, it would be necessary for the federal government to impose substantial, broad-based taxes equal to 21.2 percent of all wage and salary income. Those taxes would be in addition to the payroll taxes that most workers already pay for the existing Social Security and Medicare

programs, bringing total payroll taxes to 36.5 percent for most workers.[3] We also find that nearly two-thirds of American households (65.5 percent, comprising 73.5 percent of the population) would experience reductions in their disposable income, making them financially worse off. Those households would pay more in new taxes to fund the program than they would save as a result of the program eliminating their current spending on private health insurance and out-of-pocket medical expenses.

After accounting for both the tax increases and the reductions in private spending for health insurance and medical care, we find that average annual household disposable income would decline by $5,671 (or 11 percent) under a new government-run health care program.

Among households with employer-sponsored health benefits, 87.2 percent would be worse off financially under a new government-run health care program, and their annual disposable income would be $10,554 lower, on average. That would occur despite those households receiving wage increases, as employers responded to the new program by converting the value of current tax-free, employer-provided health benefits into additional taxable cash income.[4] The reason: Workers would pay much higher taxes to fund the cost of the new program because workers would need to (1) replace their own private spending, (2) replace non-workers' private spending, and (3) pay for the additional spending that would result from the program stimulating increased use of medical care.

Background

Over half of the Democrats in the House and 14 Democrats in the Senate have co-sponsored so-called Medicare for All bills, the key features of which are the establishment of a federal government-run health care program that would:

- Cover all U.S. residents;
- Provide comprehensive benefits, including coverage for items and services that are only covered to a limited extent today, such as dental, vision, hearing, and long-term care;
- Not charge patients any fees or co-payments for the care they receive;
- Replace existing private coverage and prohibit insurers and employers from offering plans that cover the same benefits as the new government program; and

- Replace the three major existing government coverage programs—Medicare, Medicaid, and CHIP.

As such, the proposal would fundamentally alter the structure and operations of the U.S. health system with numerous effects, not the least of which would be substantial increases in federal spending and taxation, as well as significant changes to the personal finances of American households.

Analysts from across the political spectrum have produced studies estimating the effects of such a program on total U.S. health spending and the federal budget. Those studies reached roughly similar conclusions.[5] Namely, that a government-run health care program would increase federal spending by at least $30 trillion over the first 10 years of implementation, and that were such a program currently in effect, federal spending would be more than $2 trillion higher than it is now.

However, less attention has been devoted to calculating the taxation needed to fund what amounts to a 50 percent increase in federal spending.[6] Yet, average Americans are less interested in how a government-run health care program would affect the federal budget or total U.S. health spending than in what its provisions, including the taxes to pay for it, would mean for their family's finances.

The biggest changes would result from the legislation effectively "nationalizing" spending that is privately funded today—roughly half of total U.S. health care spending.

That means that Americans would no longer pay directly for any of their medical care or health insurance, and they would have to pay higher taxes to fund the new program. Furthermore, about half of American households are currently covered under employer-sponsored health plans. The cost of that coverage is part of the total compensation paid by employers to their workers, but it is excluded from the taxable incomes of those employees. Replacing those private plans with a new government program would also result in the value of those benefits being converted into taxable cash wages.

The financial effects of the legislation would differ for specific individuals and families depending on their employment status, their incomes, and the source and scope of their current health care coverage. For any particular household, the implementation of a government-run health program would produce one or more of the following effects: (1) reductions in the amount spent directly on health insurance and medical care, as a result of the new program providing comprehensive benefits with

no premiums or co-payments for enrollees; (2) increases in the amount of taxable income, as a result of current non-taxable health benefits being converted into additional taxable compensation; and (3) changes to the amounts of federal and state taxes paid, as a result of the program eliminating current health care tax preferences and imposing additional taxes.

The analysis in this *Special Report* calculates the net effect on American families' finances in four basic steps. First, we identify the additional costs to the federal government of a government-run health care program as envisioned in the proposed legislation. Second, we account for the increase to the tax base that would result from the legislation precipitating the conversion of current tax-free, employer-sponsored health benefits into additional taxable wages and salaries. Third, we calculate the increased taxation needed to fund the additional federal spending, relative to the revised larger tax base. Fourth, we calculate the effects on household finances of the changes to their spending on medical care and taxes.

The results are expressed as the net change to household disposable income after taxes and health expenses (that is, payments for premiums, co-payments, and unreimbursed medical care). Put another way, the net effect is the change in the amount of income a household has left for other purposes after paying taxes and health expenses under current arrangements versus under a universal federal health care program.

Limitations. These figures should be understood as a close approximation of how families and individuals will be affected by Medicare for All.

We limited our analysis to providing baseline estimates for how replacing private health spending with federal spending, and funding that additional spending with tax increases, would alter the federal budget and household finances. As such, our analysis is a static accounting of funding shifts and we did not attempt to estimate the effects of behavioral changes in response to higher tax rates. Further, we did not incorporate into our analysis assumptions about aspects of the legislation that are not specific enough to estimate their effects with confidence. Instead, we provide a separate discussion of those issues and their associated uncertainties in Appendix B.

We conducted sensitivity analysis and found little difference in the distributional results when assuming that some elements of the proposal design are more, or less, expensive than our baseline estimates.

Findings

Our analysis finds that if Medicare for All, as envisioned in the current House and Senate bills, were already in place, it would increase 2020

federal spending by $2.387 trillion, more than 50 percent.[7] We also find that funding that increase in federal spending would require additional payroll taxes equal to 21.2 percent of all wage and salary income. Those taxes would be in addition to existing Social Security and Medicare payroll taxes, meaning that most working Americans would need to pay 36.5 percent of their wages in federal payroll taxes to fund both Social Security and a government-run health care program.

Among the population as a whole, household disposable income after tax and health spending would, on average, decline by $5,671 under a government-run health care program, with 65.5 percent of all households financially worse off than they are now. (See Table 1.)

Specific effects and net results would differ for individual households based on the type and scope of their current health insurance coverage, the amount of their current out-of-pocket medical spending, the amount and sources of their income, the type of taxes imposed to fund the program, and whether a household has workers.[8]

Effects on Working Households. Most households with workers (82.0 percent) would see their taxes increase by more than they would save from no longer paying privately for health insurance and medical care. That is mainly because they would need to pay new taxes to fund the new government spending that replaces both their own private spending and that of non-workers, as well as additional spending generated by the new program increasing demand for health care goods and services.

Effects on Working Households with and without Employer-Sponsored Coverage. The effect would be largest for working households with employer-sponsored insurance, whose disposable income would be $10,554 lower on average. In contrast, working households without employer coverage would see disposable income decline by an average of $4,029.

Most of that difference is explained by the fact that the average cash income of households with employer-sponsored insurance is nearly twice that of working households without employment-based coverage ($103,612 versus $58,963). That difference would further increase as employers responded to the legislation by converting tax-free health benefits into additional taxable compensation.

Effects on People Currently Enrolled in Medicare. Thirty-four percent of American households include at least one person who is covered by Medicare. Both the House and the Senate bills would replace Medicare with a new government-run health program that, unlike Medicare, would not charge premiums, deductibles, or coinsurance, and would cover

TABLE 1

Financial Effects of a Government-Run Health Care Program (Funded by an Additional 21.2% Payroll Tax) on Households

Household Health Insurance and Work Status	SHARE OF HOUSEHOLDS THAT WOULD BE FINANCIALLY ...		AVERAGE TOTAL TAX RATE		Average Change in Disposable Income	
	Better Off	Worse Off	Current Law	Proposed Reform		
All households	34.3%	65.5%	30.1%	47.0%	–$5,671	–11.0%
With workers	17.9%	82.0%	31.2%	49.7%	–$8,347	–14.3%
With ESI*	12.8%	87.2%	31.8%	51.6%	–$10,554	–15.6%
Without ESI*	28.0%	72.0%	29.2%	42.8%	–$4,029	–10.0%
Without workers	99.0%	0.0%	17.9%	16.1%	$4,884	20.6%

* Employer-sponsored insurance

NOTES: Total tax rate is all federal, state, and local taxes as a share of comprehensive income. Disposable income is after all taxes and health care expenses.

SOURCES: Heritage Foundation model based on data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, https://www.meps.ahrq.gov (accessed October 17, 2018), and federal and state tax data. See appendix for more information about the methodology.

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additional benefits. On average, Medicare pays for only about 65 percent of an enrollee's total health expenses, while the new program would cover nearly 100 percent of those costs.

Half (51 percent) of Medicare households include no workers (essentially, these are fully retired people). Those households would all be financially better off by an average of $5,368 if the new program was funded entirely through payroll taxes.[9] This subset of households also accounts for 85 percent of all households without workers.

The other half (49 percent) of Medicare households—those with workers—would be financially worse off by an average of $2,768 under a government-run health plan because 53.8 percent of them would pay

more in taxes than they would save as a result of the new program eliminating their current of out-of-pocket health spending.

Effects on Those Currently Covered by Medicaid and CHIP. Today, 18 percent of households have at least one person who is covered through Medicaid or CHIP (but not Medicare), and 90 percent of those households also have at least one worker. These households would be financially worse off by an average of $5,592, because 87 percent of them would pay more in taxes than they save from the elimination of their remaining out-of-pocket health spending. That is partly because individuals enrolled in Medicaid or CHIP would see little in the way of savings under the legislation since they already have comprehensive government-funded coverage. For the remaining 10 percent of households with Medicaid or CHIP enrollees that have no workers, those households would be financially better off by an average of $505.

Examples of Effects

To show how shifting to a government-run health care program would financially affect working households with different characteristics, we constructed the following five illustrative households, with the results summarized in Table 2. (See Appendix C for the full table for each illustrative household.)

Example 1: A Median-Income Married Couple with Children and Employer Health Benefits Would be $9,201 Worse Off. A married couple with two children and cash income near the median for all such families (about $98,000), and covered by employer-sponsored insurance, would have $9,021 less in disposable income under a government-run health care program. While this family's total income including employer-paid benefits would remain unchanged, the portion subject to taxation would increase by $13,459 (the sum of the $9,391 value of the employer contribution and $4,068 employee contribution toward the employer-sponsored insurance plan, which are currently untaxed).

Applying the higher federal payroll tax rate to the higher taxable wage base would increase their federal payroll tax bill by $24,329. Because more of their income is subject to tax, the couple would also pay an additional $1,830 in federal income taxes. While their state and local taxes would be reduced by $1,758, their total tax bill would increase by $24,400, to $53,947—47.3 percent of their total income. Eliminating their insurance premiums as well as their out-of-pocket medical expenses of $1,740 would save them $15,199 of private health care expenses, but it would not fully offset the increase in their tax bill. This middle-income family would

see its net income (after taxes and private health expenses) decline by $9,201 (13.3 percent), from $69,415 to $60,214.

Example 2: A Lower-Middle-Income Married Couple with Children and Employer Health Benefits Would be $1,619 Worse Off. A married couple with two children, cash income near $50,000, and covered by employer-sponsored insurance would have $1,619 less in disposable income under a government-run health care program. While this family's total income including employer-paid benefits would remain unchanged, the portion subject to tax would increase by $12,386 (the sum of the $8,430 value of the employer contribution and $3,957 employee contribution toward the employer-sponsored insurance plan, which are currently untaxed).

Applying the higher federal payroll tax rate to the higher taxable wage base would increase their federal payroll tax bill by $14,198. Because more of their income is subject to tax, they would also pay an additional $1,414 in federal income taxes and lose all $1,172 of their earned income credit. While their state and local taxes would be reduced by $1,029, their total tax bill would increase by $15,755 to $26,636 (43.0 percent of their total income). Eliminating their insurance premiums as well as their out-of-pocket medical expenses of $1,750 would save them $14,137 of private health care expenses, but it would not fully offset the increase in their tax bill. This lower-middle-income family would see its net income (after taxes and private health expenses) decline by $1,619 (4.4 percent), from $36,860 to $35,241.

Example 3: A Median-Income Working Single Mother Would Be $1,547 Worse Off. An unmarried mother covered by employer-sponsored insurance, with two children covered by CHIP, and with cash income near the median for all such families (about $31,000), would have $1,547 less in disposable income under a government-run health care program. While her total income, including employer-paid benefits, would remain unchanged, the portion subject to tax would increase by $6,650 (the sum of the $5,489 value of the employer contribution and $1,161 employee contribution toward the employer-sponsored insurance plan, which are currently untaxed).

Applying the higher federal payroll tax rate to the higher taxable wage base would increase her federal payroll tax bill by $8,342. Because more of her income is subject to tax, she would also pay an additional $163 in federal income tax, which would be offset by an increase in the child tax credit, and she would lose $1,390 in earned income credit. While her state and local taxes would be reduced by $673, her total tax bill would increase by $9,059 to $11,325—29.2 percent of her total income. Eliminating

her insurance premiums as well as the family's out-of-pocket medical expenses of $862 would save her $7,512 of private health care expenses, but it would not fully offset the increase in her tax bill. This family would see its net income (after taxes and private health expenses) decline by $1,547 (5.3 percent), from $29,039 to $27,492.

Example 4: A Single Mother Earning Minimum Wage Would Be $2,242 Worse Off. An unmarried mother with two children, all covered by Medicaid and with income near that of a full-time, year-round minimum wage worker (about $14,200) would have $2,242 less in disposable income under a government-run health care program. Applying the higher federal payroll tax rate to her taxable wages would increase her federal payroll tax bill by $2,789. Her federal income taxes would be unaffected, as she would continue to receive $6,806 in refundable tax credits (earned income credit and child tax credit).

Her state and local taxes would be reduced by $323. Because she receives more in refundable tax credits than she pays in total federal, state and local taxes, her current net benefit through the tax code is $2,704. Because she would be paying more in taxes under the proposed reform, her net benefits through the tax code would be reduced to $239, or 1.5 percent of her total income. This entire family is on Medicaid, so out-of-pocket medical expenses are low, at only $223, making the elimination of private health care expenses of little benefit to this household. This working-poor family would see its net income (after taxes and private health expenses) decline by $2,242 (12 percent), from $18,678 to $16,436.

Example 5: A Median-Income Single Man Without Dependents Would Be $3,542 Worse Off. An unmarried man with no dependents, income near the median for all such individuals (about $41,000), and covered by employer-sponsored insurance, would have $3,542 less in disposable income under a government-run health care program. While his total income including employer-paid benefits would remain unchanged, the portion subject to tax would increase by $6,615 (the sum of the $5,337 value of the employer contribution and $1,278 employee contribution toward the employer-sponsored insurance plan, which are currently untaxed).

Applying the higher federal payroll tax rate to the higher taxable wage base would increase his federal payroll tax bill by $10,649. Because more of his income is subject to tax, he would also pay an additional $767 in federal income tax. While his state and local taxes would be reduced by $849, his total tax bill would increase by $10,567, to $25,263—51.6 percent of his total income. Eliminating his insurance premiums as well as his out-of-pocket medical expenses of $410 would save him $7,025 of private health

TABLE 2

Financial Effects of a Government-Run Health Care Program (Funded by an Additional 21.2% Payroll Tax) on Representative Households

Representative Household	Current Cash Income	AVERAGE TOTAL TAX RATE		Average Change in Disposable Income
		Current Law	Proposed Reform	
Example #1—Married couple with two children, with cash income near the median for their family type ($98,000), all covered by employer-sponsored insurance	$97,764	25.9%	47.3%	–$9,201 (–13.3%)
Example #2—Married couple with two children, with cash income near $50,000, all covered by employer-sponsored insurance	$49,956	17.6%	43.0%	–$1,619 (–4.4%)
Example #3—Unmarried mother covered by employer-sponsored insurance, with two children covered by CHIP, with income near the median for her family type ($31,000)	$31,194	5.8%	29.2%	–$1,547 (–5.3%)
Example #4—Unmarried mother with two children, all covered by Medicaid, working full-time at minimum wage (cash income near $15,000)	$15,191	–16.7%	–1.5%	–$2,242 (–12.0%)
Example #5—Unmarried man without dependents, with income near the median for such men ($41,000), covered by employer-sponsored insurance	$40,674	30.0%	51.6%	–$3,542 (–13.0%)

NOTES: Total tax rate is all federal, state, and local taxes as a share of comprehensive income. Disposable income is after all taxes and health care expenses.

SOURCES: Heritage Foundation model based on data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, https://www.meps.ahrq.gov (accessed October 17, 2018), and federal and state tax data. See appendix for more information about the methodology.

expenses, but it would not fully offset the increase in his tax bill. This middle-income man would see his net income (after taxes and private health expenses) decline by $3,542 (13 percent), from $27,262 to $23,720.

Conclusion

Under a government-run health care program, most American workers would have to hand over 36.5 percent of their wages to the federal government. Those taxes would consist of: a new tax to fund Medicare for All—another 21.2 cents on every dollar earned—in addition to the payroll taxes of 15.3 percent that most workers already pay to fund the existing Social Security and Medicare programs. Furthermore, the new payroll tax would need to be imposed on every dollar of wages—from the first one earned by the lowest-paid worker to the last one earned by the highest-paid worker.

Overall, an estimated 65.5 percent of households comprising 73.5 percent of the population would be worse off financially under a new government-run health care program. The results would be even more skewed for households with employer-sponsored insurance, as 87.2 percent of them would be worse off financially under a government-run health care program.

Appendices available on p. 283.

This paper was originally published as Heritage Foundation *Special Report* No. 219 on November 19, 2019, and is available at https://www.heritage.org/health-care-reform/report/how-medicare-all-harms-working-americans.

SECTION 6

Government-Controlled Health Care and the Impact on the Medical Profession

Introduction

Medicare for All would not only impact your wallet, but the quality of care you receive. Government-controlled health care introduces a third player into the doctor–patient relationship: Uncle Sam. There is no opt-out—whether you like it or not, the federal government would be a part of your health care. In Section 6, two Heritage Foundation scholars—Robert E. Moffit, PhD, and Kevin Pham, MD—explore how government-controlled health care would affect every aspect of the medical profession, including the doctor-patient relationship, physician morale, and even medical progress.

Government bureaucracy is extremely hard on doctors; it adds layers of complication to an already stressful job. Medicare for All would increase physician stress and decrease physician morale. Physician suicide is already twice the rate of the general population; 62 percent of physicians have reported being somewhat or very pessimistic about the future of medicine. The 2018 Physicians Foundation survey found that excessive bureaucracy and regulations is part of what stresses doctors. Americans should be wary of adopting a system that adds to their health care providers' burden and takes them away from what they should be doing: practicing medicine, not filling out paperwork.

Not only would government-controlled health care influence physician wellbeing, it would add blockers to medical progress. Research and development is often funded by private companies, and Medicare for All would endanger that funding. In 2017, the U.S. spent $182.3 billion on medical

research, $121.8 billion of which was from private companies. While this is an enormous amount, and more than other countries spend, Americans also have access to some of the most innovative medical treatments.

Americans can take justified pride in the responsiveness of medical care that the U.S. is able to provide and the quality of doctors in the U.S. While our current health care system is far from perfect, health care reform should make medical progress and the jobs of physicians easier, not more difficult. The Left's proposals move the country in the wrong direction.

CHAPTER 17

Hello, "Medicare for All." Goodbye, Doctor–Patient Relationship.

ROBERT E. MOFFIT, PHD

"That's between you and your doctor." It's a sentiment based on the principle of doctor-patient confidentiality, a principle highly valued by most Americans.

If "Medicare for all" becomes law, however, that relationship will have to make room for a third party: Uncle Sam. And Uncle Sam will call the shots.

That's because the leading "Medicare for all" bills in Congress (H.R. 1384 and S.1804) would severely restrict Americans' right to spend their own money to pay a doctor for legal medical services outside of the government's health care system.

American doctors would be beholden to government officials, not patients, for the terms and conditions of their medical practice. They would depend almost exclusively on government for their livelihood.

Medical needs and preferences, however, vary from one person to the next. A person might prefer medical treatment outside of the government system. Some might want to pay their doctors directly for privacy reasons, or because they trust a particular physician, or some other personal reason.

But under "Medicare for all," good luck with that.

What if a doctor "participates" in the government system? The House bill provides: "An institutional or individual provider with an agreement in effect under Section 301 may not bill or enter into any private contract with any individual eligible for benefits under the Act for any item or service that is a benefit under this Act."

Well, what about "non-covered" medical services, where not one red cent of government money is involved? One might assume that a "participating" doctor and a patient entering into a private contractual relationship behind closed doors wouldn't be the government's concern.

Wrong.

For that small number of "non-covered" benefits and services, a "participating " doctor could enter into a private contract with a patient "eligible" for government benefits. But there are conditions. The doctor could not get government payment for these services. Moreover, the doctor could not get any payment (either "directly or indirectly") from any organization that also takes Uncle Sam's money for the "covered" benefits and services.

Moreover, any doctor contracting privately with a patient for "non-covered" services must sign an affidavit to that effect, and file it with the Secretary of HHS within 10 days of the contract.

The House bill would ensure that federal officials know about these private doctor-patient agreements. It is irrelevant that the agreement would be for services privately paid for and privately delivered, and not provided by the government.

What about "non-participating" doctors—that is, doctors who have not signed an agreement to participate in the government system? They would get a limited "pass"—as long as any private contract with any patient is for a benefit or service not covered by the government. Given the universal scope of government supervision and control, this would be a tiny class of doctors delivering a small number of services. No serious alternative to the system.

If, however, a "non-participating" doctor wanted to contract privately with a patient enrolled in the government system for a service "covered" by the government, then the House bill prescribes detailed terms and conditions.

Section 303 specifies that such a private contract must be in writing, signed by the parties, entered into outside of an "emergency situation"; and the patient must acknowledge that the government is not going to pay for these services or cap their costs. The "non-participating" doctor must then file an affidavit that he or she entered into such a private contract, and file it with the HHS Secretary within 10 days of the contractual agreement.

That affidavit contains a poison pill for "non-participating" physicians. It stipulates that they "...will not submit any claim for any covered item or service provided to any individual enrolled under this Act during the 2-year period beginning on the date the affidavit is signed."

In short, the doctor could not participate in the government system for two full years, or treat any other patient getting the government's "free care."

The House bill provides more than seven pages of legislative text restricting the right of doctors and patients to enter into private agreements for medical services.

The Senate bill embodies roughly the same policy. Doctors and patients could privately contract outside of the government system, but only if the doctor submits the required affidavit to the HHS Secretary and agrees to forego government payments for all other patients for one year. Few doctors could do it.

Under leading "Medicare for all" bills, then, you could no longer spend your own money to get the personalized or confidential care you want from a doctor of your choice, except under tight legal restrictions. It makes such an option virtually impossible. If your doctor likes you, he probably can't keep you.

This article was originally published in the *Sacramento Bee* in March 2019. It is available with links to sources at https://www.heritage.org/medicare/commentary/hello-medicare-all-goodbye-doctor-patient-relationship.

CHAPTER 18

"Medicare for All" Will Further Lower Physician Morale

KEVIN PHAM, MD

Last week, the administrator of the Center for Medicare and Medicaid Services, Seema Verma, spoke at The Heritage Foundation on the effect "Medicare for All" would have on American health care

Verma said many of current problems in the American health care system would only be exacerbated under Medicare for All, including access issues, payment inflexibility, and prohibitive regulation, all of which are great concerns for policymakers.

But one thing she said should be immediately alarming to everyone: Physician suicide has become the highest of any profession.

At the 2018 annual meeting of the American Psychiatric Association, a presented study found that the physician suicide rate was about 28 to 40 suicides per 100,000, which is more than twice that of the general population.

A researcher from that American Psychiatric Association meeting explained that physicians had unusually high rates of mood disorders, alcoholism, and other sorts of substance abuse issues.

The suicide rate is rising in the context of persistently low physician morale, with over half of physicians reporting somewhat or very negative feelings about the current state of medicine; 62% were somewhat or very pessimistic about the future of medicine and 46% of physicians would not recommend their children pursue a career in medicine.

The prevalence of depression for physicians was approximately even with the general population but was up to twice the general population for medical students and residents.

When residents work 28 days a month and students spend their hours away from the hospital poring over hundreds of PowerPoint slides, the resulting psychological scars go deep and frequently manifest as alcoholism.

The 2018 Physicians Foundation biennial survey suggests that the cause of the sinking morale and rising suicide rate among medical professionals is that many physicians feel "their ability to do what they are trained to do, and what attracted them to medicine in the first initially (that is, care for patients) is being circumscribed by external forces."

The external forces described include "excessive bureaucracy and regulations."

This is not to suggest that bureaucracy is driving suicide, but the nonclinical impediments between a physician and the actual practice of medicine is straining the sense of purpose in individuals who already work in a highly stressful profession.

The American Psychiatric Association meeting devoted several sessions to addressing the growing issue of physician burnout and depressed morale. As of 2018, 78% of physicians reported feeling burnout and 80% reported working at their capacity or even beyond it.

In a survey specifically on burnout, 14% of physicians reported having suicidal thoughts, and 1% reported attempting suicide.

The leading contributor to burnout was "too many bureaucratic tasks (e.g. charting, paperwork)" with 59% of respondents agreeing.

The second and third leading contributors were "too many work hours" and "increasing computerization of practice (EHRs.)"

These were all mentioned specifically by Verma as barriers that the government places between physicians and their patients.

For instance, the government has mandated the use of electronic health records systems, or EHRs, to document clinical encounters by computer. As a result of this mandate, doctor's visits have become a three-way conversation between physician, patient, and computer.

Electronic health records promised to revolutionize medicine by bringing medical practice into the electronic age and for the past 10 years, under both the George W. Bush and Barack Obama administrations, government programs have promoted their use with both incentive payments and penalties of reduced Medicare payments.

The problem is that the mandated implementation of electronic health records did not consider whether physicians felt they enhanced their practice.

In fact, 36% of physicians reported that EHRs had actually detracted from the quality of their patient care, 56% reported reduced

efficiency, and 66% reported electronic health records detracted from patient interaction.

Use of electronic health records was reported to be the least satisfying part of medical practice, followed by regulatory requirements and loss of clinical autonomy.

It is difficult to properly describe a spiritual problem like suicide by painting a technical picture with statistics.

Ultimately, the problem is that these highly trained individuals go through eight years of school, passing and performing numerous standardized tests, each more competitive than the last, then go through three to seven years of residency—more for subspecialty fellowships—and finally begin their careers under a mountain of paperwork that keeps them from doing what they trained to do.

Although Verma and her department are working diligently to reduce it, the bulk of administrative burden placed on medical practices comes from their office—the Center for Medicare and Medicaid Services—and it is inhibiting doctors from being doctors.

The way forward for health care should include not exacerbating these issues.

Much of the rigidity and absurdities of health care stem from the government's influence.

The private market can adjust to medical innovation and to competitive forces, but new rules through the government must undergo a laborious bureaucratic process exposed to powerful lobbies and special interests. New rules approved by legislation? Those must pass through two highly polarized chambers of Congress.

To keep apace with medical advancements, and to have a system respond properly to patients and to doctors, health care needs to have less, not more, government intervention.

Popular proposals in the news such as Medicare for All or the creation of public options do not address the underlying issues that are driving physicians away from medical practice, or worse.

It's a bad situation when doctors are spending over 11 hours on average on paperwork, out of their average 51-hour work week (or the equivalent of one full workday devoted to nonclinical demands).

Dramatically increasing their workload by providing taxpayer-funded coverage to all will be a disaster for both them and their patients.

This article was originally published in The Daily Signal on August 9, 2019, and is available with links to sources at https://www.dailysignal.com/2019/08/09/medicare-for-all-will-further-lower-physician-morale/.

CHAPTER 19

U.S. Must Avoid a Single-Payer Health Care System That Stresses Doctors to the Breaking Point

KEVIN PHAM, MD, *and* ROBERT E. MOFFIT, PHD

Washington policymakers increasingly face a crossroad in American health policy between two broad and vastly different directions. One leads toward a market-based system, based on consumer choice and competition; the other, toward a government-controlled, single-payer system, like that of United Kingdom, where health care financing and delivery is implemented through the British National Health Service.

Whatever direction lawmakers choose, the consequences will be profound for both doctors and patients.

Champions of a single-payer system often claim that a government-controlled health system, run by Washington officials, would provide an efficient practicing environment for physicians. The British NHS experience, however, suggests otherwise.

The National Health Service burdens physicians with a suffocating practice environment that strips them of their professional autonomy and sometimes forces them to put the interests of the British government above that of their patients. As a result, British doctors are leaving medical practice at an unprecedented rate.

The British Medical Association's latest surveys find more than 60 percent of their physicians report increased stress over the past year. Half have reported feeling unwell due to work-related stress.

Nearly half of their physicians report low or very low morale. While low morale extends across all medical branches, it is most prevalent among British general practitioners. The number of general practitioners

choosing to retire early has increased threefold, despite growing demand for their services.

Earlier this year, the *British Medical Journal* published a study of GPs who have left practice or are planning to leave. The most commonly cited reasons were the lack of professional autonomy, administrative challenges and increasingly unmanageable workloads. Notably, British general practitioners report no longer feeling satisfied practicing as physicians. As one of the respondents remarked, "to survive in today's NHS, you have to be comfortable taking risks and cutting corners."

In the National Health Service, bureaucrats set treatment targets and guidelines. Often, physicians find themselves compelled to practice in ways that will meet legal and regulatory requirements rather than meet the needs of their patients.

The surveys reveal that British GPs often feel the pressure of an unrealistic workload. British physicians complain that the system forces them to take clinical shortcuts, spending less time and attention on each patient. As a result, they also felt increasingly vulnerable to medical litigation.

The impact of low morale among highly trained medical professionals is pernicious and immediate. What drives most people to go into medicine in the first place is the profound satisfaction of restoring a person's health. Encumber that impetus to heal, and you will start to lose doctors. And when there are not enough doctors, widespread coverage does very little for the health of patients.

The specter of this British dynamic already exists in American health care. The American Association of Medical Colleges projects a shortage of up to 120,000 physicians (measured in terms of full-time equivalent positions) by 2030. A 2016 Physician's Foundation's survey found that approximately 50 percent of American doctors reported low morale or persistent feelings of burnout.

More than 60 percent of American physicians said they were pessimistic about the future of medicine, a 10 percent increase over just a two-year period. During that time, Washington had saddled physicians with additional third-party reporting requirements, especially in Medicare.

Up to 80 percent of surveyed physicians feel they are at or beyond their capacity to care properly for their patients, and 72 percent feel administrative requirements detract from the quality of their care. In America today, the top two physician complaints are the growing regulatory burden and the erosion of clinical autonomy.

These complaints are serious. Nearly half of American doctors now plan to accelerate their retirements.

Sen. Bernie Sanders, I-Vt., and others in Congress favor a federal takeover of American health care. This would be disastrous. Nationalizing American health care would only exacerbate administrative and patient workloads, further eroding physicians' ability to practice.

The experience of the British National Health Service, the most prominent single-payer system in the industrialized world, indicates that Americans could look forward to increasingly burned-out and overburdened doctors under a similar system.

Washington's policymakers must correct the features of the current system, not bear down harder on its overburdened providers.

This article was originally published in the *Dallas News* on July 24, 2018. It is available with links to sources at https://www.dallasnews.com/opinion/commentary/2018/07/24/u-s-must-avoid-a-single-payer-health-care-system-that-stresses-doctors-to-the-breaking-point/.

CHAPTER 20

How "Medicare for All" Bills Would Worsen the Doctor Shortage

ROBERT E. MOFFIT, PHD

"Medicare for All" may sound good to some Americans—until they take a closer look at how it would actually work.

Take something pretty basic: how it would affect the number of medical professionals we have in this country. "Medicare for All" would drive out many doctors and nurses—and compromise the accessibility and quality of medical care for millions of Americans.

The reason: "Medicare for All" bills mandate major payment reductions for America's health care workforce. Vermont Sen. Bernie Sanders' bill, for example, would use today's Medicare payment system for reimbursing doctors, hospitals and other medical professionals. Medicare rates are fixed by law and regulation, not some private market-style "negotiation." Those rates are set significantly below private sector rates, and often do not cover the true costs of providing medical services.

For example, in 2017 the American Hospital Association found that for every $1 American hospitals spent caring for Medicare patients, Medicare reimbursed hospitals only 87 cents. Likewise, in a study of major commercial insurers, the Congressional Budget Office reported that for 20 services provided by physicians, private payers paid amounts ranging from 11 to 139 percent more than Medicare paid.

Doctors and hospitals routinely depend on private health insurance to close the gap. The Senate and House "Medicare for All" bills, however, would outlaw private health insurance, and thus eliminate the freedom of medical professionals to negotiate payments outside of the government monopoly.

Under current law, we already have some idea what to expect with Medicare payment. Obamacare schedules major Medicare payment reductions for hospitals, nursing homes and home health agencies. In their 2018 report's most realistic scenario, Medicare's trustees warn that "by 2040, simulations suggest that approximately half of hospitals, roughly two thirds of skilled nursing facilities and over 80 percent of home health agencies would have negative total facility margins, raising the possibility of access and quality of care issues for Medicare beneficiaries." Medicare law also schedules physician payment decreases relative to private-sector payment.

Today, Medicare enrollment totals more than 58 million Americans. Sanders's bill, however, would expand Medicare's payment rates to the coverage of more than 300 million U.S. residents.

Projecting a dramatic 40 percent reduction in provider reimbursement relative to private insurance, Charles Blahous, a former Medicare trustee, observes, "The cuts in the Sanders M4A bill would sharply reduce provider reimbursements for treatments now covered by private insurance, which represent a substantially greater (more than 50 percent larger) share of national health spending than does Medicare."

True, American physicians are among the most highly paid medical professionals in the world. Overall, in 2018 the average American primary care physician earned $223,000, while specialists earned $329,000. In 2018, American staff nurses earned $73,287 on average, clinical nurse specialists earned $88,271, and nurse anesthetists earned $150,833.

Of course, liberals in Congress could cut American medical workforce compensation to "single payer" levels. Examining comparative 2016 data—including compensation in "single payer" Britain and Canada—researchers writing in the *Journal of the American Medical Association* found that American general physicians earn an average annual salary of $218,173. The comparable compensation for Canadian generalists was $146,286, while British generalists received just $134,671.

Medicine is, however, a tough and often stressful profession, and medical students routinely incur large personal debts. In 2018, according to the American Association of Medical Colleges, the median medical school debt amounted to $195,000.

Punitive payment cuts would surely be costly. By 2030, Americans already face a serious and potentially dangerous physician shortage, ranging between 15,800 and 49,300 primary-care doctors, and between 33,800 and 72,700 non-primary care doctors. Accelerated retirements, job-based burnout and growing demoralization fuel that shortfall.

Combining a mammoth pay cut with the abolition of private-sector alternatives would not only hurt morale. It would accelerate the shrinkage of the medical workforce.

Patients will suffer.

Blahous's Mercatus study of the Senate bill—projecting a 40 percent reduction in provider reimbursement—is thus far the only such estimate of its impact on medical compensation. The House bill—creating a global budget for American health spending and government fee systems for doctors and other providers—is yet to be subject to a similar econometric analysis.

There is an obvious candidate to undertake such an analysis: The Office of the Actuary at the Center for Medicare and Medicaid Services. The Actuary has regularly estimated the impact of Obamacare's scheduled Medicare payment reductions.

Congress and the Trump administration should ask the Actuary to conduct a similar analysis of the "Medicare for All" bills, not only assessing their impact on America's doctors and hospitals, but also Americans' access to high quality medical care.

Congress must secure the best and most authoritative estimates of the impact of the House and Senate bills. Silly political promises won't cut it. American doctors and patients—that is, all of us—deserve an honest prognosis.

This article was originally published in the *Sacramento Bee* in March 2019. It is available with links to sources at https://www.heritage.org/medicare/commentary/how-medicare-all-bills-would-worsen-the-doctor-shortage.

CHAPTER 21

Medicare Is No Model of Administrative Simplicity or Efficiency

ROBERT E. MOFFIT, PHD

"Medicare for All" legislation pending in Congress would give Washington total control over American health care. It would abolish private and employer-based health coverage and replace it with a new, government-run health program.

Its sponsors claim this would reduce administrative costs and produce huge savings. "Private insurance companies in this country spend between 12 and 18 percent on administration costs," says Sen. Bernie Sanders, I-Vt. "The cost of administering the Medicare program... is 2 percent. We can save approximately $500 billion a year just in administration costs."

Not so fast. Most independent analysts are reluctant to embrace such bold claims. Glenn Kessler, a fact-checker for *The Washington Post* warned backers of Medicare for All to be "cautious" in relying on "the administrative cost saving" as a talking point, and *Politifact* rated Senator Sanders' statement as "half true."

Comparisons between public and private sector administrative costs are tricky. Medicare and private insurance cover radically different populations: Medicare beneficiaries are generally older and sicker than those enrolled in private plans.

Because Medicare beneficiaries' utilize medical services at dramatically higher levels, the program's administrative costs naturally account for a lower percentage of total program spending. However, as Dr. Robert Book, a senior fellow at George Mason University, argues, measuring

administrative cost per beneficiary, rather than as a percentage of total spending, shows that Medicare's administrative cost has been historically higher than private insurance.

Medicare is no model of administrative simplicity. The program is governed by tens of thousands of pages of rules, regulations, guidelines and related paperwork. Its structure, organization, payment and pricing and related rules—including coding, documentation and reporting requirements—are mind-numbingly detailed.

This morass of bureaucratic complexity imposes high, albeit often hidden, costs, including administrative demands on harried doctors and other medical professionals who must daily comply with the program's overbearing rules and paperwork under the penalty of law.

These transactional costs—the mandatory reporting and the time, energy and effort required to satisfy these bureaucratic requirements—are very real. Writing for the *Journal of the American Medical Association*, researchers report that, for American doctors, "...the time spent on administrative issues related to reporting clinical or quality data to government or other agencies is a major problem."

Year in and year out, congressional micromanagement adds further to this complexity, as politically powerful interest groups lobby intensely for additions, subtractions, or self-serving modifications of Medicare law and regulation. Like a busy spider, Washington relentlessly multiplies the restrictive strands of its vast web of regulatory control.

Medicare's bureaucratic structure and regulatory functioning imposes mostly hidden costs on American health care system. They are every bit as real as the overhead costs of private health insurance; they just don't show up on Medicare's books.

Yet all of this bureaucracy does not render Medicare immune to waste, fraud and abuse, or "improper payments" to providers.

In Fiscal Year 2017, the Government Accountability Office (GAO) reported that improper Medicare payments totaled $52 billion, only $1.4 billion of which was recovered. Last fiscal year 2018, GAO estimated that Medicare racked up another $48.5 billion in improper payments.

Meanwhile, doctors and patients struggle with Medicare's cumbersome appeals process for months, even years, to get reimbursed for legitimate billings. Once again, these costs of Medicare's administrative failures are real, but such losses are not counted as administrative costs.

The congressional champions of "Medicare for All" make another big mistake. They assume "big" administrative savings from legislation creating, from scratch, an entirely new federal infrastructure, heavily

armed with an even greater arsenal of regulatory powers of unprecedented size and scope. Abolishing all private coverage as well as public programs, like Medicare, and starting over, as prescribed under both the House and Senate Medicare for All bills, would be a huge, complicated and costly undertaking.

Champions of government-controlled health care fixate on private health plans' administrative costs while studiously ignoring the stupendous amount of waste and inefficiency generated by existing government-controlled health programs.

Harvard University Professor Regina Herzlinger says it best. "The assertion that governmental control of the health sector would lower administrative expenses ignores all other aspects of the health care system, such as quality, convenience and innovation. It assumes that our sole interest is minimizing administrative expenses. But our interests are much more complex: we want excellent, high quality, convenient, consumer-responsive care, delivered at a reasonable price."

The fulfillment of these diverse personal needs is what "Medicare for All" will not, and cannot, deliver.

This article was originally published in the *Philadelphia Inquirer* on August 8, 2019. It is available with links to sources at https://www.inquirer.com/opinion/commentary/medicare-for-all-bernie-sanders-heritage-foundation-20190808.html.

CHAPTER 22

How "Medicare for All" Could Block Medical Progress

KEVIN PHAM, PHD

The introduction of penicillin in the 1940s was a revolution in medicine. Within a decade of its widespread use, however, bacteria began to develop resistance to the drug.

Since then, pharmacologists have been waging an ongoing battle to overcome infectious microbes' resistance to lifesaving drugs. The Democrats' insistence on single-payer health care and demonization of pharmaceutical companies may kneecap these efforts.

For example, researchers are growing more alarmed that microbes will begin adapting more quickly than pharmaceutical developments, such as in the case of methicillin-resistant Staphylococcus aureus, or MRSA.

This is a disastrous possibility, and it would become even more plausible by destroying the profit motive that drives the industry to create new antibiotics.

In several tweets, Sen. Bernie Sanders, I-Vt., hinted that this is exactly his aim. He complains that the "drugmakers make huge profits off medication developed with taxpayer-funded research."

In reality, most of the funds in medical research come out of those drugmakers' revenues.

In 2017, the United States spent $182.3 billion in medical research, but less than $40 billion of that was federal spending. In fact, the largest portion of medical R&D dollars came from industry investment totaling $121.8 billion.

In Sanders' signature "Medicare for All" bill, drug prices would be essentially set by the secretary of health and human services. Once Medicare for All empowers the secretary to decide the appropriate revenue for a drug company, what will happen to that $121 billion of research investment?

Fortunately, the Centers for Medicare and Medicaid Services under the current administration shows a different path in a final rule issued early in August.

The rule introduces add-on payment pathways for newly developed antibiotics that are designated "qualified infectious disease products" by the Food and Drug Administration.

To incentivize private drug development, this designation is granted by the FDA and reserved for new antibiotics to treat infections from new or drug-resistant pathogens.

In general, new drugs are granted periods of exclusivity by the FDA that are separate from patent protections, lasting from three to seven years depending on the drug. A "qualified infectious disease products" designation would extend this period by an additional five years.

In addition to offering greater protections for new drugs, the rule also increases the add-on payment from 50% of costs to 75% for qualified infectious disease products, and it considers them new products rather than improved products, which would eliminate the need to show "substantial clinical improvement" over an existing drug.

The criteria for substantial clinical improvement were vague and unclear, so forgoing this requirement significantly lowers the bar for introducing new antibiotics.

Rather than imposing strict regulations from a federal office onto firms and how they operate their businesses, the Centers for Medicare and Medicaid Services is leveraging the substantial medical and pharmaceutical industry to tackle an impending health crisis.

Drug-resistant strains of bacteria infect over 2 million people each year, according to the Centers for Disease Control and Prevention, and over 20,000 of them ultimately succumb to those infections.

Because of the difficulty in eradicating the bacteria and the potential toxicity of the treatment involved, hospital stays that are complicated by drug-resistant organisms are often prolonged and costlier, adding up to $20 billion in health care costs annually.

Thus, the availability of new and effective drugs is crucial to both the future health and future health costs of America.

Government spending, where appropriate, should be directed at enabling private industry to innovate solutions, particularly one so

pressing as multi-drug resistance. In this case, pharmaceutical companies will have access to add-on payment incentives if they develop and introduce new drugs.

The single-payer vision, which sees the government as capable of being the solution, would slash pharmaceutical revenues in pursuit of controlling prices. Presumably the government share of research and development, which was $39.5 billion, would then become the primary source of funding.

$39.5 billion amounts to less than 22% of the total spent on research.

As with any other enormous legislative package, unintended consequences are the norm rather than the exception. In this case, Medicare for All could lead to the loss of effective antibiotics for these highly virulent strains and the undoing of decades of medical progress.

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CHAPTER 23

What the Left Gets Wrong About Health Spending and Outcomes

ROBERT E. MOFFIT, PHD

Health spending in the United States is high and our medical performance is low, according to the liberals in Congress. According to Representative Pramila Jayapal, "The health outcomes and barriers to care in America are the worst of any industrialized nation." This is simply a misdiagnosis. Our health access and outcomes are not the worst in the industrialized world.

Writing in the *Journal of the American Medical Association*, a top level team of researchers reported that on key measures of access to health care, the United States "generally performed better than other countries." While on certain population health measures, such as life expectancy, infant mortality, and rates of obesity, American statistics (with certain crucial qualifications) are poor, on major clinical outcomes for heart attacks, strokes, and obstetric trauma, our performance is very good.

Americans do spend more on health care, paying more than $3.6 trillion last year, compared to single payer countries such as Britain and Canada. While much of our spending is often inefficient and wasteful, the reason is the absence of serious market competition. That is the conclusion of a wide range of analysts, including those with the Brookings Institution as well as the United States Department of Health and Human Services.

Liberals in Congress often overlook the benefits of heavy investment spending in our advanced medical technologies. The return on that investment is evident in greater rates of survival for patients stricken

with deadly diseases. Consider all our progress against heart disease. In a recent significant study, Harvard Professor David Cutler along with his colleagues report that between 1950 and 2015, the cardiovascular disease mortality rate fell by 73 percent. They wrote, "Falling mortality from heart disease and stroke mirrors the rise in medical spending on the aged."

It is noteworthy that our national decline in mortality preceded the 1966 implementation of Medicare. As the researchers demonstrate, mortality declines occurred among the near elderly persons ineligible for Medicare as well as among the elderly. They observe, "Improved health over this time period appears to be a response to the availability of new treatments as opposed to people being better insured." Access to health insurance coverage is not the same as the provision of high quality medical care.

We have also made impressive progress in the battle against cancer. For Americans, roughly 55 percent of cancer patient reduction in mortality was attributable to better screening and improved drug therapies. Not surprisingly, out of 15 developed countries, the United States ranked first with the availability of new cancer drugs at 96 percent, while 71 percent were available in Britain, and only 56 percent were available in Canada.

In another important study of cancer care in the United States and several European countries, University of Chicago Professor Tomas Philipson and his colleagues found that the incidence of cancer is more prevalent in the United States, and American cancer spending is higher. American cancer survival is, however, also higher and cancer mortality is lower. From 1983 to 1999, Americans spent $158 billion more on cancer care than all the Europeans combined. Our spending focused on far greater reliance on medical technology, including faster and broader access to new drugs.

The researchers cite Herceptin, a powerful but expensive drug to treat an aggressive form of breast cancer. The life saving drug was available to American women in 1998. British officials, however, did not recommend its use and reimbursement for British women until 2002. Concerning the American overperformance in battling cancer, the researchers wrote, "We found that the value of the survival gains greatly outweighed the costs, which suggests that the costs of cancer care were indeed worth it."

Americans spend more on health care for many reasons, and many of those costs, often generated by bad government policies, are indeed wasteful and inefficient. However, Americans also rely more heavily on advanced medical technology, and enjoy greater access to new drug therapies. Investments in these areas secure the value for our health care

dollars. The United States also pays doctors, nurses, and other medical professionals much more than other economically advanced countries.

The Senate "Medicare for All" bill would sharply reverse that pattern. It would impose an estimated 40 percent reduction in payments to doctors and hospitals, and would surely jeopardize patient access to quality care. The "progressives" in Congress promise that full government control over health care, through a closed system of single payer insurance, would secure universal access to higher quality health care at much lower costs. Experience in other countries, with long wait lists and health care denials, does not support such extravagant promises. Simply do not believe them.

This article was originally published in *The Hill* on July 3, 2019, and is available with links to sources at https://www.heritage.org/health-care-reform/commentary/what-the-left-gets-wrong-about-health-spending-and-outcomes.

SECTION 7

False Hope: Government-Controlled Health Care Will Not Improve Lives

Introduction

Government-controlled health care affects lives broadly, and at times, tragically. Situations abroad demonstrate what "Medicare for All" really looks like: waiting in lines for necessary medical care, and even being denied life-saving care. While logically distinct from the more mundane issue of health care financing, a cultural and legal acceptance of the right of the state to govern life and death decisions should be a warning to Americans of all political persuasions.

In the U.S., Medicaid, the government health care program for the poor, is characterized by low reimbursement for doctors and other medical professionals, making it particularly hard for Medicaid patients to secure high-quality care from medical specialists.

Medicare for All does not merely fail to improve lives, it ends lives. Under the proposed single-payer system, abortion would be considered health care. As Louis Brown explains in Chapter 26, Medicare for All would affect every aspect of the pro-life movement: the current prohibition of federal funding for abortion, crisis pregnancy centers, the normalization of abortion as health care, and religious freedom. Medicare for All is clearly a battle over abortion as well; if pro-life Americans want to protect the unborn and protect religious freedom, they must reject a single-payer system.

Section 7 examines four aspects our lives that centralized power under "Medicare for All" would affect: life expectancy, family control over medical decisions for loved ones, mandated abortion funding, and the freedom

to make decisions about our own wellbeing. Americans should be wary of government overreach; though the promises of "Medicare for All" are attractive, a closer look at the evidence reveals that in practice it is a threat to both innocent human life and the American way of life.

CHAPTER 24

Government-Controlled Health Care Won't Help Us Live Longer

ROBERT E. MOFFIT, PHD

Will government-controlled national health insurance increase Americans' life expectancy?

Sen. Bernie Sanders, I-Vt., and some of his colleagues in the House of Representatives often claim that "Medicare for All" legislation will improve American longevity and reduce American health care costs.

According to a comprehensive 2018 study in the *Journal of the American Medical Association*, the United States has the lowest life expectancy at birth (78.8 years) among 11 high-income countries. Japan has the highest level of life expectancy (83.9 years).

In a recent Democratic presidential debate, Sanders cited the work of a team of Yale University researchers who, writing in The *Lancet*, project major savings, plus a significant improvement in American life expectancy. Sanders noted that The *Lancet* is one of "the most prestigious medical journals in the world."

He added: "You know what it said? Medicare for All will lower health care costs in this country by $450 billion a year and save 68,000 lives of people who otherwise would have died."

The *Lancet* authors based their estimates on their assumptions of the effects of covering the remaining uninsured and securing continuity of coverage.

The *Lancet* researchers also say their estimate of 68,500 saved lives (to be exact) is "conservative," but such precise projections should give pause for three good reasons.

First, access to coverage is not the same as access to care, let alone timely access to high-quality care. Experience shows that single-payer systems offer "free" care at the point of service, but these systems are often understaffed by lower-paid medical professionals. That is why there are often significant wait times and delays in care. British and Canadian "single payer" records bear this out.

Not all insurance coverage is equal. For example, those on government welfare programs such as Medicaid are more likely to face steeper climbs in getting access to physicians and medical specialists and securing positive medical outcomes compared to, say, a person enrolled in a standard employer-sponsored health plan. That's not surprising.

As Dr. Douglas Blayney wrote about the treatment of cancer patients in California in March 2018: "Medicaid in California (MediCal) is neither safe nor effective. If MediCal were a drug, a responsible regulator should consider pulling it from the market."

Second, overcoming America's lower life expectancy depends on more than overcoming gaps in health coverage or deficiencies in care delivery, even among the uninsured. Behavioral and other risk factors are involved that have little to do with insurance coverage or whether health care dollars pass through public or private programs.

As a team of researchers wrote in a recent edition of the *Journal of the American Medical Association*: "Although poor access or deficiencies in quality could introduce mortality risks among patients with existing behavioral health needs or chronic diseases, these factors would not account for the underlying precipitants (such as suicidality, obesity) which originate outside the clinic."

This is a crucial point.

Consider obesity. American overconsumption of refined carbohydrates, among other factors, contributes to obesity rates that are the highest in the world—and thus contributes directly to high rates of chronic disease, particularly hypertension, heart disease, and diabetes. According to the researchers, mortality rates among Americans in the middle of life increased 114% between 1999 and 2017.

Not surprisingly, about three-quarters of all health spending is focused on treating or mediating the consequences of chronic disease.

Indeed, in a major 2017 study in the *Journal of the American Medical Association*, researchers estimated that almost three-quarters of the variation in life expectancy in the United States was attributable to behavioral and metabolic risk factors. Within those categories, there also are demographic, geographic, and socioeconomic variations among states and populations.

Moreover, few economically advanced countries record America's high level of traffic fatalities or have our homicide and suicide rates.

Nor have they experienced our burden of drug abuse. Between 1999 and 2017, according to the researchers, our midlife mortality from drug overdoses increased by a stunning 386.5%. Along with alcohol abuse, these drug overdoses (including opioids) undercut American progress in life expectancy.

Of all the member nations of the Organization for Economic Cooperation and Development, the U.S. had the highest number of opioid-related deaths at 130 per million, followed by "single-payer" Canada with 120 deaths per million. Hard to blame that notoriously elusive "free market."

Finally, the relationship between mortality and health insurance coverage is not statistically neat and clean. In a 2002 report, the Institute of Medicine concluded that lack of health insurance caused 18,000 deaths annually.

But in 2009, Richard Kronick of the University of California School of Medicine conducted a large study and concluded:

> The Institute of Medicine's estimate of the lack of insurance leads to 18,000 excess deaths each year is almost certainly incorrect. It is not possible to draw firm causal inferences from the results of observational analyses, but there is little evidence to suggest that extending insurance coverage to all adults would have a large effect on the number of deaths in the United States.

There are many other factors beyond health insurance. That's not to say policymakers shouldn't work diligently and target expanded coverage for America's remaining uninsured.

Health insurance with good access to medical professionals and advanced medical technology can secure good medical outcomes and reduced mortality as long as care is timely and of high quality. America's superior performance in combatting cancer, heart disease, and stroke testifies to that fact.

There is a lot that is right about American health care—its responsiveness and well-documented success in combating deadly disease among them—but there also is a lot wrong with it. There are gaps in coverage and quality. American health markets are also distorted, and these distortions undercut efficiency and increase the costs for individuals and families.

Barriers to market competition at the state and federal levels undercut innovation in design of health insurance benefits and productivity in

health care delivery, which also raises costs. The system is burdened by bureaucracy and paperwork, generated by giant government health programs (Medicare and Medicaid) as well as private third-party payers.

And current federal tax and regulatory policies block the portability and personal ownership of health insurance coverage, eliminating the ability of persons to take their coverage from job to job—and maintain the continuity of coverage and care—through different stages of their lives.

Rather than destroying the entire system of public and private insurance by enacting Medicare for All legislation, Congress needs to enact new policies that will expand coverage and personal choices, break down barriers to market competition, and thus lower health care costs for millions of Americans.

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CHAPTER 25

Ignore Medicare for All Advocates' Claims on Life Expectancy in U.S.—Here Are the Facts

ROBERT E. MOFFIT, PHD

If self-styled "progressives" in Congress impose total government control over health care, will ordinary Americans enjoy a longer life span?

Ponder this: If self-styled "progressives" in Congress impose total government control over health care, will ordinary Americans enjoy a longer life span?

Sen. Bernie Sanders, I-Vt., chief sponsor of the Senate "Medicare for All" bill (S. 1804), often reminds us that the United States spends roughly twice as much per capita on health care as most other economically advanced countries, but American life expectancy is lower than that of almost all these high-income nations.

Reps. Pramila Jayapal, D-Wash., and Debbie Dingell, D-Mich., lead sponsors of the House's Medicare for All bill (H.R. 1384) say, "The quality of our health care is much worse than [that of] other industrialized countries. The life expectancy in the U.S. is lower than other nations, while our infant mortality is much higher."

These are misleading generalizations. In fact, American medical outcomes for the most serious conditions—for example, lower mortality from heart attacks and strokes, as well as survival rates from a variety of cancers—are generally superior to those of other advanced countries.

America's high level of investment in advanced medical technologies, including innovative drug therapies, has improved medical outcomes and has directly contributed to longer life expectancy among our senior citizens.

According to "The Economic Report of the President," issued in March:

> The United States' all-cause mortality rates relative to those of other developed countries improve dramatically after the age of 75 years. In 1960—before Medicare—the U.S. ranked below most EU countries for longevity among those age 50–74, yet above them among for [sic] those age 75 and higher. This pattern persists today.

True, America needs to improve overall life expectancy at birth. According to a major 2018 study of 11 high-income nations in the *Journal of the American Medical Association,* Japan has the highest life expectancy at 83.9 years, and the U.S. comes in last at 78.8 years.

These disparate findings reflect the vast size and diversity of the United States, including a bewildering array of behavioral, racial, social, economic, environmental, demographic, and metabolic risk factors.

The medical journal's researchers thus caution "... the United States average, in comparison to averages of much smaller, more homogenous countries, may lead to erroneous conclusions."

> For example, the life expectancy of Minnesota, a state comparable in size and demographics to Sweden or Denmark, has more similar population health outcomes to these countries than Minnesota has in comparison to Mississippi.

In a 2017 study for the *Journal of the American Medical Association*, researchers found that 74 percent of American variation in life expectancy—indeed, the largest source of variation—was attributable to behavioral and metabolic risk factors.

The recent annual declines in American life expectancy, based on data from the Centers for Disease Control and Prevention, were largely attributable to increased drug overdoses (opioids) and suicides.

Then, there is the special category of infant mortality. "Our infant mortality rate, kids and babies who are dying, is the highest," says Jayapal, the Washington lawmaker.

The truth is more complicated. In their 2018 study, the JAMA researchers report that American infant mortality is indeed higher than in 10 other high-income countries. Notably, however, the researchers also found that when adjusting for low birth weights, the U.S. statistical ranking improves significantly.

They write: "When adjusting neonatal mortality to exclude deaths of infants born weighing less than 1,000g [about 2.2 lbs.], the United States ranked fifth relative to the other countries, with 1.61 deaths per 1,000 live births, compared with a mean of 1.70 for all 11 countries."

Comparisons of infant mortality between the United States and other countries are often flawed because definitions of terms and measurements are different.

As Sally Pipes, president of the Pacific Research Institute, notes, "The United States ... counts every live birth in its infant-mortality statistics. But France only includes babies born after 22 weeks of gestation. In Poland, a baby has to weigh more than 1 pound, 2 ounces to count as a live birth.

"The World Health Organization notes that it is common practice in several countries, including Belgium, France, and Spain to 'register as live births only those infants who survived for a specified period beyond birth.'"

Note also that the United States also has high rates of pre-term births. American medical professionals, including those participating in Medicaid, will thus intervene in complex and difficult cases and literally spend hundreds of thousands of dollars to save the life of a premature infant.

Medical professionals in other countries do not necessarily make the same moral and financial commitments.

Factors influencing longevity are far more complex than how a nation organizes the financing and delivery of medical care. Total government control over the financing and delivery of health care, championed by self-styled "progressives," will not guarantee Americans' longer life spans.

Waiting in line for medical care is no prescription for a longer life.

Personal behavioral changes, including diet and exercise, can make a difference in longevity, but so also can the American-style investment in innovative medical technologies and America's superior responsiveness in treating deadly disease.

This article was originally published in The Daily Signal on April 18, 2019, and is available with links to sources at https://www.dailysignal.com/2019/04/18/ignore-medicare-for-all-advocates-claims-on-life-expectancy-in-us-here-are-the-facts/.

CHAPTER 26

Health Care: The Greatest Pro-Life Political Battle of Our Time

LOUIS BROWN

The system of health care we have in America is decisive in determining whether our country protects our most vulnerable citizens: the unborn, their pregnant mothers, the poor, and the disabled. The right to life and religious freedom hang in the balance.

Today, our country may be less than three years away from a single-payer, centrally planned health care program. Senator Bernie Sanders (D-Vermont) and Congresswoman Pramila Jayapal (D-Washington) introduced the Medicare for All Act in the US Senate and House earlier this year, to great fanfare. The proposed legislation has been supported by several other presidential candidates, including Senators Booker, Warren, and Harris, as well as over 100 Members of Congress.

Establishing a single-payer health care program, such as Medicare for All, would place over 15 percent of the nation's economy under government control, forcing over 150 million Americans to lose their private health insurance. Under Medicare for All and similar proposals, the federal government would make most of the major decisions about what medical procedures should and should not be paid for, what care patients can and cannot receive, and what procedures doctors can and cannot do.

Patient freedom would not survive a single-payer federally controlled health care system. The right to life would not survive a single-payer health care system. The right of religious freedom and faithfully Catholic health care would not survive such a federally controlled single-payer system.

Fortunately, there is a better way. Now is the time to advance a vision for patient-centered health care that preserves patient freedom, provides a safety net for the poor and vulnerable, and authentically upholds human and civil rights in our country.

The Stakes of the Health Care Debate

I am particularly sensitive to the importance of upholding civil rights in health care, since I attended a historically black law school with hopes of becoming a civil rights attorney. After graduation, through God's providence, I came to see that the right to life is the foundation for all human and civil rights. These words of St. John Paul II became a beacon of light to me:

> Above all, the common outcry, which is justly made on behalf of human rights—for example, the right to health, to home, to work, to family, to culture—is false and illusory if the right to life, the most basic and fundamental right and the condition for all other personal rights, is not defended with maximum determination.

Our American way of life is founded upon sacrosanct human and civil rights, all of which rest upon the fundamental right to life. Without these rights, the Republic would be lost.

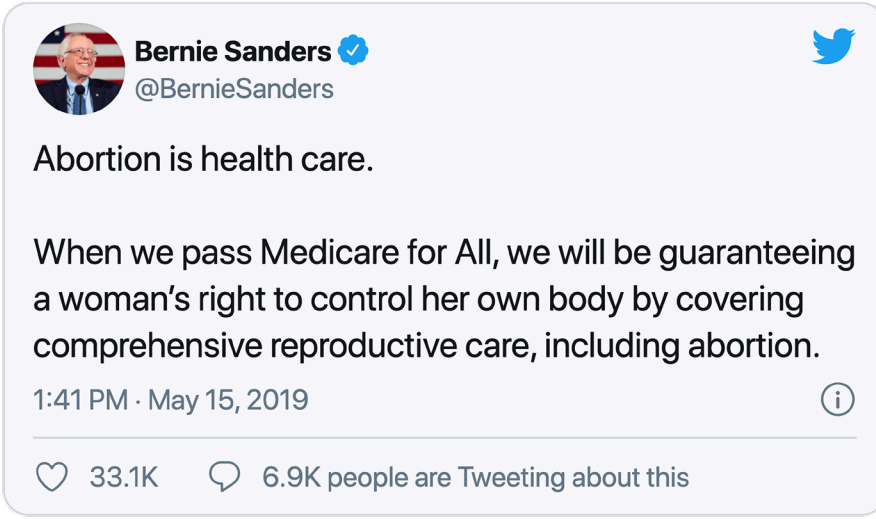
Today's health care debate will play a large role in determining whether these treasured freedoms will survive. Health care deals with foundational questions about each person's life, dignity, and identity. On a practical level, Medicare For All touches on every major issue in the pro-life movement, including whether:

1. federal law will continue to prohibit federal funding for abortion, preserving the Hyde Amendment;

2. pro-life women's medical clinics and crisis pregnancy centers will remain open;

3. abortion will be falsely normalized as "health care" across the country; and

4. religious freedom will be protected for patients, doctors, hospitals, health insurers, other health care entities, and employers more broadly.



In addition, the outcome of this health care debate will determine whether patients and consumers will control their own health care decisions. It will determine whether persons who are chronically ill or disabled will receive the medical care they deserve or will be denied care because they do not have sufficient "quality of life." Ultimately, the outcome of this debate will decide whether we respect the right to life.

A Federal Abortion Mandate

Specific provisions of the Medicare for All legislation introduced this year clearly demonstrate that it attempts to land a death blow to the pro-life movement. The Act's provisions, for example, create a federal abortion mandate. Section 201 of both the House and Senate bills require that the Medicare for All program pay for "comprehensive reproductive, maternity, and newborn care." Within the health care industry, the term "comprehensive reproductive care" includes elective abortion.

Furthermore, Section 701 of both the House and Senate legislation prohibit any restrictions on the use of funds for reproductive health: "Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund." In other words, Section 701 would override existing legislation that prevents federal funding of abortions.

If there is any doubt left as to whether Medicare for All creates a federal abortion mandate throughout the health care system, Senator

Sanders' own tweet demonstrates that the legislation would entrench publicly funded abortion throughout the American health care system.

Attacks on Religious Freedom

In addition to its threats to life, Medicare for All threatens religious freedom and the right of conscience through a provision that coerces medical professionals to perform procedures against their moral or religious convictions.

Section 104 of both the Senate and House Medicare for All bills is misleadingly referred to as a "nondiscrimination provision." Troublingly, this section would require doctors and hospitals to either perform gender transition therapy, sex reassignment surgery, and other related procedures, or face the prospect of a federal civil rights lawsuit.

Section 104 of the Medicare for All legislation was likely adapted from the Obama-era HHS regulation issued to enforce Section 1557 of the Affordable Care Act. Just last month, a federal district court judge struck down the Section 1557 regulation on the basis that it violated the federal Religious Freedom Restoration Act and the Administrative Procedures Act. Though the House version of the legislation prohibits discrimination based on religion, neither the House nor Senate bill provides meaningful protection for religious liberty or the individual right of conscience.

It is impossible to see how authentic Catholic health care could survive in a Medicare for All world in which elective abortions are mandated within a single-payer, federally controlled health care system; in which doctors, medical professionals, and hospitals are required to provide sex-reassignment surgery and other procedures that violate their religious beliefs or face a federal civil rights lawsuit; and in which the Department of Health and Human Services issues regulations under the wrongful presumption that abortion and sex-reassignment surgery are health care.

These same concerns about patient freedom, the right to life, religious freedom, and human and civil rights still exist under the "public option" that former Vice President Joe Biden has discussed, or under the "Medicare for All Who Want It" plan that Mayor Pete Buttigieg recently announced. Even an optional national health care plan would still inevitably result in a government-controlled, national health care system, because such a sweeping federal government program would crush private health care options in the marketplace. Private health care cannot compete with the resources of the federal government. Furthermore, it is almost certain that any national health care option would include a federal abortion mandate and reject any meaningful protection for religious freedom.

What Can Be Done?

What can you do about this?

First, be informed. Be aware that this battle to reform the nation's health care system has massive implications for the pro-life movement to protect the unborn, mothers, and the poor and vulnerable.

Second, seek to understand Christian principles on the culture of life and health care, and share that understanding with others. Read relevant Church encyclicals concerning respect for human life. Stay engaged in the health care debate by sharing this story, other pro-life perspectives, and your own experience with your family, friends, church, associates, and community.

Third, join the movement for religious freedom in health care by signing up for the Christus Medicus Foundation's *Catholic Journal on Religious Freedom and Health Care*, news alerts, and breaking news in Congress about relevant legislative and policy developments. If you are a doctor, medical professional, or otherwise involved in the health care industry, discern joining your local guild of the Catholic Medical Association.

Fourth, consider supporting and spreading the word about Health Care Choices 2020, a new patient-centered health care plan that respects the right to life, protects the poor and vulnerable, and would significantly reduce health care costs.

Legally, it is essential to ensure that our country have federal judges and US Supreme Court justices who respect the Constitution and the foundational principles of America. Politically, however, the greatest pro-life battle of our time is the struggle to define health care and the kind of health care system we should have in the United States. It has never been more urgent to join this great struggle to build a culture of love and justice.

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Conclusion: The Truth About Government-Controlled Health Care

ROBERT E. MOFFIT, PHD

Washington's health policy decisions directly affect the life and well-being of every American.

Americans care deeply about health care. While they admire and respect their doctors, Americans are frustrated with bureaucratic paperwork, the lack of transparency in the pricing of medical services, surprise billing and rising health care costs. As a general rule, most Americans are still satisfied with their private or employment-sponsored health insurance, which is financing their access to medical care. Nonetheless, too many still do not have either good coverage or access to the best care.

A major part of the problem is the impact of increasing government domination of the health care sector of the economy. Today, approximately 143.3 million persons are enrolled in, or heavily subsidized by, the big federal health programs: Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Obamacare health insurance exchange plans. In other words, out of a total estimated population of 331 million Americans, 43.3 percent of the legal residents of the nation are enrolled in these large federal health programs or entitlements.[1] While private businesses and households are still responsible for most American health care spending (55 percent), the total government share of 45 percent is expected to grow while the private-sector share is on track to shrink.[2]

Mere numbers, however, do not tell the entire story. As University of Pennsylvania economist Mark Pauly has demonstrated, government

policies, ranging from regulatory interventions to tax policies, directly affect *how* Americans spend their money on health care; and this "government-affected" spending, as opposed to "market-like" spending, reached "close to 80 percent" in 2016 alone.[3] This growth in the government share of health spending has been accompanied by a rapid growth in government control, which has spawned often ill-conceived, economically inefficient, and outdated government interventions in American health care financing and delivery. The result: health care that is too costly, and health insurance programs, in both the public and the private sector, that patients often find too bureaucratic, complex, and confusing.

Today nearly every American citizen, regardless of income or medical condition, has access to either public or private health insurance coverage, financed by large taxpayer subsidies or generous federal tax breaks. Many Americans, however, do not have a choice of health plans that provide personalized, patient-centered care, meaning the kind of health coverage and care that they personally choose and control and that is directly accountable to them. Key decisions on the kinds of health plans, benefits, and payment arrangements that are available are legally reserved to government officials, corporate human resources officials, or health insurance executives.

On the supply side of the equation, federal and state government policies have contributed to the increasing consolidation of health care markets among health insurers and hospital systems, reducing the number of independent medical practices, restricting patient choices and thus driving up consumer costs. In sharp contrast to other sectors of America's more open market economy, there is far too little price transparency in health care; consumers and patients often do not know the price of medical goods and services until the mysterious bill arrives.

Americans are also anxious. They worry over whether they, and their loved ones, will be able to access the care they need, when they need it. As noted, health care costs are high for a variety of reasons; but these costs are also inflated by government rules, regulations, and mandates that distort the markets, restrict personal choice and create inefficiencies. For example, under the Affordable Care Act (ACA), millions of middle-class Americans, ineligible for the law's taxpayer subsidies, are being priced out of the market for health insurance. At the same time, these ACA plans have narrow networks of doctors and hospitals, and choice in these markets is constrained. Today, in 71 percent of the nation's counties, individuals and families have either no choice, or a choice between only two insurers offering coverage in the ACA health insurance exchanges.[4]

Lower-income Americans who have no choice but to rely on Medicaid, a welfare program, do not fare any better. Indeed, many Medicaid recipients struggle to find doctors who will take care of them, largely because physicians cannot afford to take the program's low payment rates.

Health care reform is warranted, and indeed necessary. The debate is not about whether American health care needs serious reform—policy analysts of all political persuasions agree that it does. Rather, the question is whether Congress should dramatically improve the existing system of public and private coverage, expanding Americans' personal choice and control, or whether Congress should instead outlaw private and employment-based health coverage and launch a total government takeover of American health care.

A total government takeover would be a massive and disruptive enterprise, consolidating the federal government's direct control over the entire health care sector of the economy, currently valued at approximately $3.6 trillion.[5] That would be an unprecedented expansion of government power, and it would inevitably increase costs and the burdens on providers, stifle innovation, and inevitably limit access to high-quality care, especially for patients in need of complex and technologically advanced medical services.

The policy choice is stark. For all Americans, at issue is whether their health care is to be government-controlled, centralized, and monolithic, or whether health care financing and delivery is to be driven by the decisions of individuals in consultation with their doctors in an open and pluralistic set of markets governed by consumer choice and competition. In the introduction to this volume, Marie Fishpaw and Meridian Paulton outlined a blueprint to achieve such a consumer-driven, patient-centered system.

The vision of reform that generally animates the various contributors is likewise one that would maximize personal freedom in health care, meaning the ability of all Americans to choose the care and the coverage that they determine is best for themselves and their families. This national debate is not only a clash of competing visions; it also an exercise in public education: It exposes the Left's internal contradiction in making lofty promises of universal and high-quality care with the hard reality of routine, politically engineered, government limitations on patient access to that promised care.

The vision of total government ownership and control over health insurance and care delivery takes concrete form in the comprehensive and detailed legislation of congressional progressives. Senator Bernie

Sanders (D–VT) and Representative Pramila Jayapal (D–WA) are sponsoring "Medicare for All" legislation (companion bills H.R. 1384 and S. 1129) to establish a "single payer" health care system for the United States. The legislation has not only attracted the co-sponsorship of prominent Senate Democrats, such as Elizabeth Warren (MA) and Kamala Harris (CA), but also a majority of the Democratic Members of the U.S. House of Representatives.

Senator Sanders, Representative Jayapal, and the co-sponsors of their bills leave little doubt about the nature and scope of the health care system that they envision. Both bills would abolish all private and employer-sponsored health plans as well as traditional Medicare and most other government health programs. Instead, Americans would get health care through a new, single, national health insurance program, which would also restrict the ability of patients to engage the services of physicians outside of the government program.

The advocates of Medicare for All promise a universal program of publicly financed health care that would be fairer, more equitable, more economical, and more efficient than the current system. Practical experience, as already indicated, tells a very different story. In "single payer" countries, such as Britain and Canada, millions of patients have faced frustrating delays and denials of medical care, experiencing long and often painful waits for needed medical services.

Because such a radical government takeover of heath care becomes politically unpopular when the trade-offs are made clear, it is not surprising that congressional co-sponsors of "Medicare for All" legislation resort to a temporary fallback as an incremental step toward their ultimate goals and vision: the so-called public option. Currently, there are a half dozen "public option" bills in the House and the Senate.

Such an approach is presented as a moderate compromise. It is not.

The carefully designed provisions of these bills set dynamics in motion that will secure the same objective—a government-takeover of virtually all American health care on the installment plan. As Representative Jan Schakowsky (D–IL), a single-payer advocate who has also co-sponsored legislation to advance a public option, declares: "I know that many of you here today are single payer advocates, and so am I.... Those of us who are pushing for a public health insurance option, don't disagree with the goal.... This is a fight about strategy for getting there and I believe we will."[6] Exactly.

Conceptually, the public option would be a new government health plan that would compete directly against private health insurance plans in the individual, group, or small group markets, or all three; it would

be armed with special statutory and regulatory advantages that private health plans would not enjoy. As Nina Owcharenko Schaefer shows in Chapter 1, in most instances, Congress would authorize the new government plan to set artificially low provider payment rates, enabling the plan to offer premium rates below the private market rates; it would be able to compel provider participation, directly or indirectly; and, unlike private health plans, it would have access to the federal Treasury to make up financial losses and "stay in business" at taxpayer expense. Over time it would come to dominate the health insurance markets and displace private health plans altogether.

Voila! Single payer on the installment plan.

Progressives' passion, energy, and legislative efforts, however, are focused on achieving single-payer health care, as embodied in the House and Senate Medicare for All bills. If Congress were to impose such total government control over nearly one-fifth of the entire health sector of the American economy, creating a health insurance monopoly, Americans would have to accept the inevitable consequences of that policy choice.

Major Impacts

High aspirations or congressional declarations of good intentions amount to little or nothing. In the case of the single-payer proposals, the central issue is how such proposals would work in practice. As contributors to this volume have emphasized, there are inevitable trade-offs that must accompany its adoption. Such trade-offs would include the true costs to individuals and families in taxes following the abolition of all private payment, and whether Americans will pay more or less for health care. They would also include the financial and operational impacts on doctors, nurses, and other medical professionals under a government payment system. Finally, there is the primary issue of patient access to timely medical care: What happens to people who do not and cannot get the care they want or need from the government program? This is a crucial question in a system where government exercises monopoly power over health insurance, and alternatives to private coverage are outlawed and private medical care is restricted.

Medicare for All legislation would affect Americans in a variety of ways—in ways that belie the promises made by advocates of the proposal.

Impact on Provider Payment. Congressional champions of Medicare for All promise serious cost control, but the history of America's own experience with government price controls and payment caps shows that politicians' promises of cost control are often false.

Cost control in markets is secured through intense price competition among suppliers of goods and services to meet and satisfy consumer demand. Cost control in the single-payer system is secured by shifting costs to doctors and medical professionals in the form of payment reductions, thus either reducing the supply of available medical goods and services or reducing compensation and profit margins. Government officials cannot control patient demand for medical benefits or services, so they control their supply through global budgets (a government cap on aggregate health care spending, which often results in waiting lists and a denial of timely access to needed medical care), caps on spending or government administrative payment systems or price controls (a very old political strategy that almost inevitably results in shortages of medical goods and services), or some combination of these.

Champions of Medicare for All point to traditional Medicare as a model, but they often neglect to say that Medicare "works" because it is dependent on the private sector. Medicare reimbursement for hospitals currently covers 87 percent of hospital costs, while private health insurance reimburses hospitals at 145 percent of costs.[7] In effect, Medicare payment policy shifts costs to private health insurance and providers, and privately covered enrollees subsidize Medicare services through higher private insurance premiums, as well as federal payroll and income taxes. If there is no private market at all, then, of course, the cost shift has only one place to go—ultimately to the patients themselves; once again, mostly in the form of delays and denials of care.

Senator Sanders's bill (S. 1129), for example, would apply Medicare rates to the reimbursement of medical treatment of almost 330 million Americans. Such a policy would, in fact, be definition, secure a major reduction in America's high health care spending. Former Medicare Trustee Charles Blahous estimates that the Senate bill would reduce provider payment by 40 percent.[8] Emphasizing that the United States spends more in aggregate and per capita than any other economically advanced country, Senator Sanders, along with certain single-payer supporters in academia and the media, have proudly acknowledged and applauded such an outcome.

Achieving such severe "cost control" would depend on the vicissitudes of congressional politics. Medicare for All legislation, if enacted as drafted, would result either in an unprecedented cut in American health care spending, with a negative impact on the supply of medical goods and services, thus jeopardizing patient access to care, or in health spending increases in excess of the government's pre-set spending targets.

There is a reason why prominent independent analysts, such as Blahous, are skeptical of this approach to cost control. Based on the history of the Medicare program, as well as more recent experiences with the ACA, it is doubtful whether ordinary Americans, let alone physicians and other medical professionals, would tolerate dramatic provider payment reductions. Congress has back-tracked, resisted, or refused to enforce Medicare payment reductions of much lesser impact.

Americans should consider the record. After Congress enacted the Balanced Budget Act of 1997, slashing payment for medical providers, particularly home health agencies, more than 3,000 home health agencies left the program. In subsequent budget cycles, Congress, step by step, reversed these Medicare payment reductions. In 1997, Congress also designed and enacted the sustainable-growth-rate (SGR) formula, tying physician payment to the growth of the economy, to update annual physicians' payment and to control Medicare Part B costs. When faced with the physician payment cuts required by its own formula, Congress routinely blocked their implementation—no fewer than 17 times between 2002 and 2015 alone. The result: Year after year—over a period of 17 years—when faced with impending Medicare physician payment cuts, Congress blocked implementation of cost-control mechanisms.

Likewise, with the ACA of 2010, Congress created a powerful agency, the Independent Payment Advisory Board (IPAB), to control the growth in Medicare spending by establishing a formula to bring Medicare spending growth in line with the growth in the general economy as measured by gross domestic product. Since the ACA's inception, however, IPAB generated intense bipartisan opposition. In 2018, Congress repealed it.

Under the ACA, Congress has already authorized 10-year payment reductions in Medicare Part A, the part of the program that pays hospitals, amounting to more than $800 billion. Both the Congressional Budget Office and the Medicare Actuary have publicly expressed doubt as to whether Congress would actually follow through on these payment reductions for hospitals, nursing homes, home health services, and hospice care. Under the most realistic scenario, according to the 2019 Medicare Trustees report: "By 2040, simulations suggest approximately 40 percent of hospitals, roughly two thirds of skilled nursing facilities, and nearly 80 percent of home health agencies would have negative total facility margins, raising the possibility of access and quality of care issues for Medicare beneficiaries."[9]

If Congress were to fail to impose the provider payment cuts envisioned in Senator Sanders's Medicare for All legislation, a major source of

program savings would disappear. As Blahous observes: "Unless lawmakers are willing to impose far more sudden and potentially disruptive provider payment reductions than they have historically been willing to implement, M4A's coverage expansion should be expected to further increase national health spending growth."[10]

Impact on National Health Spending. Single-payer advocates often claim that under their program America would not only improve the health of its citizens, but also that the United States would spend less overall than it does today on health care. While estimates vary, the most prominent independent analysts—at the Urban Institute, the Rand Corporation, and the Mercatus Center at George Mason University—project that the United States would spend even more.

Single-payer advocates routinely low-ball their spending estimates. Based on a 2016 version of his Medicare for All proposal, for example, Senator Sanders initially estimated that his national health insurance program would require additional federal spending of $13.8 trillion over 10 years. Since that time, a variety of independent estimates have emerged, all differing dramatically from Senator Sanders's initial assessment. According to the National Health Expenditure Survey, conducted by the Centers for Medicare and Medicaid Services, health spending under current law is projected to be $52 trillion between 2020 and 2029. Based on that estimate, Urban Institute analysts determined that a single-payer program would require an increase in federal spending of $34 trillion over that same period, while private and state government spending would decrease by $27 trillion. In other words, total American health care spending would increase by $7 trillion.[11]

Urban Institute analysts concede that the proposed single-payer program would lower administrative costs, and that reimbursement for doctors and other medical professionals as well as prescription drugs would be lower, but they also conclude that the demand for new and generous "free" care would outweigh all of these savings, and that overall national health spending would thus increase.

Among independent analysts, with a few notable exceptions,[12] there is a consensus on this vital point. In 2016, Urban Institute analysts estimated that the Sanders proposal would require $32 trillion in additional federal spending over 10 years, but, based on the Senator's proposed financing, the program would be left with a shortfall of $16.6 trillion.[13] Writing for the Mercatus Center, Blahous initially estimated an additional $32.6 trillion increase in federal spending. Blahous warned that the sheer size of the additional federal obligation would require "[d]oubling all currently

projected federal individual and corporate income tax collections," which would still "be insufficient to finance the added federal costs of the plan."[14] The Center for Health and the Economy estimated a cost ranging from $34.6 to $47.5 trillion over a 10-year period, generating deficits ranging between $1.1 to $2.1 trillion annually.[15] A Rand Corporation study estimated that if the program were implemented in 2019, the initial increase in national health care spending could range, depending on utilization, anywhere from 1.8 percent to 9.8 percent.[16]

Profound uncertainty exists in predictions of future health spending and costs, and naturally, operating under different assumptions, estimates vary significantly. But the most prominent experts, as noted here, project higher spending, and the funding for this comprehensive program would require massive tax increases on working families—not just the "rich"—to cover the anticipated costs.

Impact on the Pocketbooks of Individuals and Families. Single-payer proponents often claim that with the substitution of broad-based federal taxation for private health insurance premiums, deductibles, and out-of-pocket costs, American households would pay less for health care than they do today.

House and Senate sponsors often emphasize the need for already heavily taxed "rich" folks to pay their "fair share" to cover the cost of the program. However, given the sheer magnitude of this program, including the absorption of all outstanding obligations to fund existing entitlements, it would be impossible for Congress to finance it without substantially taxing middle-class and even lower-income citizens.[17]

Senator Sanders makes clear that his proposed program would involve broad-based taxation on the general population, not just the economically advantaged few. In examining an initial version of the Sanders' proposal, Professor Kenneth Thorpe of Emory University estimated that the Sanders proposal—*if it were fully funded*—would require a 14.3 percent payroll tax, as well as a 5.7 percent income-related premium; in other words, a level of taxation equal to 20 percent of payroll. Professor Thorpe concluded that 71 percent of all working families would pay more for health care than they do under the current system.

Confirming Thorpe's general findings, Heritage Foundation analysts report in Chapter 16 that the federal taxation required to finance Medicare for All would mean a hefty tax of 21.2 percent on earnings. Altogether an estimated 73.5 percent of Americans would have less money in their pockets as a result of this level of taxation. American households losing employer-sponsored health plans would experience an average income

reduction of $10,554, and about 87 percent of these households would be worse off.[18]

Impact on Access to Care. Single-payer advocates often imply that the costs of a system of universal government coverage are worth it because the new system would secure universal access to care. In fact, universal coverage for all will not guarantee universal access for all, let alone timely access to high-quality care.

The internal logic of the program contradicts universal provision. If health care is a legal right, meaning universal government entitlement, free at the point of service, for nearly 330 million Americans, then it is, for all practical purposes, what economists call a free good. If health care is indeed a free good, then of course the economic demand for this free good is unlimited. But unlimited demand, at any given point in time, must collide with limited supply. This means that government officials—not doctors or patients—are going to have to make big decisions about who gets care, how they get care, when they get care, and under which circumstances they get care. The key decisions in such a system, in other words, are inevitably political, budgetary, and bureaucratic decisions—not medical decisions.

Government rationing is inevitable in such a system—as the experience of patients living in similar systems has shown. There would be delays or denials of care, and these restrictions would be engineered and enforced by government officials. As Bacchus Barua and Steven Globerman of Canada's Frasier Institute, a prominent think tank, show in Chapter 12, Canadian patients have the longest wait times among patients of developed countries of the world. This is especially true for patients trying to get needed care from a medical specialist.

Likewise, as Professor Timothy Evans of Middlesex University reports in Chapter 10 on Britain's National Health Service (NHS), patient waiting lists are lengthening both for specialty and emergency care, where far too many British patients are forced to wait four hours or more in overcrowded and understaffed British hospitals. This longstanding problem of lengthening NHS waiting lists is dramatically worsening as the NHS tries to cope with the COVID-19 pandemic.

The British media report faithfully on the periodic crises that plague the NHS. British patients are not only routinely subject to long waiting lists, but there is also a shortage of medical specialists, and competition for intensive care beds. In 2017, for example, 4.1 million British patients were on NHS waiting lists, including waiting lists for cancer surgery. As Sally Pipes of the Pacific Research Institute reports: "More than one in

five British cancer patients waits longer than two months to begin treatment after receiving a referral from a general practitioner. In Scotland, fewer than 80 percent of patients receive needed diagnostic tests—endoscopies, MRIs, CT scans, and the like—within three months."[19]

Patients will face costs if America trades its public–private combination of health insurance arrangements for a monolithic system similar to that of Britain or Canada. In 2018, a team of researchers writing for the *Journal of the American Medical Association* detailed the international metrics of access to care, including specialty care, in a timely fashion. For the United States, only 6 percent of patients had to wait more than two months to see a medical specialist, compared to 39 percent of patients in Canada, and 19 percent of patients in Britain. Congress would do well to avoid a replication of either the British or the Canadian experience.

Impact on the Quality of Patient Care. Single-Payer advocates promise to improve the quality of patient care. Experience, particularly in Britain and Canada, shows a relatively poor performance in delivering it in a timely fashion.

For example, compared to American performance on the delivery of timely medical interventions in treating heart disease and cancer, two of the world's deadliest killers, single-payer countries do relatively poorly in securing access to crucial components of high-quality care. For example, screening for breast cancer was higher in the United States than in all other high-income countries.[20] In treating heart disease, Americans lead other high-income countries in the availability of coronary bypass surgery at a rate of 79 per 100,000 population; Canadians have a rate of 58 per 100,000 and the British have a rate of just 26 per 100,000. Likewise, only France leads the United States in the performance of coronary angioplasty, at a rate of 393 per 100,000 compared to 248 for the United States. Canada registered 157 per 100,000 and Britain only 128.[21] These are comparative measures of advanced medical care, and they show that Americans have greater access to the surgeries they need than patients in other countries.

These comparisons go beyond access to care and extend to access to drugs as well. In the United Kingdom, the oldest of Western single-payer systems, Britain's National Institute for Clinical Effectiveness (NICE), approved the availability of Herceptin, a very effective breast cancer drug, for British women in 2002,[22] while it had been made available to American women as early as 1998. These access restrictions for new pharmaceutical therapies have been a continuing feature of both the British and the Canadian systems, as well as other countries with government control over health care financing. For example, while 90 percent of new

anti-viral drugs are available in the United States, only 60 percent of these new drugs are available in Britain and only 46 percent in Canada. While 91 percent of new cardiovascular drugs are available in the United States, only 73 percent of these therapies are available in Britain and Canada.[23]

When access and quality performance measures are broken down by payer, the comparative performance of the United States is compromised by the plight of Medicaid enrollees. Not surprisingly, according to the research team writing in the *Journal of the American Medical Association*, the Medicaid cohort registered the highest number of asthma-related hospital admissions.[24] This is not surprising. Compared to patients in private-sector health insurance, Medicaid patients have historically had a difficult time getting doctors and medical specialists to take care of them because of excessive regulations and low Medicaid reimbursements, and they have thus failed to secure the same level of access to high-quality care and the superior medical outcomes enjoyed by private-sector patients.[25]

In the absence of the interaction of supply and demand as a mechanism for setting prices in a market, government officials administering a single-payer system control health care spending and pricing by constraining the supply of medical goods and services. They can, and do, for example, eliminate certain drugs from the government formularies. But in financing medical care, single-payer systems usually adopt one or both methods of constraining supply—a global budget (a government cap on aggregate health care spending, which often results in waiting lists and a denial of the timely access to needed medical care), and price controls (government caps on the prices of specific medical services, a very old political strategy that almost inevitably results in shortages of medical goods and services). In both cases, patient care is often compromised because of the reduced availability of needed medical services, particularly those requiring the use of advanced medical technology in the treatment of complex or difficult cases.

Impact on Patient Freedom. Not all single-payer systems are the same with regard to the ability of persons to exercise their personal freedom in caring for their health. In Britain, as Professor Evans notes, patients can, and indeed do, go outside of the government system to enroll in alternative private insurance and contract privately with British physicians. In Canada, as Barua and Globerman explain, provinces either prohibit or discourage the provision of private health care.

For the United States, the sponsors of the House and Senate legislation would narrow the exit ramps from the government system. No alternative private insurance would be allowed to compete with the government

program; nor could an American citizen contract privately with a physician, unless that physician refrained from participating in the national health insurance program for one full year. Moreover, the leading House and Senate single-payer bills would also mandate compulsory taxpayer funding of abortion, coerce doctors and nurses to participate in medical practices and procedures that they consider to be unethical, and eviscerate their personal rights of conscience.[26] Altogether, these proposed legislative restrictions on Americans' personal freedoms would be unprecedented.

Impact on Medical Professional's Ability to Practice Medicine, and on Their Morale. American doctors and allied medical professionals are already undergoing enormous pressures in trying to care for their patients. Faced with a variety of external stresses, many are demoralized not only because of the impact of government payment schemes in the large federal entitlements, Medicare and Medicaid; they are also on the receiving end of a steady stream of decisions from third-party administrators, struggling with bureaucratic paperwork in both the public and private sectors, that progressively weaken their professional independence and autonomy.

The metrics tell a stark story. According to the Association of American Medical Colleges, America is already faced with a serious physician shortage by 2030; the estimate is wide ranging, between 42,600 and 121,300 doctors.[27] The reasons for this shortage are in a cluster of work-related pathologies, including physician burnout, early retirements, and a deepening pessimism among physicians over the future of the medical profession itself.[28] The main culprit, however, is the growing and deepening demoralization among doctors who are wrestling with administrative burdens, including excess paperwork. These burdens are imposed by both public and private payers, including the largest payers, Medicare and Medicaid, the giant federal entitlement programs. Based on the provisions of the two leading House and Senate single-payer bills, the existing physician compliance and reporting requirements and the level of government intrusion into medical practice would be even worse than it is under today's more pluralistic practice environment.

Under the House and Senate single-payer legislation, physicians and other medical professionals would not only be required to endure unprecedented reimbursement reductions, they would also be subject to an even more comprehensive regulatory regime that would detail their conditions of medical practice and the limited circumstances in which they might be able to pursue the independent care of patients outside of the government program.

American doctors and nurses should not be fooled into believing that a single-payer health care program, meticulously regulated by distant federal officials, will somehow improve their working conditions. And the continued deterioration of medical working conditions will negatively affect patients—as it always does. In their universal system of government-controlled care, Canadian physicians are not able to treat all of the Canadian patients that need treatment. Not surprisingly, as of 2016, more than 63,000 Canadians left Canada to get the surgeries they needed.[29] In the United Kingdom, as Dr. Kevin Pham reports in Chapter 18, British doctors and nurses are doing heroic work in trying to cope with periodic funding problems, shortages of medical equipment, and surges of patients in often-overcrowded and understaffed hospitals, which remain the delayed destination of literally millions of British citizens awaiting care.

Improvement in the American medical practice environment will only be possible if both federal and state policymakers enact competently crafted legislative and regulatory changes that would not only reduce the bureaucratic hassles that are demoralizing American doctors and other medical professionals, but would also restore, as much as possible, the traditional doctor–patient relationship.

Conclusion

Self-styled "progressives" in Congress and elsewhere are proposing a government takeover of American health care. Such a takeover would destroy Americans' existing coverage and their right to alternatives outside the government program; and it would erect a system of total political control over virtually every aspect of the financing and delivery of medical care. Nor would it ensure delivery of its central premise and promise: care for every American.

Beyond closing off individuals' alternatives to coverage outside the government program and restricting their medical care through independent physicians, such a government takeover would also introduce an unprecedented politicization of American health care. Congress, beset by frenzied lobbying by powerful special interest groups, would ultimately determine health care budgets and spending, as well as the rules and regulations that would govern care delivery by doctors, hospitals, and other medical professionals. Patients' personal choices, as well as the professional independence of their doctors and other medical professionals, would be subordinated to the turmoil of congressional politics and the bureaucratic machinations of distant administrators. The machinery of

federal control would dwarf the existing federal bureaucratic apparatus that runs today's Medicare, Medicaid, and Obamacare programs.

The scholars who contributed to this volume have outlined the substance of "single payer" legislation, the many promises made on its behalf, and the many costs and consequences entailed in adopting such a large and disruptive program of centralized government control. They have indicated, in impressive detail, the patient experiences in Britain and Canada, the unprecedented tax impact of single-payer legislation on the economic well-being individuals and families, and the threat that such an impersonal system poses to physician autonomy and patient freedom, including personal access to high-quality and specialized medical care.

Progressive politicians are promising high-quality health care for every American at lower personal and national cost. They are promising far more than they can ever deliver. It is what they do.

Chapter 16: How "Medicare for All" Harms Working Americans

Appendix A: Data and Methodologies

For reasons of both clear presentation and confidence in projections, our analysis assumes that the program is fully implemented in 2020.[1]

I. Estimates of Additional Federal Spending

Appendix A Table 1 summarizes our baseline estimates for the effects on the federal budget of adopting a program with the same key features as those in the "Medicare for All" bills currently pending in the House and Senate.[2] It shows that a government-run health care program would increase 2020 federal spending by almost $2.4 trillion.[3] Our sources and calculations for each item in Appendix A Table 1 are as follows:

Replacing Private Spending. The program would replace current private-sector spending on health insurance and medical care with new federal spending for the same goods and services for the same population.

We used the most recent National Health Expenditure (NHE) estimates for private insurance and out-of-pocket spending. Because the program benefits do not include coverage for non-prescription drugs and non-durable medical supplies, we subtracted the NHE estimates for spending on those items from the NHE estimates for total out-of-pocket spending.[4]

Replacing State Spending. The new program would replace Medicaid and CHIP. Currently, states pay a share of the costs for Medicaid and CHIP and also make payments to Medicare for drug coverage for

APPENDIX A TABLE 1

Additional Federal Spending for a Government-Run Health Care Program, in Billions of Dollars in 2020

Changes in Direct Spending	
Replace private health insurance[a]	+$1,344.2
Replace out-of-pocket payments[b]	+$344.9
Replace state payments for Medicaid, CHIP and Medicare[c]	+$275.7
Increased utilization: acute care[d]	+$390.0
Increased utilization: long-term care[e]	+$79.5
Total Change in Direct Spending	**+$2,434.3**
Changes in Revenues	
Eliminate Medicare premiums[f]	–$118.8
Eliminate ACA insurer taxes and employer penalties[g]	–$22.3
Eliminate tax exclusion for employer-sponsored health benefits[h]	+$175.3
Eliminate other health care tax preferences[g]	+$13.5
Total Change in Revenues	**+$47.8**
Net Change in Federal Spending	**+$2,386.5**

SOURCES:

a Centers for Medicare and Medicaid Services, National Health Expenditure Data, NHE Projections, 2018-2027, Table 4, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html (accessed November 10, 2019).

b Total out-of-pocket spending (NHE Projections, Table 4) minus out-of-pocket spending on non-prescription medicines and non-durable medical supplies (NHE Projections, Table 12).

c Authors' calculations based on CBO, Medicaid Baseline, CHIP Baseline, and Medicare Baseline, May 2019, adjusted to calendar year.

d Charles Blahous, "The Costs of a National Single-Payer Healthcare System," July 30, 2018, Table 3, https://www.mercatus.org/publications/federal-fiscal-policy/costs-national-single-payer-healthcare-system (accessed November 10, 2019).

e John Holahan et al., "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending," May 9, 2016, https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending (accessed November 10, 2019).

f Congressional Budget Office, "Medicare—CBO's May 2019 Baseline," May 2019, https://www.cbo.gov/system/files/2019-05/51302-2019-05-medicare_0.pdf (accessed November 10, 2019); data have been adjusted to calendar year.

g Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO's May 2019 Projections," https://www.cbo.gov/system/files/2019-05/51298-2019-05-healthinsurance.pdf (accessed November 10, 2019); data have been adjusted to calendar year.

h Authors' calculations derived by applying, for each tax, the average marginal rate calculated from data on workers with ESI in the Census Bureau, Current Population Survey, and then subtracting CBO's projection for the OASDI deficit.

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dual-eligible beneficiaries. However, under the program, the federal government would become responsible for all of the cost of covering those same individuals. We calculated that additional cost to the federal government using the most recent Congressional Budget Office (CBO) projections.[5]

One study assumed that the federal government would be able to capture much of the states' savings, while another study reported alternative figures for spending by payer with, and without, that assumption applied.[6] However, the pending bills do not include provisions to capture state savings, and any design for doing so would face significant practical and political obstacles.[7]

For instance, Senator Elizabeth Warren (D–MA) proposes a "maintenance-of-effort requirement" on state and local governments under which current spending by those governments on Medicaid and CHIP and employee health benefits would be redirected to funding for the new federal program. She states, "This is similar to the mechanism that the George W. Bush Administration used to redirect Medicaid spending to the federal government under the Medicare prescription drug program."[8]

It is true that when Congress created the Medicare Part D prescription drug program, it included a provision to "claw-back" state Medicaid savings, stipulating that federal funding for the rest of a state's Medicaid program would be reduced by an equivalent amount if the state did not pay its savings into Medicare.[9]

Yet, under a new federal health program that replaces Medicaid, Congress would no longer have that leverage over states, since states would no longer need federal Medicaid funding. Furthermore, even if Congress chose to retain the existing Medicaid program just for institutional long-term care, as the Senate bill would, state savings from federalizing the rest of Medicaid would still exceed the loss to states of all federal funding for long-term care.

Increased Utilization. Because the program would be universal and would provide comprehensive benefits with first-dollar coverage, it would increase demand for health care goods and services. In the case of acute care services, the program would stimulate increased utilization in three ways: (1) by expanding coverage to U.S. residents who are not currently insured; (2) by providing comprehensive coverage of benefits that are currently covered to only a limited extent (such as dental and vision care); and (3) by eliminating all, or nearly all, patient cost sharing. In the case of long-term-care services, the primary effect would be the replacement of "informal care" provided by relatives, with "formal care" provided by home health workers and nursing facilities.

Appendix A Table 1 lists the estimated costs of increased utilization separately for acute-care services and for long-term care services. In each case, the estimates reported are the more conservative (that is, lower) of the projections in other studies.[10]

Loss of Medicare Premium Revenues. Medicare enrollees pay premiums to the federal government for coverage under Part B (physician services) and Part D (prescription drugs). The legislation would subsume Medicare into the new program, which would provide those benefits—but without charging premiums to enrollees. While the bills do not explicitly repeal the relevant provisions of the Medicare statute, we assume that Medicare premiums would no longer be collected and that the federal government would need to replace those lost revenues.[11]

Loss of Affordable Care Act (ACA) Tax and Penalty Revenues. Federal spending on ACA subsidies would also be transferred to the new program, but federal revenues generated by some other ACA provisions would disappear. Specifically, because both private health insurance policies and employer-sponsored health benefit plans would be eliminated, revenues collected from the ACA's excise taxes on health insurance policies and on high-cost employer health plans, and from fines imposed on large employers that do not provide their workers with minimum coverage, would all fall to zero.[12]

Elimination of Tax Preferences for Private Health Insurance. The House and Senate bills do not explicitly repeal the current tax preferences for private health care coverage. However, the bills functionally eliminate those tax preferences by prohibiting insurers and employers from offering coverage that duplicate benefits offered under the new government program.[13]

The largest such tax preference, by far, is the tax exclusion for employer-sponsored health benefits. Under that provision of the tax code, amounts spent by employers and employees on employer-sponsored health benefits are excluded from the employee's taxable income for purposes of both the federal income tax and the Social Security and Medicare payroll taxes. Replacing those private tax-free health benefits with coverage through a government health program would not only make that tax preference irrelevant but, as discussed in section II. Estimated Changes to the Tax Base, would also result in employers converting the value of those benefits into additional taxable wages paid to their workers.

Appendix A Table 1 reports our estimate of the additional tax revenues that the federal government would receive from the conversion of currently tax-free health benefits into additional taxable income. We constructed our estimate as follows:

1. We used data from the Census Bureau's Current Population Survey to calculate the average marginal tax rates for the income tax, Social Security tax, and Medicare tax for workers with employer-sponsored health benefits.

2. We applied the resulting average marginal tax rates to the aggregate amount of newly taxable income (see section II. Estimated Changes to the Tax Base) to derive the increases in federal revenues from the three taxes.

3. We subtracted from our estimate of increased Social Security tax revenues, the CBO's estimate for the unfunded (deficit) portion of Social Security benefits for the year, as Social Security revenues are first applied to paying current benefits and annual benefit spending now exceeds annual revenues.[14]

Similarly, the legislation would also functionally eliminate the income tax deduction for health insurance premiums paid by the self-employed and the non-refundable portion of the ACA income tax credits for individual-market coverage purchased through the exchanges. We include the CBO's estimates for those provisions as additional revenues in Appendix A Table 1.

II. Estimated Change to the Tax Base

The largest effect of adopting the proposed program would be the replacement of almost all private spending on medical care with new federal spending. Because most current private health spending is through tax-free employer plans, that change would also significantly increase the tax base. Consequently, it is necessary to account for that effect before calculating the additional taxes needed to fund a government-run health care program.

Standard economic analysis expects that under the envisioned scenario (replacing employer-sponsored health insurance with a public program providing at least the same level of coverage) employers would convert spending on health benefits into additional taxable wages.[15] That is because what matters to employers is the total amount of compensation paid for a worker's labor, not the form in which the compensation is paid. Also, the sponsor of the Senate bill has recently proposed that, as part of the transition to the new program, employers would be required by law to convert the value of employee health plans into additional cash wages

or other benefits.[16] However, because other fringe benefits either have statutory maximums, or are subject to payroll taxes, or both, there is little scope for employers and workers to shift current spending on health benefits into other forms of tax-free compensation. Consequently, we assume that the entire value of employer-sponsored health benefits becomes additional taxable compensation.

Appendix A Table 2 reports the components of the revised tax base. First is the CBO's estimate of total wages and salaries. Second is an estimate of self-employment labor-income subject to the Medicare payroll tax.[17] Third is the estimate of the additional cash income that would accrue to workers from converting pre-tax employer health benefit spending into taxable compensation.[18] Summed, they show the revised tax base on labor income. The aggregate effects are that about 12 percent of total employee compensation would be shifted from non-taxed health benefits into taxable wages, increasing the total labor-income tax base by about 9.5 percent.

III. Estimating the Additional Tax Burden

Appendix A Table 1 shows that the net increase in federal spending under the program would be $2,387 billion in 2020, and Appendix A Table 2 shows that, after accounting for the conversion of employer-sponsored health benefits into additional taxable income, the 2020 labor-income tax base would be $11,274 billion. Consequently, the new federal taxes needed to fund the additional federal spending under the program would equal 21.2 percent of taxable payroll in 2020. That result is consistent with the findings of two other studies that provided tax-burden estimates.[19]

The House and the Senate bills do not specify how the additional federal spending under the program would be funded. In order to estimate the tax effects of the proposal we applied the following assumptions:

1. We assumed that the additional federal spending under the program would need to be funded through increased taxation. The current federal health programs that the legislation would fold into the new program are partially funded by federal borrowing, so we assume that level of deficit financing would continue under the new program. However, it does not seem plausible that additional borrowing could be used to finance the program's new spending, given the federal government's large, and growing, long-term fiscal imbalance.[20]

APPENDIX A TABLE 2

Effects on Tax Base of Eliminating Employer-Sponsored Insurance

Figures are in billions of dollars in 2020.

Effect on Tax Base	
Taxable wages and salaries under current law[a]	$9,588.8
Self-employment income subject to Medicare tax[b]	$500.2
Conversion of spending on employer-sponsored health benefits into taxable income[c]	$1,184.8
Tax Base After Policy Change	**$11,273.8**

SOURCES:

a Congressional Budget Office, "An Update to the Budget and Economic Outlook: 2019 to 2029," August 21, 2019, Table B-1, https://www.cbo.gov/publication/55551 (accessed November 10, 2019).

b Congressional Budget Office, "Budget and Economic Data," https://www.cbo.gov/about/products/budget-economic-data (accessed November 10, 2019); data on payroll tax revenues.

c Centers for Medicare and Medicaid Services, National Health Expenditure Data, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (accessed November 10, 2019); data used were 2017 NHE Historical Table 24 and 2018 NHE Projections Table 4.

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2. We calculated the additional federal tax burden as a percentage of taxable payroll, expressed as a uniform (uncapped) increase in the payroll tax rate. Not only is percentage of payroll a standard measure for quantifying the tax burden of social insurance programs, but a uniform payroll tax increase would generate fewer and smaller behavioral response effects than other possible tax increases.

3. We assume that all of the increase in payroll taxes would be imposed on workers, and consequently, that the employer's total employee compensation costs are the same after implementation as they were before implementation. Were all or part of the tax increase instead imposed on employers, it would produce additional adverse effects on cash compensation, employment, and business profitability—which, in turn, would necessitate even higher tax rates to collect sufficient revenues.[21]

4. Under the program, the federal government would need to replace current state and local government spending on Medicaid and CHIP. However, for purposes of calculating the effects on household finances we assume that states would pass their resulting savings on to their residents in the form of reduced state taxes. Thus, we account for that funding shift as a cost to the federal budget and as an offsetting saving to household budgets.[22]

Currently, most American workers pay federal payroll taxes of 15.3 percent, of which 2.9 percent funds Medicare and 12.4 percent funds Social Security. Increasing payroll taxes by 21.2 percentage points to fund a government-run health program would mean that the payroll tax rate for most workers would be 36.5 percent.[23] That result would be consistent with the payroll tax levels in a number of European nations, such as France, Germany, and Sweden, which operate comprehensive social insurance programs for both medical care and pensions.

Results Under Income Tax Financing Scenarios. As noted, we assumed that the program would be funded by a uniform increase in the (uncapped) payroll tax rate imposed entirely on workers because it is the scenario that would generate the least behavioral responses. The alternative of funding part, or all, of the program's additional costs through increased income taxes would involve many more complexities, uncertainties, and behavioral responses. However, for comparison purposes, we also ran static analyses of the effects on household finances of partial and full funding through increased income tax rates.

Partial Income Tax Funding Scenario. Senator Sanders has suggested that part of the funding for his proposal could come from an "income-based premium" that appears to function as an increase of four percentage points in all federal ordinary income tax rates, and states that those whose income is less than their standard deduction would not be affected.[24] Multiplying this tax rate by the $9,813 billion of income that would be subject to non-zero ordinary income tax rates at the federal level, we estimate that this tax would raise $393 billion in revenue in calendar year 2020.[25] Under this scenario, the payroll tax would still need to be increased by 17.7 percentage points, making the total payroll tax 33.0 percent for most workers, to fund the remaining additional cost of the program.

We found that the distributional effects under this scenario would differ only marginally from those under our baseline assumption of financing the added spending entirely through a payroll tax increase. Overall, 64.4 percent of households—containing 71.8 percent of the total

population—would see their disposable income after taxes and health expenses decline, down slightly from 65.5 percent and 73.5 percent, respectively, in the base scenario. Among households with workers, 84.7 percent of those with employer-sponsored insurance and 71.0 percent of those without employer-sponsored insurance would have lower disposable incomes, nearly the same as the 87.2 percent and 72.0 percent figures, respectively, in the base scenario. Only 2.7 percent of households without workers have high enough income from other sources that this partial financing through an income tax would cause their disposable income to decline under a government-run health program.

Income-Tax-Only Funding Scenario. For further comparison, we also ran our analysis using the assumption that all of the additional costs were funded by uniformly increasing all current income tax rates. Under static calculations, which do not account for behavioral response or macroeconomic effects, all ordinary income tax rates would need to be increased by 24.3 percentage points in order to fund the program. This would mean, for example, that the current 10 percent income tax bracket would be increased to 34.3 percent, while the current 37.0 percent income tax bracket would be increased to 61.3 percent, higher than at any point since the early 1980s. For this scenario, our result (an increase in income tax rates of 24.3 percentage points) is consistent with the result of the Committee for a Responsible Federal Budget (CRFB) study (a 25 percent income surtax).[26]

Even under this scenario, we found that a slight majority of households would see their disposable income decline. The 52.2 percent of all households with lower disposable income after taxes and health expenses would include 67.0 percent of households with workers with employer-sponsored insurance, 44.6 percent of households with workers without employer-sponsored insurance, and 23.6 percent of households without workers. The households without workers who experience a decline in disposable income are generally retirees with substantial income beyond Social Security.

In addition to triggering numerous behavioral and macroeconomic effects, this scenario would also likely result in Congress making other changes to the income tax code, some of which, such as increasing tax rates on capital gains or subjecting a larger share of Social Security benefits to taxation, might further reduce the disposable incomes of retirees.

IV. Estimating the Effects on Household Finances

Our analysis is limited to the direct effects on household finances. We did not attempt to calculate welfare gains or losses to individuals

resulting from the program altering the quantity of medical goods and services consumed.

We used the latest available (2016) data from the Medical Expenditure Panel Survey (MEPS) to estimate the net effects of the program on household finances. The MEPS Household Component (MEPS HC) of the survey includes basic demographic and health coverage information as well as specific questions about each person's medical conditions, expenditures, attitudes, and experiences. Much of the reported data are verified and supplemented with information from health care providers to ensure quality. The data are weighted to ensure that they are representative of the U.S. civilian non-institutionalized population.

We assume that household members generally share resources, so aggregate changes in income and expenditures at the household level best reflect the change in well-being of individual members of the household.

We used the latest available data, collected from 12,704 households for the year 2016, to estimate the financial effects of a government-run health care program. We did so as follows:

1. Convert existing employer-sponsored insurance into taxable wages and salaries;

2. Impose existing federal tax law plus an additional 21.2 percent payroll tax, bringing the total federal payroll tax to 36.5 percent for most wage and salary income;

3. Assume that all state and local taxes are reduced by 17.5 percent, to account for lower state revenue requirements due to the elimination of state payments for Medicaid, CHIP, and Medicare; and

4. Eliminate private health care expenditures, including premiums and out-of-pocket expenses.

With respect to the conversion of employer-sponsored insurance:

- Employee contributions may currently be deducted from gross income prior to the computation of both payroll and income taxes. Thus, we assume that all employee contributions are currently not taxed, and under the program become part of the worker's taxable income for purposes of both types of taxes.

- Employer contributions are estimated based on data from the MEPS Insurance Component (MEPS IC), which surveys employers on the characteristics of their insurance plans. An employer's contribution toward health insurance premiums will currently vary across eligible employees within any given firm based on whether the employee elects self-only or family coverage or declines coverage altogether. Converting those contributions into additional taxable wages or salaries for each employee on an individual basis would create both practical and legal issues for employers as it could produce significantly different new base pay rates for employees that previously received identical base pay. Consequently, we assume that under the reform each employer would convert the aggregate amount of its health plan contribution into base pay increases for all employees that were eligible to participate in the plan at the time of its dissolution. We further assume that the amount of increased pay would be equal to the average amount per eligible employee that the employer had been contributing. That additional wage and salary income is then taxed at the employee's ordinary rates.

- We assume that the employer's total employee compensation costs are the same after implementation as they were before implementation.[27]

With respect to federal, state, and local taxes:

- We assume that the additional federal payroll tax is paid by the employee, which is consistent with its primary economic incidence.

- For federal taxes other than income and payroll taxes, we applied average tax rates as a share of income, by income level and family structure of the tax-filing unit, for the year 2017 from the Tax Policy Center's microsimulation tax model.[28]

- For state and local taxes, we applied average tax rates as a share of income, by income level of the tax-filing unit, for the year 2018 from the Institute on Taxation and Economic Policy's microsimulation tax model.[29]

- We took the figure for total state Medicaid and CHIP spending of $262 billion in 2019 and divided it by total state and local tax revenues of $1,497 billion for the most recent 12 months to derive a ratio of 17.5

percent.[30] We then assumed that household state and local taxes would be reduced by that percentage. Because it is highly unlikely that all states would cut taxes to offset their reduced Medicaid spending, and also highly unlikely that states would cut taxes dollar for dollar to exactly match spending reductions, these estimates are biased toward showing households being better off than they actually are likely to be under a government-run health care program.

With respect to creating the composite household for each illustrative example, we:

- Selected all MEPS households that fit the criteria for household structure.
- Identified a target income value, generally the median reported total income for the household type.
- Retained all households with reported total income within 10 percent of the target value, in order to obtain a sufficiently large sample so that later calculations would be less sensitive to households that were outliers in terms of the composition of income or the level or composition of medical expenses.
- Averaged the reported values across these households to create values for the composite household for each category of income or medical expense. Each composite illustrative household therefore has the average characteristics of all households with the stated household structure and total reported income within 10 percent of the stated target value.

Appendix B: Uncertainties

There are two types of assumptions that we did not incorporate into our baseline analysis: (1) behavioral effects related to economic decision making, and (2) aspects of the proposed legislation that are not specific enough to estimate with confidence.

Work Disincentives and Economic Growth. The creation of a government-run health program that replaces privately funded employer-sponsored health benefits would likely induce some workers to reduce their hours worked or to cease working. The workers most likely to do so are the ones for whom maintaining their current private coverage is a primary

factor motivating them to continue working today. We expect that this work-disincentive effect would be greatest for workers above the age at which they can qualify for retirement benefits and for secondary workers in households with more than one worker. We did not attempt to estimate the magnitude of this effect. To the extent that it occurs, it would reduce the tax base for funding the program and require higher taxes on remaining workers.

We also did not attempt to estimate overall macroeconomic effects of this potential reduction in work hours or other aspects of the proposal that could slow economic growth and reduce the tax base relative to the baseline. Therefore, our estimated tax rates are likely to be somewhat lower than those that would be required to fund the program.

Provider Payments. The House and Senate bills offer only broad guidelines for how federal officials are to set payments. Consequently, our analysis did not include any assumptions about changes to provider payment rates under the program. We instead assume that the program will reimburse providers at rates equivalent to the payer-weighted average rates that they currently receive.

The House bill would pay institutional providers on the basis of negotiated global budgets, encourage salaried employment of physicians, and create a new fee schedule for providers that continue to be reimbursed on a fee-for-service basis.[31] Given that the House bill does not further specify how those new budgets and rates would be set, it is impossible to project eventual payments under the House bill and compare them with current reimbursement levels.

Under the Senate bill, providers would be paid according to "fee schedules" that are "consistent with" Medicare's current processes for setting payment rates.[32] Medicare physician payment rates are currently estimated to be about 75 percent of those for private preferred provider organization (PPO) plans, while Medicare hospital payment rates are about 60 percent of those for private insurance.[33] Hospital payment rates for Medicaid are about the same as those for Medicare, while physician Medicaid rates are generally lower than Medicare. Given that there are currently about 58 million Medicare beneficiaries, 74 million Medicaid and CHIP enrollees, and about 175 million Americans covered by private insurance, uniform reimbursement at Medicare rates would result in significant net income reductions for hospitals and doctors.

While the cost of the program could be reduced by paying providers less, analysts differ in their assessments of how far payments could be reduced before patient access to care becomes restricted due to an

insufficient supply of providers to meet demand.[34] However, we find that even significant provider payment reductions would have only a modest effect on the required new federal spending and taxes.[35]

Administrative Costs. Analysts differ over whether administrative costs would be lower under a government-run health program. Given that the changes will have only marginal effects on the overall cost of the program, we did not attempt to estimate them.

One recent study compared the health spending of Medicare enrollees covered by traditional Medicare (public plan) with those in Medicare Advantage (private plans) and found that, after adjusting for possible differences between the two groups, total spending for the Medicare Advantage group was 9 percent to 25 percent lower than that for the traditional Medicare group. The study found that the difference "primarily reflects lower utilization of services rather than lower payments for the same services."[36] That suggests that eliminating the administrative costs associated with private plans managing utilization and encouraging the substitution of less expensive care could actually result in a net increase in total costs under the envisioned government-run health program.

In contrast, three studies that estimated the cost of Medicare for All concluded that administrative costs could be as low as 6 percent of total program costs.[37] One of those studies quantified that, under the assumption that the new program operated with administrative costs at the 6 percent level, the projection of $4,091 billion in total national health spending in 2020 would be reduced by $74 billion.[38] Similarly, a 2013 analysis of the Vermont single-payer proposal projected that administrative costs would account for 7 percent of total costs for that program.[39] Also, a 2018 analysis of a proposed single-payer program for New York projected that administrative costs would be 6 percent of total cost, in part based on that study's finding that administrative costs currently account for 7 percent of New York Medicaid program expenditures.[40]

Reduced Pharmaceutical Spending. Both the House and Senate bills would have the government negotiate the prices it pays for prescription drugs, "promote the use of generic medications," and establish a drug formulary. Given that generics now account for about 90 percent of prescriptions, but just 23 percent of total drug spending, any savings would have to come predominantly from reduced spending on newer medicines that still have market exclusivity.[41] Even so, total spending on pharmaceuticals accounts for only about 10 percent of total personal health spending, meaning that there is limited scope for savings in this area. One study estimated $54 billion in savings in 2020 from system-wide reductions in

prescription drug payments, but the author of the study noted that his estimate is based on an "aggressive assumption" that almost all current brand-name prescriptions would be filled with generics at an average price reduction of 80 percent.[42] Thus, such estimates are highly uncertain and it is hard to envision how payment reductions at, or even near, that level could be achieved without effectively eliminating incentives for the development of new drugs in the process.

Increased Social Security Payments. The conversion of tax-free employer coverage into taxable wages would increase the "average indexed monthly earnings" (used to calculate a worker's Social Security benefits) of most of the workers receiving wage increases. That would make many of those workers eligible for higher-benefit payments when they retire, which would have a secondary effect on the federal budget of increasing Social Security's future obligations.

APPENDIX C TABLE 1

Financial Effects of a Government-Run Health Care Program: Median-Income Married Couple with Two Children, All Covered by Employer-Sponsored Insurance (Page 1 of 2)

	Income	Current Law	Proposed Reform	Change
	Wage and salary income	$95,653	$105,044	$9,391
+	Other taxable income	$1,694	$1,694	$0
+	Other nontaxable income	$417	$417	$0
=	Cash income	$97,764	$107,155	$9,391
+	Employer portion of federal payroll taxes	$7,006	$7,006	$0
+	Employer contribution toward health insurance premium	$9,391	$0	–$9,391
=	Comprehensive income	$114,162	$114,162	$0

	Federal Payroll Taxes	Current Law	Proposed Reform	Change
	Wage and salary income	$95,653	$105,044	$9,391
–	Employee contribution toward health insurance premium	$4,068	$0	–$4,068
=	Income subject to federal payroll tax	$91,585	$105,044	$13,459
	Federal payroll tax rate	15.3%	36.5%	21.2%
	Federal payroll taxes paid	$14,013	$38,341	$24,329
	As a share of comprehensive income	12.3%	33.6%	21.3%

	Federal Income Taxes	Current Law	Proposed Reform	Change
	Income subject to federal payroll tax	$91,585	$105,044	$13,459
+	Other taxable income	$1,694	$1,694	$0
=	Income subject to federal income tax	$93,279	$106,738	$13,459
	Federal income taxes before credits	$7,205	$9,035	$1,830
–	Earned income credit	$0	$0	$0
–	Child tax credit	$4,000	$4,000	$0
=	Federal income taxes paid	$3,205	$5,035	$1,830
	As a share of comprehensive income	2.8%	4.4%	1.6%
	Total federal payroll and income taxes	$17,218	$43,376	$26,158
	As a share of comprehensive income	15.1%	38.0%	22.9%

	Other Federal, State, and Local Taxes	Current Law	Proposed Reform	Change
	Federal excise, estate, and other taxes	$2,283	$2,283	$0
+	State and local sales and excise taxes	$3,082	$2,543	–$539
+	State and local income taxes	$3,653	$3,014	–$639
+	State and local property taxes	$3,311	$2,731	–$579
=	Other federal, state, and local taxes paid	$12,329	$10,571	–$1,758
	As a share of comprehensive income	10.8%	9.3%	–1.5%
	Total taxes	$29,547	$53,947	$24,400
	As a share of comprehensive income	25.9%	47.3%	21.4%

APPENDIX C TABLE 1

Financial Effects of a Government-Run Health Care Program: Median-Income Married Couple with Two Children, All Covered by Employer-Sponsored Insurance (Page 2 of 2)

	Private Health Care Expenses	Current Law	Proposed Reform	Change
	Employer contribution toward health insurance premium	$9,391	$0	–$9,391
+	Employee contribution toward health insurance premium	$4,068	$0	–$4,068
+	Out–of–pocket health care expenses	$1,740	$0	–$1,740
=	Total private health care expenses	$15,199	$0	–$15,199
	As a share of comprehensive income	13.3%	0.0%	–13.3%

Total Taxes	Current Law	Proposed Reform	Change
Total taxes and private health care expenses	$44,746	$53,947	$9,201
As a share of comprehensive income	39.2%	47.3%	8.1%

Disposable Income	Current Law	Proposed Reform	Change
Disposable income after taxes and private health care expenses	$69,415	$60,214	–$9,201
Percent change			–13.3%

SOURCES: Heritage Foundation model based on data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, https://www.meps.ahrq.gov (accessed October 17, 2018), and federal and state tax data. See appendix for more information about the methodology.

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APPENDIX C TABLE 2

Financial Effects of a Government-Run Health Care Program: Married Couple with Two Children, All Covered by Employer-Sponsored Insurance, with Income Near $50,000 (Page 1 of 2)

	Income	Current Law	Proposed Reform	Change
	Wage and salary income	$49,604	$58,034	$8,430
+	Other taxable income	$301	$301	$0
+	Other nontaxable income	$51	$51	$0
=	Cash income	$49,956	$58,386	$8,430
+	Employer portion of federal payroll taxes	$3,492	$3,492	$0
+	Employer contribution toward health insurance premium	$8,430	$0	-$8,430
=	Comprehensive income	$61,878	$61,878	$0

	Federal Payroll Taxes	Current Law	Proposed Reform	Change
	Wage and salary income	$49,604	$58,034	$8,430
–	Employee contribution toward health insurance premium	$3,957	$0	-$3,957
=	Income subject to federal payroll tax	$45,647	$58,034	$12,386
	Federal payroll tax rate	15.3%	36.5%	21.2%
	Federal payroll taxes paid	$6,984	$21,182	$14,198
	As a share of comprehensive income	11.3%	34.2%	22.9%

	Federal Income Taxes	Current Law	Proposed Reform	Change
	Income subject to federal payroll tax	$45,647	$58,034	$12,386
+	Other taxable income	$301	$301	$0
=	Income subject to federal income tax	$45,948	$58,335	$12,386
	Federal income taxes before credits	$2,077	$3,490	$1,414
–	Earned income credit	$1,172	$0	-$1,172
–	Child tax credit	$4,000	$4,000	$0
=	Federal income taxes paid	-$3,095	-$510	$2,586
	As a share of comprehensive income	-5.0%	-0.8%	4.2%
	Total federal payroll and income taxes	$3,889	$20,673	$16,784
	As a share of comprehensive income	6.3%	33.4%	27.1%

	Other Federal, State, and Local Taxes	Current Law	Proposed Reform	Change
	Federal excise, estate, and other taxes	$1,114	$1,114	$0
+	State and local sales and excise taxes	$2,351	$1,940	-$411
+	State and local income taxes	$1,671	$1,378	-$292
+	State and local property taxes	$1,856	$1,531	-$325
=	Other federal, state, and local taxes paid	$6,992	$5,963	-$1,029
	As a share of comprehensive income	11.3%	9.6%	-1.7%
	Total taxes	$10,881	$26,636	$15,755
	As a share of comprehensive income	17.6%	43.0%	25.5%

APPENDIX C TABLE 2

Financial Effects of a Government-Run Health Care Program: Married Couple with Two Children, All Covered by Employer-Sponsored Insurance, with Income Near $50,000 (Page 2 of 2)

	Private Health Care Expenses	Current Law	Proposed Reform	Change
	Employer contribution toward health insurance premium	$8,430	$0	-$8,430
+	Employee contribution toward health insurance premium	$3,957	$0	-$3,957
+	Out-of-pocket health care expenses	$1,750	$0	-$1,750
=	Total private health care expenses	$14,137	$0	-$14,137
	As a share of comprehensive income	22.8%	0.0%	-22.8%

Total Taxes	Current Law	Proposed Reform	Change
Total taxes and private health care expenses	$25,018	$26,636	$1,619
As a share of comprehensive income	40.4%	43.0%	2.6%

Disposable Income	Current Law	Proposed Reform	Change
Disposable income after taxes and private health care expenses	$36,860	$35,241	-$1,619
Percent change			-4.4%

SOURCES: Heritage Foundation model based on data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, https://www.meps.ahrq.gov (accessed October 17, 2018), and federal and state tax data. See appendix for more information about the methodology.

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APPENDIX C TABLE 3

Financial Effects of a Government-Run Health Care Program: Median-Income Unmarried Mother Covered by Employer-Sponsored Insurance, with Two Children Covered by CHIP (Page 1 of 2)

	Income	Current Law	Proposed Reform	Change
	Wage and salary income	$29,059	$34,548	$5,489
+	Other taxable income	$648	$648	$0
+	Other nontaxable income	$1,486	$1,486	$0
=	Cash income	$31,194	$36,683	$5,489
+	Employer portion of federal payroll taxes	$2,134	$2,134	$0
+	Employer contribution toward health insurance premium	$5,489	$0	-$5,489
=	Comprehensive income	$38,817	$38,817	$0

	Federal Payroll Taxes	Current Law	Proposed Reform	Change
	Wage and salary income	$29,059	$34,548	$5,489
–	Employee contribution toward health insurance premium	$1,161	$0	-$1,161
=	Income subject to federal payroll tax	$27,899	$34,548	$6,650
	Federal payroll tax rate	15.3%	36.5%	21.2%
	Federal payroll taxes paid	$4,269	$12,610	$8,342
	As a share of comprehensive income	11.0%	32.5%	21.5%

	Federal Income Taxes	Current Law	Proposed Reform	Change
	Income subject to federal payroll tax	$27,899	$34,548	$6,650
+	Other taxable income	$648	$648	$0
=	Income subject to federal income tax	$28,547	$35,197	$6,650
	Federal income taxes before credits	$306	$469	$163
–	Earned income credit	$3,628	$2,238	-$1,390
–	Child tax credit	$3,106	$3,269	$163
=	Federal income taxes paid	-$6,428	-$5,038	$1,390
	As a share of comprehensive income	-16.6%	-13.0%	3.6%
	Total federal payroll and income taxes	-$2,159	$7,572	$9,732
	As a share of comprehensive income	-5.6%	19.5%	25.1%

	Other Federal, State, and Local Taxes	Current Law	Proposed Reform	Change
	Federal excise, estate, and other taxes	$582	$582	$0
+	State and local sales and excise taxes	$1,863	$1,537	-$326
+	State and local income taxes	$815	$673	-$143
+	State and local property taxes	$1,165	$961	-$204
=	Other federal, state, and local taxes paid	$4,425	$3,753	-$673
	As a share of comprehensive income	11.4%	9.7%	-1.7%
	Total taxes	$2,266	$11,325	$9,059
	As a share of comprehensive income	5.8%	29.2%	23.3%

APPENDIX C TABLE 3

Financial Effects of a Government-Run Health Care Program: Median-Income Unmarried Mother Covered by Employer-Sponsored Insurance, with Two Children Covered by CHIP (Page 2 of 2)

	Private Health Care Expenses	Current Law	Proposed Reform	Change
	Employer contribution toward health insurance premium	$5,489	$0	-$5,489
+	Employee contribution toward health insurance premium	$1,161	$0	-$1,161
+	Out–of–pocket health care expenses	$862	$0	-$862
=	Total private health care expenses	$7,512	$0	-$7,512
	As a share of comprehensive income	19.4%	0.0%	-19.4%

Total Taxes	Current Law	Proposed Reform	Change
Total taxes and private health care expenses	$9,778	$11,325	$1,547
As a share of comprehensive income	25.2%	29.2%	4.0%

Disposable Income	Current Law	Proposed Reform	Change
Disposable income after taxes and private health care expenses	$29,039	$27,492	-$1,547
Percent change			-5.3%

SOURCES: Heritage Foundation model based on data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, https://www.meps.ahrq.gov (accessed October 17, 2018), and federal and state tax data. See appendix for more information about the methodology.

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APPENDIX C TABLE 4

Financial Effects of a Government-Run Health Care Program: Minimum-Wage Unmarried Mother with Two Children, All Covered by Medicaid (Page 1 of 2)

	Income	Current Law	Proposed Reform	Change
	Wage and salary income	$13,155	$13,155	$0
+	Other taxable income	$956	$956	$0
+	Other nontaxable income	$1,080	$1,080	$0
=	Cash income	$15,191	$15,191	$0
+	Employer portion of federal payroll taxes	$1,006	$1,006	$0
+	Employer contribution toward health insurance premium	$0	$0	$0
=	Comprehensive income	$16,197	$16,197	$0

	Federal Payroll Taxes	Current Law	Proposed Reform	Change
	Wage and salary income	$13,155	$13,155	$0
–	Employee contribution toward health insurance premium	$0	$0	$0
=	Income subject to federal payroll tax	$13,155	$13,155	$0
	Federal payroll tax rate	15.3%	36.5%	21.2%
	Federal payroll taxes paid	$2,013	$4,802	$2,789
	As a share of comprehensive income	12.4%	29.6%	17.2%

	Federal Income Taxes	Current Law	Proposed Reform	Change
	Income subject to federal payroll tax	$13,155	$13,155	$0
+	Other taxable income	$956	$956	$0
=	Income subject to federal income tax	$14,111	$14,111	$0
	Federal income taxes before credits	$62	$62	$0
–	Earned income credit	$5,270	$5,270	$0
–	Child tax credit	$1,598	$1,598	$0
=	Federal income taxes paid	-$6,806	-$6,806	$0
	As a share of comprehensive income	-42.0%	-42.0%	0.0%
	Total federal payroll and income taxes	-$4,794	-$2,005	$2,789
	As a share of comprehensive income	-29.6%	-12.4%	17.2%

	Other Federal, State, and Local Taxes	Current Law	Proposed Reform	Change
	Federal excise, estate, and other taxes	$243	$243	$0
+	State and local sales and excise taxes	$1,150	$949	-$201
+	State and local income taxes	$16	$13	-$3
+	State and local property taxes	$680	$561	-$119
=	Other federal, state, and local taxes paid	$2,089	$1,766	-$323
	As a share of comprehensive income	12.9%	10.9%	-2.0%
	Total taxes	-$2,704	-$239	$2,466
	As a share of comprehensive income	-16.7%	-1.5%	15.2%

APPENDIX C TABLE 4

Financial Effects of a Government-Run Health Care Program: Minimum-Wage Unmarried Mother with Two Children, All Covered by Medicaid (Page 2 of 2)

	Private Health Care Expenses	Current Law	Proposed Reform	Change
	Employer contribution toward health insurance premium	$0	$0	$0
+	Employee contribution toward health insurance premium	$0	$0	$0
+	Out-of-pocket health care expenses	$223	$0	-$223
=	Total private health care expenses	$223	$0	-$223
	As a share of comprehensive income	1.4%	0.0%	-1.4%

Total Taxes	Current Law	Proposed Reform	Change
Total taxes and private health care expenses	-$2,481	-$239	$2,242
As a share of comprehensive income	-15.3%	-1.5%	13.8%

Disposable Income	Current Law	Proposed Reform	Change
Disposable income after taxes and private health care expenses	$18,678	$16,436	-$2,242
Percent change			-12.0%

SOURCES: Heritage Foundation model based on data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, https://www.meps.ahrq.gov (accessed October 17, 2018), and federal and state tax data. See appendix for more information about the methodology.

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APPENDIX C TABLE 5

Financial Effects of a Government-Run Health Care Program on a Median-Income Unmarried Man Without Dependents, Covered by Employer-Sponsored Insurance (Page 1 of 2)

	Income	Current Law	Proposed Reform	Change
	Wage and salary income	$40,121	$45,458	$5,337
+	Other taxable income	$263	$263	$0
+	Other nontaxable income	$290	$290	$0
=	Cash income	$40,674	$46,011	$5,337
+	Employer portion of federal payroll taxes	$2,972	$2,972	$0
+	Employer contribution toward health insurance premium	$5,337	$0	-$5,337
=	Comprehensive income	$48,983	$48,983	$0

	Federal Payroll Taxes	Current Law	Proposed Reform	Change
	Wage and salary income	$40,121	$45,458	$5,337
–	Employee contribution toward health insurance premium	$1,278	$0	-$1,278
=	Income subject to federal payroll tax	$38,843	$45,458	$6,615
	Federal payroll tax rate	15.3%	36.5%	21.2%
	Federal payroll taxes paid	$5,943	$16,592	$10,649
	As a share of comprehensive income	12.1%	33.9%	21.7%

	Federal Income Taxes	Current Law	Proposed Reform	Change
	Income subject to federal payroll tax	$38,843	$45,458	$6,615
+	Other taxable income	$263	$263	$0
=	Income subject to federal income tax	$39,106	$45,721	$6,615
	Federal income taxes before credits	$2,924	$3,690	$767
–	Earned income credit	$0	$0	$0
–	Child tax credit	$0	$0	$0
=	Federal income taxes paid	$2,924	$3,690	$767
	As a share of comprehensive income	6.0%	7.5%	1.6%
	Total federal payroll and income taxes	$8,867	$20,283	$11,416
	As a share of comprehensive income	18.1%	41.4%	23.3%

	Other Federal, State, and Local Taxes	Current Law	Proposed Reform	Change
	Federal excise, estate, and other taxes	$980	$980	$0
+	State and local sales and excise taxes	$2,351	$1,940	-$411
+	State and local income taxes	$1,029	$849	-$180
+	State and local property taxes	$1,469	$1,212	-$257
=	Other federal, state, and local taxes paid	$5,829	$4,980	-$849
	As a share of comprehensive income	11.9%	10.2%	-1.7%
	Total taxes	$14,696	$25,263	$10,567
	As a share of comprehensive income	30.0%	51.6%	21.6%

APPENDIX C TABLE 5

Financial Effects of a Government-Run Health Care Program on a Median-Income Unmarried Man Without Dependents, Covered by Employer-Sponsored Insurance (Page 2 of 2)

	Private Health Care Expenses	Current Law	Proposed Reform	Change
	Employer contribution toward health insurance premium	$5,337	$0	-$5,337
+	Employee contribution toward health insurance premium	$1,278	$0	-$1,278
+	Out–of–pocket health care expenses	$410	$0	-$410
=	Total private health care expenses	$7,025	$0	-$7,025
	As a share of comprehensive income	14.3%	0.0%	-14.3%

Total Taxes	Current Law	Proposed Reform	Change
Total taxes and private health care expenses	$21,721	$25,263	$3,542
As a share of comprehensive income	44.3%	51.6%	7.2%

Disposable Income	Current Law	Proposed Reform	Change
Disposable income after taxes and private health care expenses	$27,262	$23,720	-$3,542
Percent change			-13.0%

SOURCES: Heritage Foundation model based on data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, https://www.meps.ahrq.gov (accessed October 17, 2018), and federal and state tax data. See appendix for more information about the methodology.

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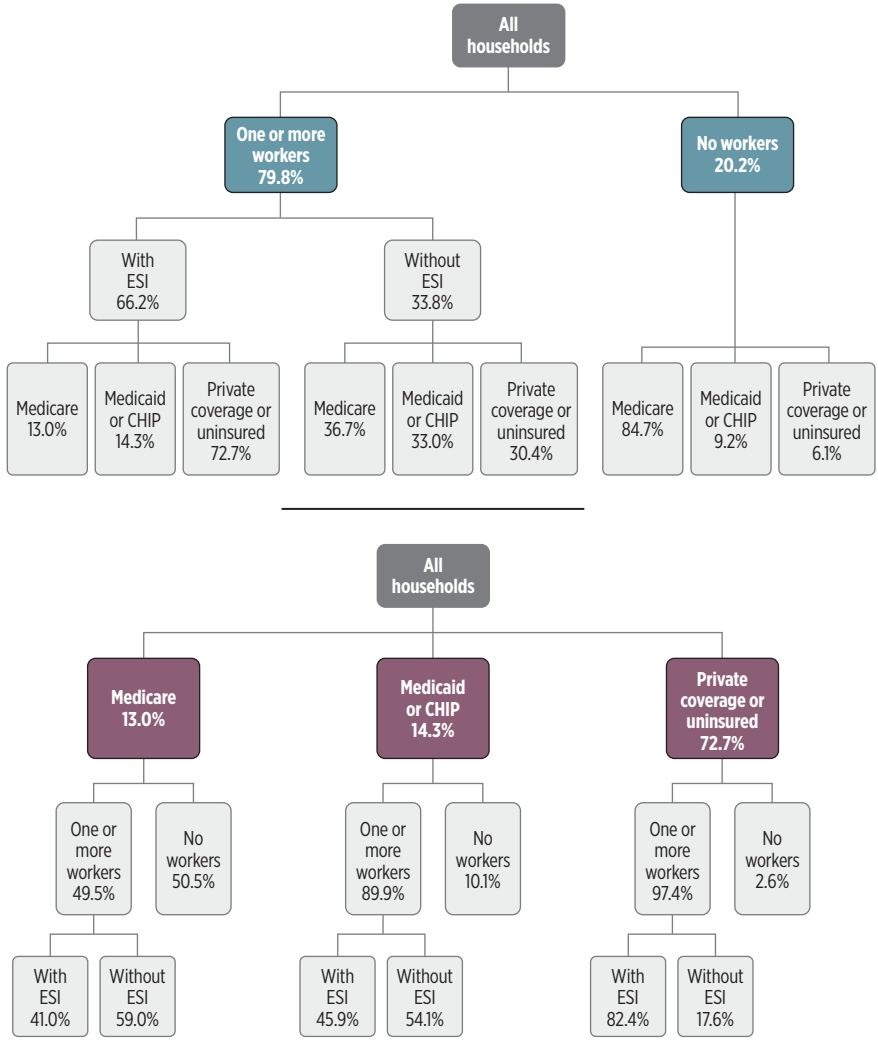
APPENDIX C FIGURE 1

Outlining U.S. Health Care Coverage



NOTES: Figures are for 2016. ESI stands for employee-sponsored insurance. "Medicare" households have at least one person who is covered by Medicare. "Medicaid or CHIP" households have at least one person who is covered by Medicaid or CHIP, but not Medicare. "Private Coverage or Uninsured" households have no one covered by Medicare, Medicare, or CHIP.

SOURCES: Heritage Foundation calculations based on data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, https://www.meps.ahrq.gov (accessed October 17, 2018).

heritage.org

ADDITIONAL RESOURCES

Bacchus Barua and David Jacques, "Comparing Performance of Universal Health Care Countries, 2018," Fraser Institute, 2018, https://www.fraserinstitute.org/sites/default/files/comparing-performance-of-universal-health-care-countries-2018.pdf.

Jay Bhattachayra and Jonathan Ketcham, "Why Not Have Medicare for All?," Cato Unbound, April 21, 2020, https://www.cato-unbound.org/2020/04/21/jay-bhattacharya/economic-case-against-medicare-all.

Charles Blahous, "How Much Would Medicare for All Cut Doctor and Hospital Reimbursements?" Economics 21 *Commentary*, October 10, 2018, https://economics21.org/m4a-reimbursements-blahous.

Charles Blahous, "The Costs of a National Single-Payer Healthcare System," Mercatus Center *Working Papers*, July 30, 2018, https://www.mercatus.org/publications/government-spending/costs-national-single-payer-healthcare-system.

Charles Blahous, "The Unanswered Questions of Medicare for All," AEI *Economic Perspectives Report*, February 15, 2019, https://www.aei.org/research-products/report/the-unanswered-questions-of-medicare-for-all/.

Douglas W. Blayey, "Efficacy of Medicaid for Patients with Cancer in California," JAMA Network Oncology, March 1, 2018, https://www.ncbi.nlm.nih.gov/pubmed/29192302.

Linda Blumberg et al., "From Incremental to Comprehensive Health Insurance Reforms: How Various Reform Options Compare on Coverage and Cost," Urban Institute, October 2019, https://www.urban.org/sites/default/files/2019/10/15/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_options_compare_on_coverage_and_costs.pdf.

Maryaline Catillon, David Cutler and Thomas Getzen, "Two Hundred Years of Health and Medical Care: The Importance of Medical Care for Life Expectancy Gains," National Bureau of Economic Research *Working Paper* No. 25330, December 2018, https://www.nber.org/papers/w25330.pdf.

Lanhee J. Chen, "The Myth of the 'Moderate' Public Option," *The Wall Street Journal*, January 23, 2020, https://www.wsj.com/articles/the-myth-of-the-moderate-public-option-11579824695

Mohammad Ziaul Islam Chowdhury and Monsur Ahmed Chowdhury, "Canadian Health Care System: Who Should Pay for All Medically Beneficial Treatments? A Burning Issue," *International Journal of Health Services*, November 2, 2017, https://www.ncbi.nlm.nih.gov/pubmed/29095077.

Tom Church, Daniel L. Heil and Lanhee J. Chen, "The Fiscal Effects of the Public Option," Partnership for America's Health Care Future, January 24, 2020, https://americashealthcarefuture.org/wp-content/uploads/2020/01/Final-The-Fiscal-Effects-Of-The-Public-Option-1.24.20.pdf.

Committee for a Responsible Federal Budget, "Choices for Financing Medicare for All: A Preliminary Analysis," October 28, 2019, http://www.crfb.org/sites/default/files/Choices_for_Financing_Medicare_for_All.pdf.

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.

Vilsa Curto, Liran Einav, Amy Finkelstein, Jonathan Levin, and Jay Bhattacharya, "Healthcare Spending and Utilization in Public and Private Medicare," National Bureau of Economic Research *Working Paper* No. 23090, January 2017, https://www.nber.org/papers/w23090.pdf.

Mark Dayan, Deborah Ward, Tim Gardner, and Elaine Kelly, "How Good Is the NHS?" Institute for Fiscal Studies, June 25, 2018, https://www.ifs.org.uk/uploads/HEAJ6319-How-good-is-the-NHS-180625-WEB.pdf.

Laura Dwyer-Lindgren, Amelia Bertozzi-Villa, Rebecca W. Stubbs, et al., "Inequalities in Life Expectancy Among US Counties, 1980 to 2014," JAMA Network, July 2017, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2626194.

Alison P. Galvani, Alyssa S. Parpia, Eric M. Foster, Burton H. Singer and Meagan C. Fitzpatrick, "Improving the prognosis of health care in the USA," The Lancet, February 15, 2020, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)33019-3/fulltext.

Steven Globerman, Bacchus Barua, and Sazid Hasan, "The Supply of Physicians in Canada: Projections and Assessment," Fraser Institute, January 18, 2018, https://www.fraserinstitute.org/sites/default/files/supply-of-physicians-in-canada.pdf.

Dana Goldman, "Why Bernie Sanders' Plan for Universal Health Care Is Only Half Right," Brookings Institution, September 13, 2017, https://www.brookings.edu/blog/fixgov/2017/09/13/why-bernie-sanderss-plan-for-universal-health-care-is-only-half-right/.

John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer National Health Insurance Around the World* (Lanham, MD: Rowman & Littlefield Publishers, 2004).

Anne Gulland, "Will Private Practice Remain an Attractive Option for Doctors?" *British Medical Journal*, Vol. 356 (March 2017), https://www.bmj.com/content/356/bmj.j1258.

John Holahan and Linda J. Blumberg, "Estimating the Cost of a Single-Payer Plan," Urban Institute, October 2018, https://www.urban.org/sites/default/files/publication/99151/estimating_the_cost_of_a_single-payer_plan_0.pdf.

Jodi L. Liu and Christine Eibner, "National Health Spending Estimates Under Medicare for All," RAND Corporation, 2019, https://www.rand.org/pubs/research_reports/RR3106.html.

Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, "Health Care Spending in the United States and Other High-Income Countries," JAMA Network, March 13, 2018, https://jamanetwork.com/journals/jama/article-abstract/2674671.

The Physicians Foundation, "2018 Survey of America's Physicians," September 2018, https://physiciansfoundation.org/research-insights/the-physicians-foundation-2018-physician-survey/.

Sally C. Pipes, *False Premise, False Promise: The Disastrous Reality of Medicare for All* (New York: Encounter Books, 2020).

Eric C. Schneider et al., "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care," The Commonwealth Fund, July, 2017, https://interactives.commonwealthfund.org/2017/july/mirror-mirror/assets/Schneider_mirror_mirror_2017.pdf.

Steven H. Woolf and Heidi Schoomaker, "Life Expectancy and Mortality Rates in the United States, 1959-2017," JAMA Network, November 26, 2019, https://jamanetwork.com/journals/jama/article-abstract/2756187.

ENDNOTES

Government-Controlled Health Care: Rhetoric Versus Reality

MARIE FISHPAW *and* MERIDIAN PAULTON

1. Abby Goodnough and Trip Gabriel, "'Medicare for All' vs. 'Public Option': The 2020 Field Is Split, Our Survey Shows, *The New York Times*, June 23, 2019, https://www.nytimes.com/2019/06/23/us/politics/2020-democrats-medicare-for-all-public-option.html (accessed June 24, 2020).
2. Lanhee J. Chen, "The Myth of the 'Moderate' Public Option," *The Wall Street Journal*, January 23, 2020, https://www.wsj.com/articles/the-myth-of-the-moderate-public-option-11579824695 (accessed June 24, 2020).
3. Friends of Bernie Sanders, "Medicare for All: Leaving No One Behind," https://live-berniesanders-com.pantheonsite.io/issues/medicare-for-all/ (accessed September 13, 2018).
4. Medicare's broad popularity is detailed in this poll: Mira Norton, Bianaca DiJulio, and Mollyann Brodie, "Medicare and Medicaid at 50," Henry J. Kaiser Family Foundation, July 17, 2015, https://www.kff.org/medicaid/poll-finding/medicare-and-medicaid-at-50/ (accessed December 7, 2018).
5. Centers for Medicare and Medicaid Services, "Medicare Enrollment Dashboard 2019," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard (accessed June 12, 2020).
6. Bernie Sanders as quoted by Shelby Livingston, "Sanders Unveils Single-Payer Healthcare Bill," *Modern Healthcare*, September 13, 2017, http://www.modernhealthcare.com/article/20170913/NEWS/170919952 (accessed April 24, 2019).
7. Diane Archer, "Yes, Medicare for All Is Expensive. That's Not the Point," *The Washington Post*, August 1, 2018, https://www.washingtonpost.com/opinions/yes-medicare-for-all-is-expensive-thats-not-the-point/2018/08/01/0b4a0708-95a8-11e8-80e1-00e80e1fdf43_story.html?utm_term=.21600a6f66b6 (accessed October 29, 2018).
8. Friends of Bernie Sanders, "Medicare for All: Leaving No One Behind."
9. Edmund F. Haislmaier and Jamie Bryan Hall, "How 'Medicare for All' Harms Working Americans," Heritage Foundation *Special Report* No. 219, November 19, 2019, https://www.heritage.org/sites/default/files/2019-11/SR219.pdf, and Marie Fishpaw and Jamie Hall, "In Charts, How 'Medicare for All' Would Make Most Families Poorer," Daily Signal, November 19, 2019, https://www.dailysignal.com/2019/11/19/in-charts-how-medicare-for-all-would-make-most-families-poorer/.
10. Physicians for a National Health Program, "Single Payer FAQ," http://www.pnhp.org/facts/single-payer-faq (accessed April 24, 2019).
11. Bacchus Barua, "Waiting Your Turn: Wait Times for Health Care in Canada," The Fraser Institute, 2017, https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2017.pdf (accessed August 19, 2018).
12. Ibid.
13. Ibid.
14. Irene Papanicolas, Liana R. Woskie, and Ashish Jha, "Health Care Spending in the United States and Other High-Income Countries," *Journal of the American Medical Association*, Vol. 319, No. 10 (2018), pp. 1024–1039.
15. Carl Baker, "NHS Key Statistics: England, May 2018," House of Commons Library, May 21, 2018, http://researchbriefings.files.parliament.uk/documents/CBP-7281/CBP-7281.pdf (accessed August 20, 2018).
16. Ibid.
17. Laura Donnelly and Henry Bodkin, "NHS Hospitals Ordered to Cancel All Routine Operations in January as Flu Spike and Bed Shortages Lead to A&E Crisis," *The Telegraph*, January 3, 2018, https://www.telegraph.co.uk/news/2018/01/02/nhs-hospitals-ordered-cancel-routine-operations-january/ (accessed August 20, 2018).
18. Irene Papanicolas, Liana R. Woskie, and Ashish Jha, "Health Care Spending in the United States and Other High-Income Countries," *Journal of the American Medical Association*, Vol. 319, No. 10 (2018), pp. 1024–1039.

19. John S. O'Shea, "Reforming Veterans Health Care: Now and for the Future," Heritage Foundation *Issue Brief* No. 4585, June 24, 2016, https://www.heritage.org/health-care-reform/report/reforming-veterans-health-care-now-and-the-future.
20. VA Office of the Inspector General: Office of Audits and Evaluations, "Review of Alleged Mismanagement at the Health Eligibility Center," September 2, 2015, https://www.va.gov/oig/pubs/VAOIG-14-01792-510.pdf (accessed June 24, 2020),
21. John Ubaldi, "VA Still in Disarray Four Years After Veterans Wait-List Death Scandal," *In Homeland Security*, https://inhomelandsecurity.com/va-disarray-4-years-veterans-scandal/ (accessed June 24, 2020).
22. Anna Sansom et al., "Why Do GPs Leave Direct Patient Care and What Might Help to Retain Them? A Qualitative Study of GPs in South West England," *British Medical Journal*, Vol. 8, No. 1 (2017), https://bmjopen.bmj.com/content/8/1/e019849 (accessed September 18, 2018).
23. Senator Bernie Sanders, "Health Care for All," *The Huffington Post*, December 1, 2013, https://www.huffingtonpost.com/rep-bernie-sanders/a-single-payer-system-lik_b_4021534.html (accessed April 24, 2019).
24. Glenn Kessler, "Medicare, Private Insurance and Administrative Costs: A Democratic Talking Point," *The Washington Post*, September 19, 2017, https://www.washingtonpost.com/news/fact-checker/wp/2017/09/19/medicare-private-insurance-and-administrative-costs-a-democratic-talking-point/?utm_term=.2c1fc1f66069 (accessed September 13, 2018).
25. Ed Weisbart, "A Single-Payer System Would Reduce U.S. Health Care Costs," *AMA Journal of Ethics*, November 2012, https://journalofethics.ama-assn.org/article/single-payer-system-would-reduce-us-health-care-costs/2012-11 (accessed September 13, 2018). See also Daniel Marans, "Insurance Companies Just Accidentally Made the Case for Medicare for All," *The Huffington Post*, March 9, 2017, https://www.huffpost.com/entry/insurance-companies-medicare-for-all_n_58c1b1fae4b054a0ea690dc8 (accessed April 24, 2019).
26. Robert A. Book, "Medicare Administrative Costs Are Higher, Not Lower, Than for Private Insurance," Heritage Foundation *WebMemo* No. 2505, June 25, 2009, https://www.heritage.org/health-care-reform/report/medicare-administrative-costs-are-higher-not-lower-private-insurance.
27. Ibid.
28. Robert A. Book, "Measuring the Burden of Administrative Costs," testimony of Robert A. Book, PhD, Healthcare and Economics Expert, Advisor to the American Action Forum, Senior Research Director, Libris Research, LLC, before the Committee on Health, Education, Labor and Pensions, U.S. Senate, July 31, 2018, https://www.help.senate.gov/imo/media/doc/Book.pdf (accessed April 24, 2019).
29. Charles Blahous, "The Costs of a National Single-Payer Healthcare System," Mercatus Center at George Mason University, July 2018, https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf (accessed August 20, 2018).
30. Jim Norman, "Healthcare Once Again Tops List of Americans' Worries," Gallup, April 1, 2019, https://news.gallup.com/poll/248159/healthcare-once-again-tops-list-americans-worries.aspx (accessed September 8, 2020).

Section 1 Introduction

1. Representative Jan Schakowsky, Health Care for America Rally, 2009, video, timestamp 5:25, https://www.youtube.com/watch?v=W_MtLyDfXJA&feature=youtu.be&t=327 (accessed June 26, 2020).

The "Public Option": Government-Run Health Care on the Installment Plan

NINA OWCHARENKO SCHAEFER *and* ROBERT E. MOFFIT, PHD

1. Medicare for All Act of 2019, S. 1129, 116th Cong., 1st Sess. https://www.congress.gov/bill/116th-congress/senate-bill/1129/text (accessed December 4, 2019). The bill has 14 Senate co-sponsors.
2. Medicare for All Act of 2019, H.R. 1384, 116th Cong., 1st Sess., https://www.congress.gov/bill/116th-congress/house-bill/1384/text (accessed December 4, 2019). The bill has 118 House sponsors, roughly half the entire Democratic membership of the U.S. House of Representatives.

3. Soon after, Professor Jacob Hacker, a Yale University political science professor, released another variation on the public option, and the general public option concept was adopted by candidate Senator John Edwards during the 2008 Democratic presidential primary. Helen A. Halpin and Peter Harbage, "The Origins and Demise of the Public Option," *Health Affairs*, Vol. 29, No. 6, (2010), pp. 1117–1124, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.0363 (accessed December 4, 2019).
4. Helen Anne Halpin, "Getting to a Single Payer System Using Market Forces: The CHOICE Program," Robert Wood Johnson Foundation *Covering America Series*, 2003, http://research.policyarchive.org/21872.pdf (accessed December 4, 2019).
5. See Nina Owcharenko Schaefer and Robert E. Moffit, "The Obama Health Care Plan: More Power to Washington," Heritage Foundation *Backgrounder* No. 2197, October 15, 2008, https://www.heritage.org/health-care-reform/report/the-obama-health-care-plan-more-power-washington.
6. Quoted in Conn Carroll, "Still Not Convinced the Public Option Is a Trojan Horse for Single Payer?" The Daily Signal, August 3, 2009, https://www.dailysignal.com/2009/08/03/still-not-convinced-the-public-option-is-a-trojan-horse-for-single-payer/.
7. Even former Vice President Joseph Biden and House Speaker Nancy Pelosi (D–CA) endorsed this approach, although generally speaking, the public option would undermine employer-based health insurance, as well as the few private options available in the non-group market under the ACA. See Joseph Antos and James C. Capretta, "The Heavy Hand of the Public Option," RealClearPolicy, June 18, 2019, https://www.realclearpolicy.com/articles/2019/06/18/the_heavy_hand_of_the_public_option_111222.html (accessed December 4, 2019), and James C. Capretta, "A Public Option Would Cause More Problems for Obamacare's Private Insurers, and That's Probably the Point," *National Review*, August 25, 2016, https://www.nationalreview.com/2016/08/obamacare-public-option-fix-will-further-undermine-private-insurance/ (accessed December 4, 2019).
8. The Medicare for America Act of 2019, H.R. 2452, 116th Cong., 1st Sess.
9. Co-sponsors as of this writing.
10. Ibid., Title I, Subtitle A, § 101, and § 102.
11. Ibid., Title I, Subtitle A, Sec. 103.
12. The Medicare for America Act of 2019, H.R. 2452, 116th Congress, 1st Sess., Title I, Subtitle A, § 104.
13. Ibid., § 105 (a).
14. Ibid., § 105.
15. Ibid., § 105 (b)(3). In short, the government would compel doctors and other medical professionals to provide medical procedures that many, if not most, Americans would consider unethical or immoral.
16. Ibid., § 106.
17. Ibid., § 106 (d).
18. As defined in CFR Title 45, § 152.2.
19. The Medicare for America Act of 2019, H.R. 2452, 116th Cong., 1st Sess., Title I, Subtitle B, Part A, § 2202 (a).
20. In 2025, individuals enrolled in both Medicare and Medicaid would also be transferred to the government plan. Ibid., § 2202 (b)(2).
21. Ibid., § 2202 (b)(3).
22. Medicare Advantage for America plans would be available under new rules. See ibid., Title I, Subtitle B, Part C.
23. Ibid., Title I, Subtitle B, Part C, § 112 (b)(4). See also, Title I, Subtitle B, Part C, § 112.
24. For example, new rules on defining "qualified" employer-based coverage include requiring that the plan cover 80 percent of the actuarial value of Medicare, provide at least a 70 percent premium contribution, and cover dental, vision, and hearing benefits. For new rules on qualified employer coverage, see Targeted Reforms, ibid., Title I, Subtitle C, § 126.
25. Ibid., Title I, Subtitle B, Part C, § 112 (b)(4).
26. Ibid., § 2202 (b)(3).
27. Ibid. § 2202(b)(1).
28. Ibid., Title I, Subtitle B, Part A, § 2203 (a).
29. Ibid., Title I, Subtitle B, Part A, § 2203 (d).
30. Ibid., Title I, Subtitle B, Part A, § 2204.
31. Ibid., Title I, Subtitle C, § 134.
32. Ibid., Title I, Subtitle B, Part A, § 2205.
33. Ibid., Title I, Subtitle B, Part A, § 2206 (b).
34. Ibid., Title I, Subtitle B, Part A, § 2205 (e) and (f).

35. Ibid., Title I, Subtitle B, Part A, § 2206 (c).
36. Ibid., Title I, Subtitle B, Part A, § 2206 (d).
37. Ibid., Title III.
38. A maintenance of effort requirement would be set by the states. See ibid., Title I, Subtitle B, Part A, § 2209.
39. Ibid., Title I, Subtitle B, Part A, § 2207.
40. Ibid., Title I, Subtitle B, Part A, § 2208.
41. Ibid., Title I, Subtitle B, Part C.
42. Ibid., Title I, Subtitle C.
43. Ibid., Title I, Subtitle B, Part B.
44. Ibid., Title II.
45. Choose Medicare Act, S. 1261, 116th Cong., 1st Sess., and Choose Medicare Act, H.R. 2463, 116th Cong., 1st Sess.
46. Co-sponsors as of this writing.
47. Ibid., § 2 (c)(2).
48. Ibid., § 2 (b).
49. Ibid., § 9.
50. Ibid., § 10.
51. Ibid., § 2 (b).
52. Ibid., § 2 (c)(3).
53. Ibid., § 3.
54. Ibid., § 2 (d).
55. Ibid., § 6 and § 7.
56. Ibid., § 2 (e)(2). The bill also places emphasis on alternative payment models. See § 2 (f).
57. Ibid., § 5 and § 2 (g).
58. Ibid., § 2 (e)(3).
59. Ibid., § 2 (e)(4).
60. Ibid., § 8.
61. Ibid., § 2 (h).
62. Ibid., § 11.
63. Medicare-X Choice Act of 2019, S. 981, 116th Cong., 1st Sess., also Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess.
64. Co-sponsors at the time of this writing.
65. Ibid., § 2202.
66. Ibid., § 2201 (a)(2).
67. Ibid., § 2203. The Secretary would also set rates for additional services not covered by Medicare, and the Secretary may adopt innovative payment models for services provided under Medicare-X.
68. Ibid., § 2206.
69. Ibid., § 2206.
70. Ibid., § 4.
71. Ibid., § 2207. The bill also puts emphasis on "innovative payment models." See § 2209.
72. See Sec. 5 for new Medicare Part D authority.
73. Ibid., § 2208.
74. Ibid., § 2201.
75. Ibid., § 3.
76. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., and Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, H.R. 2085, 116th Cong., 1st Sess.
77. Co-sponsors at the time of this writing.
78. Ibid., § 2795 (b)(1).
79. Ibid., § 2795 (c)(1).
80. Ibid., § 2795 (b)(3).
81. Ibid., § 2795 (c)(2).
82. Ibid., § 2795 (c)(3).
83. Ibid., § 2795 (d)(1).

84. Medicare at 50 Act, S. 470, 116th Cong. H.R. 1346 establishes a similar Medicare buy-in program as well as other provisions related to reinsurance, risk corridors, and cost-sharing enhancements.
85. Co-sponsors at the time of this writing.
86. Ibid., § 1899C (a).
87. Ibid., § 1899C (g)(4).
88. Ibid., § 1899C (h).
89. Ibid., § 1899C (c).
90. Ibid., § 1899C (f).
91. Ibid., § 3.
92. Explicitly excludes health insurance issuers and any entity that directly or indirectly receives consideration from an insurance issuer.
93. Ibid., § 1899C (j).
94. Ibid., § 1899C (i).
95. Ibid., § 1899C (d).
96. State Public Option Act, S. 489, 116th Congress, 1st. Sess., and State Public Option Act, H.R. 1277, 116th Cong., 1st Sess.
97. Co-sponsors as of this writing.
98. Ibid., § 2 (a).
99. Ibid., § 2 (b).
100. Ibid., § 6.
101. Ibid., § 2 (e).
102. Ibid., § 2 (d)(1). See also, Patient Protection and Affordable Care Act of 2010, Public Law No. 111-148, Title I, Subtitle C, Part I, § 2701.
103. If an individual is enrolled in the Medicaid buy-in program but is eligible through another route, the state may only impose premiums or cost sharing based on traditional Medicaid requirements. See Ibid., § 2(d)(3).
104. Ibid., § 2 (d)(4).
105. Ibid., § 4.
106. Ibid., § 5.
107. Ibid., § 2 (c)(1).
108. Ibid., § 3.
109. This number represents 178,350 with employer based coverage and 34,846 with direct purchase coverage. See U.S. Census Bureau, "Health Insurance Coverage in the United States: 2018," November 2019, Table 1, https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.
110. "Medicare Extra: Universal Coverage for Less Than $3 Trillion and Lower Health Care Costs for All," Center for American Progress, July 23, 2019, https://www.americanprogress.org/issues/healthcare/reports/2019/07/23/472520/medicare-extra/.
111. Lane Koenig et al., "The Impact of Medicare-X on Coverage Healthcare Use and Hospitals," KNG Health Consulting, March 12, 2019, p. ii, https://www.aha.org/guidesreports/2019-03-11-impact-medicare-x-choice-coverage-healthcare-use-and-hospitals (accessed December 5, 2019).
112. See scenarios 4–6 in Linda Blumberg et al., "From Incremental to Comprehensive Health Insurance Reforms: How Various Reform Options Compare on Coverage and Cost," Urban Institute, October 2019, https://www.urban.org/sites/default/files/2019/10/15/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_options_compare_on_coverage_and_costs.pdf (accessed December 5, 2019).
113. Scott Atlas, "Public Option Kills Private Insurance," *The Wall Street Journal*, July 16, 2019, https://www.wsj.com/articles/public-option-kills-private-insurance-11563309118 (accessed December 5, 2019).
114. Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau of Economic Research *Working Paper* No. 12858, January 2007, https://www.nber.org/papers/w12858.pdf (accessed December 5, 2019).
115. Doug Badger and Jamie Bryan Hall, "Why Millions Are Still Uninsured Despite Government Intervention," The Daily Signal, October 28, 2019, https://www.dailysignal.com/2019/10/28/why-millions-are-still-uninsured-despite-government-intervention/.
116. Medicare for America Act, H.R. 2452, 116th Cong., 1st Sess., Title I, Subtitle B, § 2206 (c)(1).
117. Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess., § 2208 (a) and (b).
118. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., § 2795 (d).

119. Choose Medicare Act, S. 1261, 116th Cong., 1st Sess., § 2201 (e)(3).
120. Medicare at 50 Act, S. 470, 116th Cong., 1st Sess., § 1899C (a)(2).
121. State Public Option Act, S. 489, 116th Cong., 1st Sess., § 2 (a)(1)(A).
122. Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess., § 2208.
123. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., § 2795 (d).
124. Other proposals offer no explicit opt-out.
125. Medicare for America Act, H.R. 2452, Title I, Subtitle B, § 2202 (b)(2)(B) and (C).
126. The "navigator" described in the Choose Medicare Act, H.R. 6117, 115th Cong., 1st Sess., § 3 refers to navigators from the ACA, or individuals who "conduct public education activities to raise awareness of the availability of qualified health plans," from the Patient Protection and Affordable Care Act 42 U.S. Code 18031 § 1311 (i)(3)(A).
127. The Medicare at 50 Act seeks to "carry out outreach, public education activities, and enrollment activities to raise awareness of, and encourage, enrollment under this section." Medicare at 50 Act, S. 470, 116th Cong., 1st Sess., § 1899C (j)(1)(A).
128. Ibid.
129. For example, the Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess., § 2203, and Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., § 2795 (b)(1)(D) would require the government plans to operate at both silver and gold levels.
130. Medicare for America Act of 2019, H.R. 2452, Title I, Subtitle B, § 2202 (b)(3)(C).
131. Choose Medicare Act, S. 1261, § 2201 (a).
132. Says CMS Administrator Seema Verma, "Access will be compromised for patients, and reimbursement cuts in the public plan will shift more pressure to employer sponsored plans to make up the difference, driving up costs for 180 million Americans with private insurance." Cited in Nathaniel Weixel, "Trump Health Officials Bash Public Option as No Better than Medicare for All," *The Hill*, July 22, 2019, https://thehill.com/policy/healthcare/454145-verma-bashes-public-option-as-no-better-than-medicare-for-all (accessed December 5, 2019). Also see Seema Verma, "I'm the Administrator of Medicare and Medicaid. A Public Option Is a Bad Idea," *The Washington Post*, July 24, 2019, https://www.washingtonpost.com/opinions/a-public-option-for-health-insurance-is-a-terrible-idea/2019/07/24/fb651c1a-ae2e-11e9-8e77-03b30bc29f64_story.html (accessed December 4, 2019).
133. Medicare for America Act of 2019, H.R. 2452, Title I § 106, and Subtitle B, § 2207.
134. Ibid., Title II.
135. Choose Medicare Act, S. 1261, § 2(h).
136. Medicare-X Choice Act of 2019, H.R. 2000, § 2201(b).
137. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, H.R. 2085, 116th Cong., 1st Sess., § 2(c)(3).
138. For example, the bill would create a 90 percent enhanced match rate for administration costs of the new Medicaid buy-in program and extend the ACA enhanced match rate for expansion states. See State Public Option Act, S. 489, 116th Cong., 1st Sess., § 4 and § 5. See also Medicare at 50 Act, S. 470, 116th Cong., 1st Sess., § 1899C (j)(4).
139. "Unlike a private Insurance plan, there's no particular reason why a publicly run product couldn't experience ongoing losses, so long as the law provided for direct or indirect taxpayer subsidization." Capretta, "A Public Option Would Cause More Problems for Obamacare's Private Insurers, and That's Probably the Point."
140. Medicare-X Choice Act of 2019, S. 981, 116th Cong., 1st Sess., § 2207 (b).
141. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, § 2795 (c)(2).
142. Medicare at 50 Act, S. 470, 116th Cong., 1st Sess. § 1899C (2).
143. Medicare for America Act, H.R. 2452, Title I, Subtitle B, § 2206 (b).
144. Choose Medicare Act, S. 1261, § 2201 (e)(2).
145. In 2016, Medicaid reimbursement rates were an average of 72 percent of Medicare payment rates. See Kaiser Family Foundation, "Medicaid-to-Medicare Fee Index," https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed December 13, 2019).
146. Medicare for America Act of 2019, H.R. 2452, Title I, Subtitle B, § 2205.
147. Choose Medicare Act of 2019, S. 1261, Sec. 2 (e)(4).

148. Milena Sullivan and Ekemini Isaiah, "The VA National Formulary for Top Medical Benefit Drugs Is Narrower than Current Medicare Part B Drug Coverage," Avalere, August 13, 2019, https://avalere.com/insights/the-va-national-formulary-for-top-medical-benefit-drugs-is-narrower-than-current-medicare-part-b-drug-coverage (accessed December 5, 2019).
149. *The 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare insurance Trust Funds*, April 22, 2019, p. 180, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf (accessed December 5, 2019).
150. Kayla Holgash and Martha Heberlein, "Physician Acceptance of New Medicaid Patients," Medicaid and CHIP Payment and Access Commission, January 2019, https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf (accessed December 5, 2019).
151. Halpin, "Getting to a Single Payer System Using Market Forces: The CHOICE Program."

Total Control: The House Democrats' Single-Payer Health Care Prescription

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1. In celebrating the emergence of the single-payer bills, a champion in the media observes: "There is one thing we can be thankful for: Medicare for All is now a mainstream position in the Democratic Party, to the point where most of the leading Democratic candidates say they support it." Libby Watson, "A Public Option Isn't Good Enough," *Splinter*, February 1, 2019, https://splinternews.com/a-public-option-isn-t-good-enough-1832011806 (accessed July 8, 2019).
2. "The bills swiftly transform the entire $3.7 trillion health care system, touching on everything from building primary and rural health care capacity to addressing socioeconomic disparities to getting all health care providers to use the same electronic billing format." Alice Miranda Ollstein and Joanne Kenen, "From Abortion to Immigration, Things You Didn't Know Were in Medicare for All," *Politico*, April 10, 2019, p. 1, https://www.politico.com/story/2019/04/10/sanders-medicare-for-all-1341799 (accessed July 8, 2019).
3. Niran S. Al-Agba, "'Medicare for All' a Far Cry from Other Nations' Universal Care," Medpage Today, May 9, 2019, https://www.medpagetoday.com/blogs/kevinmd/79740 (accessed July 8, 2019).
4. U.S. Census Bureau, American Community Survey, Tables S2701, S2702, S2703, and S2704 for the year 2017, https://factfinder.census.gov (accessed March 24, 2019).
5. Among some strong supporters of the legislation, the destruction of Americans' employer-sponsored health plans is a reasonable price for securing a government monopoly: "A vocal minority of people with employer provided coverage they actually like doesn't mean you should ignore what's best for everyone." Watson, "A Public Option Isn't Good Enough."
6. Cited in Shefall Luthra, "There's a New 'Medicare-for All' Bill in the House. Why Does It Matter?" *Kaiser Health News*, February 27, 2019, https://khn.org/news/theres-a-new-medicare-for-all-bill-in-the-house-why-does-it-matter/ (accessed July 8, 2019).
7. Ollstein and Kenen, "From Abortion to Immigration, Things You Didn't Know Were in Medicare for All."
8. Medicare for All Act of 2019, Title VII, Section 701 (a), (3), p. 91.
9. According to analysts with the National Right to Life Committee, "Working in tandem, Sections 103 and 104 and 301 are likely to be interpreted to require physicians to perform an abortion, even if they are morally opposed to them, as this would constitute discrimination under this definition." See The National Right to Life Committee, "NRLC Strongly Opposes H.R. 1384, the 'Medicare for All Act of 2019,'" April 29, 2019, https://www.nrlc.org/federal/ahc/nrlc-strongly-opposes-h-r-1384-the-medicare-for-all-act-of-2019/ (accessed July 8, 2019).
10. The previous version of the House bill (H.R. 676) specified that the financing would come from "existing federal revenues" for health care. It would require new personal income taxes on the "top five percent of income earners"; "modest and progressive excise taxes on payroll and self-employment income"; and a "modest tax" on unearned income, plus a "small tax" on stocks and bond transactions. See H.R. 676, Section 211. Such legislative language, however, was unamenable to econometric analysis.
11. Luthra, "There's a New 'Medicare for All' Bill in the House."
12. Charles P. Blahous, testimony before the Committee on Rules, U.S. House of Representatives, April 30, 2019, p. 2, https://docs.house.gov/meetings/RU/RU00/20190430/109356/HHRG-116-RU00-Wstate-BlahousC-20190430.pdf (accessed July 8 2019).
13. Ibid., p. 1.

14. Ibid., p. 2.
15. Rand Corporation analysts estimate that the total cost of the program, if implemented in 2019, would amount to $3.89 trillion, or a 1.8 percent increase in total spending over the status quo. However, it would amount to a 221 percent increase in federal health spending. Moreover, in the absence of a serious constraint on the supply of health care services, in the face of a rising demand, total health care spending could rise from $3.89 trillion to $4.2 trillion, a 9.8 percent increase. Jodi L. Liu and Christine Eibner, "National Health Spending Estimates Under Medicare for All," RAND Corporation, 2019, https://www.rand.org/pubs/research_reports/RR3106.html (accessed July 8, 2019).
16. Medicare for All Act of 2019, Title VI, Section 601, (a) (8), p. 62.
17. Adam Shaw, "Medicare for All Sponsor Says Plan Would Gut 1 Million Private Jobs," FoxNews, May 3, 2019, https://www.foxnews.com/politics/medicare-for-all-would-gut-a-million-private-insurance-jobs (accessed July 8, 2019).
18. Medicare for All Act of 2019, Title I, Section 101, p. 4.
19. Among economically advanced nations, the House bill, covering foreign residents regardless of their legal status, would be unprecedented: "[T]he majority of universal health care systems in the developed world are considerably less 'universal" when covering immigrants, who are mostly excluded." Al-Agba, "'Medicare for All' a Far Cry from Other Nations' Universal Care."
20. Congressional Budget Office, "Key Design Components and Considerations for Establishing a Single-Payer Health Care System," May 1, 2019, p. 3, https://www.cbo.gov/publication/55150 (accessed July 8, 2019).
21. Medicare for All Act of 2019, Title I, Section 102, p. 5. The Senate bill embodies the same general eligibility policy.
22. Ibid., Section 105 (b), p. 8.
23. Ibid., Title I, Section 102, pp. 4 and 5.
24. Ibid., Title I, Section 103, p. 5.
25. Ibid., Title I, Section 104, p. 5.
26. Ibid., Title I, Section 104, (c), p. 7.
27. Insurance enrollment is based on 2017 data, compiled by the Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," 2017, https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed July 8, 2019). Medicare enrollment is taken from the *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, April, 2019, p. 173, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf (accessed July 8, 2019).
28. Medicare for All Act of 2019, Title I, Section 107 (a), p. 9.
29. Ibid., Title VII, Section 701, (a), p. 93.
30. Ibid., Title VII, Section 701 (2) (A), pp. 89 and 90.
31. "Private health insurance plays a major role in most developed countries with universal coverage." See Al-Agba, "'Medicare for All' a Far Cry from Other Nations' Universal Care."
32. Congressional Budget Office, "Key Design Components," p. 13.
33. "The Department of Health and Human Services would have significant discretion in interpreting what specific services are 'medically necessary.' That means political leaning or scientific debates could sway what's covered, even from administration to administration." Luthra, "There's a New 'Medicare for All' Bill in the House."
34. Medicare for All Act of 2019, Section 201 (c) (1) (2), p. 12.
35. Ibid., Section 201, (e), p. 14.
36. Ibid., Title II, Section 203 (b), pp. 14 and 15.
37. Ibid., Section 203 9c) (1), pp. 15 and 16. The legislative text is unclear as to how certain likely problems would be resolved, particularly in cases where the best professional judgment of physicians clashes with provisions of the "non-discrimination" clause, patient preferences, or physicians' professional ethical obligations under the Hippocratic Oath. The consequence is likely to be the creation of an authoritarian administrative system where transient political fashions would govern medical ethics, rather than traditional ethical or moral norms. In any case, these provisions are pregnant with intense conflict and court litigation.
38. "Most universal coverage systems offer narrow benefit packages and incorporate cost-sharing for patients." Al-Agba, "'Medicare for All' a Far Cry from Other Nations' Universal Care."
39. Congressional Budget Office, "Key Design Components," pp. 10 and 11.
40. Medicare for All Act of 2019, Title II, Section 204 (a), pp. 17 and 18.
41. Ibid., Title II, Section 204, (c), pp. 18 and 19.

42. Ibid., Title II, Section 204, c (s), pp. 18 and 19.
43. Ibid., Title II, Section 204 (d), p. 20.
44. The previous House version had 10 benefit categories. See H.R. 676, Title I, Section 102.
45. Congressional Budget Office, "Key Design Components," p. 10.
46. Ibid.
47. Ibid., p. 10.
48. Medicare for All Act of 2019, Title II, Section 204 (c) (1).
49. Liu and Eibner, "National Health Spending Estimates Under Medicare for All."
50. For an excellent overview of this problem, see Kevin Pham, "America's Looming Doctor Shortage: What Policymakers Should Do," Heritage Foundation *Backgrounder* No. 3343, September 5, 2018, https://www.heritage.org/health-care-reform/report/americas-looming-doctor-shortage-what-policymakers-should-do.
51. Kevin Pham and Robert E. Moffit, "Britain's Inability to Handle Last Year's Flu Season Shows Perils of Socialized Medicine," The Daily Signal, August 13, 2018, https://www.dailysignal.com/2018/08/13/britains-inability-to-handle-last-years-flu-season-shows-perils-of-socialized-medicine/.
52. Medicare for All Act of 2019, Title III, Section 301 (b), pp. 22–24.
53. Ibid., Title III, Section 301 (b), pp. 24 and 25. It is worth noting that current Medicare law has a "prompt payment" requirement, and, in the case of a delay in paying providers' "paper" claims, the federal government must pay interest after 30 days. It appears that the House bill contains no similar legal requirement.
54. Ibid., Title III, Section 302 (c) (1), pp. 33 and 34.
55. Ibid., Title III, Section 302, (c), (2), pp. 34 and 35.
56. Ibid., Section 502 (a) (b) (c), pp. 53–55. Administrative standard setting is, however, often incompatible with personalized patient care. "Standardization of care in a medical condition, though advocated by many, belies the complexity of care delivery and the variety of patient circumstances." Michael E. Porter and Elizabeth Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston: Harvard Business School Press, 2006), p. 178.
57. Medicare for All Act of 2019, Title V, Section 502 (a), (b), (c), pp. 55–57.
58. Ibid., Title III, Section 303, p. 36.
59. Ibid., Title III, Section 303, pp. 36–38.
60. Ibid., Title III, Section 303, p. 42.
61. According to the CBO, "In England, private insurance gives people access to private providers, faster access to care or coverage for complementary or alternative therapies, but participants must pay for it separately in addition to paying their individual required tax contributions to the NHS." Congressional Budget Office, "Key Design Components," p. 13. Not surprisingly, with the growth in waiting lists, British private options have expanded in recent years. For an account of this expansion, see Tim Evans, "London Calling: Don't Commit to Nationalized Health Care," Heritage Foundation *Backgrounder* No. 3405, May 3, 2019, pp. 6 and 7, https://www.heritage.org/health-care-reform/report/london-calling-dont-commit-nationalized-health-care.
62. Anne Gulland, "Will Private Practice Remain an Attractive Option for Doctors?" *British Medical Journal*, Vol. 356 (March 2017), https://www.bmj.com/content/356/bmj.j1258 (accessed July 9, 2019).
63. Under the House bill, the congressional grant of power to the HHS Secretary would be unprecedented, and yet so would the politicization of health care decision making. Professors Porter and Teisberg thus warn: "It simply strains credulity to imagine that a large government entity would streamline administration, simplify prices, set prices according to true costs, help patients make choices based on excellence and value, establish value-based competition at the provider level, and make politically neutral and tough choices to deny patients and reimbursement to substandard providers." Porter and Teisberg, *Redefining Health Care*, pp. 89 and 90.
64. Medicare for All Act of 2019, Title IV, Section 401, (a), (1), pp. 43 and 44.
65. Medicare for All Act of 2019, Title IV, Section 401, (a) (3), p. 44.
66. Ibid., Title IV, Section 401 (b) (10), p. 45.
67. Ibid., Title IV, Section 401, (c) (1), pp. 48 and 49.
68. Ibid., Title IV, Section 403 (c), pp. 50 and 51. In short, these regional directors would take over the local health-planning responsibilities that are now mostly exercised by state agencies.
69. "Single-payer health systems typically include some form of global budgeting. Most hospitals in Canada operate under annual global budgets. Some countries define global budgets more broadly to cover total health care spending or spending for major categories of services." Congressional Budget Office, "Key Design Components," p. 19. The House bill defines the global budget in the broad sense of covering total health care spending.

70. Medicare for All Act of 2019, Section 601, (a), p. 59.
71. Ibid., Title VI, Section 613, pp. 74–77.
72. Ibid., Title VI, Section 612, p. 73.
73. Ibid., Title IX, Section 903, pp. 98–101.
74. Ibid., Title VI, Section 614 (c), p. 80.
75. Ibid.
76. Ibid., Section 616 (1), pp. 83 and 84.
77. Ibid., Title VI, Section 616, (3) (A), p. 85.
78. Ibid., Title VI, Section 616 (A), p. 86.
79. Ibid., Title VI, Section 616 (3) (D), p. 87.
80. Blahous, testimony before the Committee on Rules, U.S. House of Representatives, p. 4.
81. Medicare for All Act of 2019, Title X, Section 1001, p. 101.
82. Ibid., Title X, Section 1002, (b) (4), p. 104.
83. Ibid., Title X, Section 1002, (c) (2), p. 105.
84. Ibid., Title X, Section 1002, pp. 103–106.
85. Paying for Senior Care, "2019 Health & Human Services Poverty Guidelines/Federal Poverty Levels," May 2019, https://www.payingforseniorcare.com/longtermcare/federal-poverty-level.html (accessed July 9, 2019).
86. Medicare for All Act of 2019, Title X, Section 1002, pp. 107–111.
87. Congressional Budget Office, "Key Design Components," p. 3.
88. Liu and Eibner, "National Health Spending Estimates Under Medicare for All."
89. On this point, the congressional sponsors are clear: "There is a moral imperative to correct the massive deficiencies in our current health system and to eliminate profit from the provision of care." Sense of the Congress, Medicare for All Act of 2019, p. 78. So, too, are the inevitable consequences: "If the economic decision mechanisms of the market are abolished, they must be replaced by political (governmental) mechanisms for distribution. Just as the market rewards economic services, political distribution systems will reward political services, that is, services in the production and distribution of power." Ernest van den Haag, "Confusion, Envy, Fear and Longing," in Van den Haag, ed., *Capitalism: Sources of Hostility* (New Rochelle, NY: Epoch Books, 1979), p. 28.
90. For an excellent discussion of the ACA's impact on market concentration, see Christopher M. Pope, "How the Affordable Care Act Fuels Health Care Market Consolidation," Heritage Foundation *Backgrounder* No. 2928, August 1, 2014, http://thf_media.s3.amazonaws.com/2014/pdf/BG2928.pdf.
91. "Taxes that could finance a single payer system include income taxes (both individual and corporate), payroll taxes, and consumption taxes, all of which have different implications for progressivity of the financing system. A system financed by debt might require additional taxes in the future." Congressional Budget Office, "Key Design Components," p. 28.
92. "The relatively slow growth in (Britain's) global budget since 2010 has created severe financial strains on the health care system. Provider payment rates have been reduced, many providers have incurred financial deficits, and wait times for receiving care have increased." Congressional Budget Office, "Key Design Components," p. 26.
93. Reflecting on the April 30, 2019, House Rules Committee hearing, Blahous, a witness, observed: "Multiple experts who testified at the hearing agreed that most of these new federal costs would arise from the federal government's taking on spending currently done by the private sector, e.g., through private health insurance and individual payments out of pocket. Under M4A the federal government would also assume health spending obligations currently financed by state and local governments. The fact that most of this spending is really being done by someone else does not, however, imply that the federal government could successfully finance it without causing significant damage to the U.S. economy." Charles Blahous, "The Winners and Losers of 'Medicare for All,'" Economics 21, May 22, 2019, https://economics21.org/medicare-for-all-winners-and-losers (accessed July 9, 2019).
94. For an overview of this approach, see Edmund F. Haislmaier, Robert E. Moffit, and Nina Owcharenko Schaefer, "The Health Care Choices Proposal: Charting a New Path to a Down Payment on Patient-Centered, Consumer-Driven Health Care Reform," Heritage Foundation *Backgrounder* No. 3330, July 11, 2018, https://www.heritage.org/sites/default/files/2018-07/BG3330_0.pdf.

Government Monopoly: Senator Sanders' "Single-Payer" Health Care Prescription

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1. Senator Sanders introduced the Medicare for All Act of 2017 on September 13, 2017, https://www.congress.gov/115/bills/s1804/BILLS-115s1804is.pdf (accessed October 24, 2017). The bill is co-sponsored by Senators Baldwin, Blumenthal, Bookers, Franken, Gillibrand, Harris, Heinrich, Hirono, Leahy, Markey, Merklely, Schatz, Shaheen, Udall, Warren, and Whitehouse.
2. Representative Conyers' bill is the Expanded and Improved Medicare for All Act (H.R. 676), https://www.congress.gov/115/bills/hr676/BILLS-115hr676ih.pdf (accessed October 24, 2017).
3. Medicare for All Act, Title VII, Section 801, p. 58.
4. Chuck Todd, Mark Murray, and Carrie Dann, "Trump's Approval Rating Ticks Up—with the Help of a Bipartisan Deal," NBC News, September 21, 2017, https://www.nbcnews.com/politics/first-read/trump-s-approval-rating-ticks-help-bipartisan-deal-n803351 (accessed October 24, 2017).
5. Medicare for All Act, Title IX, Section 901 (a)(1)(A), p. 61. Section 106 of the bill specifies that the health benefits to be provided by the new government plan "shall first be available under the Act for items and services furnished on January 1 of the fourth calendar year that begins after the date of enactment of this Act."
6. Medicare for All Act, Title IX, Section 901 (a)(2), p. 62.
7. Whether a national health reform proposal covers Members of Congress and federal employees has been a recurrent controversy in the national health care debates since the collapse of the Clinton Health Plan in 1994. Currently, the controversy is focused on the Obama Administration's administrative provision of special insurance subsidies for Members of Congress and staff enrolled in the ACA health insurance exchange program. There was no congressional authorization or appropriation for these special subsidies.
8. Medicare for All Act, Title IX, Section 901, p. 64.
9. Medicare for All Act, Title IX, Section 901, pp. 64 and 65.
10. For a discussion of the problems of VA health care and proposals for reform, see John S. O'Shea, "Reforming Veterans Health Care: Now and for the Future," Heritage Foundation *Issue Brief* No. 4548, June 24, 2016, http://www.heritage.org/health-care-reform/report/reforming-veterans-health-care-now-and-the-future. For a discussion of problems in the Indian Health Service, see the Government Accountability Office, "Indian Health Service: Actions Needed to Improve Oversight of Quality of Care," *Report to Congress*, January 9, 2017, https://www.gao.gov/products/GAO-17-181 (accessed October 24, 2017).
11. Medicare for All Act, Title VII, Section 701, p. 57.
12. Christine Grimaldi, "Sanders' 'Medicare for All' Covers Abortion Care, Ends Hyde Amendment," *Rewire*, September 13, 2017, https://rewire.news/article/2017/09/13/sanders-medicare-covers-abortion-care-ends-hyde-amendment/ (accessed October 24, 2017).
13. Medicare for All Act, Title IV, Administration, Subtitle A—General Administration Provisions, Section 401, pp. 31 and 32.
14. Ibid., p. 32.
15. Comparisons between private and public insurance administrative costs are often tricky, because the functions of the programs are different, and their impact on providers' own administrative costs vary considerably. Officially, Medicare's administrative costs vary between 1 percent and 3 percent, though Medicare officials ignore the administrative costs imposed on private providers in compliance with Medicare's formidable regulatory regime. In analyzing the 2016 version of the Sanders proposal, Urban Institute researchers estimated the administrative costs of the new government plan at 6 percent: "A new system would have a host of important administrative functions necessary to effective operations, such as rate setting for many different providers of different types; quality control over care provisions; development, review and revision of regulations; provider oversight and enforcement of standards; bill payment to providers; and other functions." Linda J. Blumberg, John Holohan, Lisa Clemans-Cope, and Matthew Buettgens, "Response to Criticisms of Our Analysis of the Sanders Health Care Reform Plan," The Urban Institute, May 18, 2016, https://www.urban.org/research/publication/response-criticisms-our-analysis-sanders-health-care-reform-plan (accessed October 25, 2017).
16. David Weigel, "Sanders Introduces Universal Health Care, Backed by 15 Democrats," *The Washington Post*, September 13, 2017, https://www.washingtonpost.com/powerpost/sanders-will-introduce-universal-health-care-backed-by-15-democrats/2017/09/12/d590ef26-97b7-11e7-87fc-c3f7ee4035c9_story.html?utm_term=.ed8434ace7d8 (accessed October 24, 2017).

17. Dana Goldman, "Why Bernie Sanders' Plan for Universal Health Care Is Only Half Right," The Brookings Institution, September 13, 2017, https://www.brookings.edu/blog/fixgov/2017/09/13/why-bernie-sanderss-plan-for-universal-health-care-is-only-half-right/ (accessed October 24, 2017).
18. Senator John Barrasso (R–WY) has asked the Congressional Budget Office (CBO) to provide a complete cost estimate of S. 1804. "As the country engages in a serious debate about how best to reform our health care system," notes Barrasso, "it is imperative that the public understand the cost of Senator Sanders' Medicare for All Proposal." See Senator John Barrasso's letter to CBO Director Dr. Keith Hall: News release, "Barrasso Requests CBO Score on Sanders' Single-Payer Health Care Bill," Office of John Barrasso, September 14, 2017, https://www.barrasso.senate.gov/public/index.cfm/2017/9/barrasso-requests-cbo-score-on-sanders-single-payer-health-care-bill (accessed October 24, 2017).
19. For a discussion of the Medicare record, see Robert E. Moffit, "Medicare's Next 50 Years: Preserving the Program for Future Retirees," Heritage Foundation *Special Report* No. 185, July 29, 2016, pp. 9–11, http://www.heritage.org/health-care-reform/report/medicares-next-50-years-preserving-the-program-future-retirees.
20. Jodi Liu, "Savings from a Single Payer Health System Would Not be Automatic," The Rand Corporation, The Rand Blog, September 2013, https://www.rand.org/blog/2017/09/savings-from-a-single-payer-health-system-would-not.html (accessed October 24 2017).
21. Ian Millhiser, "7 Tough Questions Single-Payer Advocates Must Answer Before Their Ideas Can Become Law," *Think Progress*, September 13, 2017, https://thinkprogress.org/tough-questions-single-payer-7a5daec51693/ (accessed October 24, 2017).
22. *Politico* and Harvard T. H. Chan School of Public Health, "The Public's Views of Tax Reform and Other Domestic Issues," September 2017, p. 7, http://www.politico.com/f/?id=0000015e-a4d7-d873-adfe-bdd740140000 (accessed October 24, 2017).
23. Medicare for All, Title I, Section 102, p. 4.
24. Medicare for All, Title I, Section 105, p. 6. "The bill provides HHS with discretion to more broadly define eligibility requirements so long as the rules inhibit travel and immigration to the U.S. for the sole purpose of obtaining health care services." Katie Keith and Timothy Jost, "Unpacking the Sanders Medicare for All Bill," *Health Affairs Blog*, September 14, 2017, http://healthaffairs.org/blog/2017/09/14/unpacking-the-sanders-medicare-for-all-bill/ (accessed October 24, 2017).
25. Medicare for All, Title I, Section 105, p. 6.
26. Medicare for All, Title I, Section 104, p. 5.
27. For a discussion of the troublesome features of Section 1557, see Roger Severino and Ryan T. Anderson, "Proposed Obamacare Gender Identity Mandate Threatens Freedom of Conscience and the Independence of Physicians," Heritage Foundation *Backgrounder* No. 3089, January 8, 2016, http://thf-reports.s3.amazonaws.com/2015/BG3089.pdf.
28. "The bill…explicitly defines sex discrimination, which has been the subject of ongoing litigation under Section 1557, to include sex stereotyping and discrimination based on gender identity, sexual orientation, and pregnancy and related medical conditions, including termination of pregnancy." Keith and Jost, "Unpacking The Sanders Medicare for All Bill," p. 6.
29. For an account of the profound moral implications of physician-assisted suicide, see Ryan T. Anderson, "Always Care, Never Kill: How Physician Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality," Heritage Foundation *Backgrounder* No. 3004, March 24, 2015, http://thf_media.s3.amazonaws.com/2015/pdf/BG3004.pdf.
30. For an excellent analysis of this problem, see Edmund F. Haislmaier, "The Obama Administration's Design for Imposing More Health Care Mandates," Heritage Foundation *Backgrounder* No. 3093, February 11, 2016, http://www.heritage.org/health-care-reform/report/the-obama-administrations-design-imposing-more-health-care-mandates.
31. Medicare for All Act, Title I, Section 104, pp. 5 and 6.
32. Medicare for All Act, Title I Section 106, p. 7.
33. Medicare for All Act, Title I, Section 107, pp. 7 and 8.
34. Medicare for All Act, Title II, Section 201, pp. 9 and 10.
35. It is impossible to predict, of course, how government benefit setting will evolve. Because abortion is a mandatory medical procedure under the bill, requiring physician participation or exclusion from medical practice, the same standard, absent formal conscience protection, could also apply to physician-assisted suicide. While government officials, under Section 203 of the bill, can change or modify benefits, the broad language of Section

104 prohibits any provider discrimination against persons under a potentially wide variety of medical conditions, inviting litigation, further benefit expansion, and thus higher public costs. If the government should respond to higher benefit costs through either budgetary constraints or price controls on given medical services, it could be argued that a reduction of a person's access to such services would amount to discrimination.

36. Medicare for All Act, Title II, Section 203, p. 12.
37. Ibid., p. 13.
38. The term "Medicare industrial complex" was coined by Bruce Vladeck, a former Administrator of the Health Care Financing Administration, the agency that has been renamed the Center for Medicare and Medicaid Services. For his excellent account of Medicare as a battleground for special interest lobbying, see Bruce Vladeck, "The Political Economy of Medicare," *Health Affairs*, Vol. 18, No. 1 (January/February 1999), pp. 22–36, http://content.healthaffairs.org/content/18/1/22.abstract (accessed October 24, 2017).
39. For a description of the problems of the current Medicare appeals process, see Bob Soltis, *Hurry Up and Wait: Our Broken Medicare Appeals System* (Raleigh, NC: Lulu Publishing Services, 2015). See also, Moffit, "Medicare's Next 50 Years," pp. 13 and 14.
40. Medicare for All Act, Title II, Section 202, p. 11.
41. Ibid., p. 12.
42. Ibid.
43. On the additional costs to beneficiaries and taxpayers, see Robert E. Moffit and Drew Gonshorowski, "Double Coverage: How It Drives Up Medicare Costs for Patients and Taxpayers," Heritage Foundation *Backgrounder* No. 2805, June 4, 2013, http://thf_media.s3.amazonaws.com/2013/pdf/bg2805.pdf.
44. U.S. Code, Title 42, Section 1395.
45. Medicare for All Act, Title II, Section 203, p. 13.
46. Medicare for All Act, Title II, Section 204, pp. 14–16.
47. Medicare for All Act, Title II, Section 203, p. 16.
48. Medicare for All Act, Title III, Section 301, pp. 21 and 22.
49. Ibid., pp. 23 and 24.
50. Medicare for All Act, Title III, Section 303, p. 30.
51. For a discussion of Medicare private contracting law, see Robert E. Moffit, "Congress Should End the Confusion Over Medicare Private Contracting," Heritage Foundation *Backgrounder* No. 1347, February 18, 2000, http://www.heritage.org/health-care-reform/report/congress-should-end-the-confusion-over-medicare-private-contracting.
52. Christina Boccuti, Christina Swope, Anthony Damico, and Tricia Neuman, "Medicare Patients' Access to Physicians: A Synthesis of the Evidence," Kaiser Family Foundation *Issue Brief*, December 10, 2013, https://www.kff.org/medicare/issue-brief/medicare-patients-access-to-physicians-a-synthesis-of-the-evidence/ (accessed October 24, 2017).
53. Medicare for All Act, Title IV, Section 401, pp. 31 and 32.
54. Ibid., p. 35.
55. Medicare for All Act, Title IV, Section 411, p. 39.
56. Virgil Dickson, "CMS Offers Solutions as Improper Medicaid Payments Skyrocket," *Modern Healthcare*, August 30, 2016, http://www.modernhealthcare.com/article/20160830/NEWS/160839990 (accessed October 24, 2017).
57. Moffit, "Medicare's Next 50 Years," pp. 18 and 19.
58. Medicare for All Act, Title VI, Section 601, pp. 44 and 45.
59. Medicare for All Act, Title VI, Section 601, p. 46.
60. This is what Congress did with the sustainable growth rate (SGR) formula for limiting and updating physician payment in the Medicare program. Members of Congress, year after year, repeatedly repudiated their own handiwork.
61. Medicare for All Act Title VI, Section 611, p. 47.
62. The Senate bill sponsors at least recognize the need to regularize and make transparent this process of "value determination." Today, this is, for the most part, an opaque and mysterious process. Of course, it affects directly members of the American medical profession subjected to it, and indirectly, of course, the general public. If anything deserves the light of day, the current bureaucratic process of stakeholder valuation of Medicare's physician services should be at the top of the health care transparency agenda.
63. Medicare for All Act, Title VII, Section 701, p. 55.
64. Ibid., pp. 56 and 57.
65. Ibid.

66. Medicare for All Act, Title X, Section 1001, pp. 65–69.
67. Medicare for All Act, Title X, Section 1001, p. 71.
68. Medicare for All Act, Title Y, Section 1001, p. 84.
69. On the catastrophic limits for Medicare Advantage, that is, the annual out-of-pocket limits for Medicare beneficiaries, see Medicare.com, https://q1medicare.com/q1group/MedicareAdvantagePartDQA/FAQ.php?faq=What-is-MOOP-or-the-Medicare-Advantage-maximum-out-of-pocket-limit-&faq_id=605&category_id=149 (accessed October 24, 2017).
70. Medicare for All Act, Title X, Section 1012, p. 87.
71. Medicare for All Act, Title X, Section 1013, pp. 90 and 91.
72. Medicare for All Act, Title X, Section 1014, p. 93.
73. Medicare for All Act, Title X, Section 1002, p. 72–83.
74. Ibid., p. 75.
75. Ibid., p. 76.
76. Ibid., pp. 76 and 77.
77. Ibid., p. 79.
78. Ibid., p. 80.
79. For a description of the measure, see Robert E. Moffit, "Statement on the Tri-Committee Draft Proposal for Health Care Reform," testimony before the Education and Labor Committee, U.S. House of Representatives, June 23, 2009, http://www.heritage.org/testimony/statement-the-tri-committee-draft-proposal-health-care-reform.
80. Senator Sanders does not specify whether all of these options may be necessary or some combination of them, and merely offers them for further consideration.
81. Bernie Sanders, "Options to Finance Medicare for All," September 2017, https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all?id=8E063228-2387-4805-BFD2-82EA218861DA&download=1&inline=file (accessed October 24, 2017).
82. Ibid.
83. Ibid.
84. Ibid.
85. Kenneth E. Thorpe, "An Analysis of Senator Sanders Single Payer Plan," Healthcare–Now!, January 27, 2016, p. 1, https://www.healthcare-now.org/296831690-Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal.pdf
(accessed October 24, 2017).
86. Ibid.
87. Ibid.
88. John Holohan et al., "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending," The Urban Institute *Research Report*, May 2016, https://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000785-The-Sanders-Single-Payer-Health-Care-Plan.pdf (accessed October 25, 2017).
89. Ibid., p. 2.
90. Ibid., p. 3.

The National Debate over Government-Controlled Health Care

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1. See Edmund F. Haislmaier, Robert E. Moffit, and Nina Owcharenko Schaefer, "The Health Care Choices Proposal: Charting a New Path to a Down Payment on Patient-Centered, Consumer-Driven Health Care Reform," Heritage Foundation *Backgrounder* No., 3330, July 11, 2018, https://www.heritage.org/health-care-reform/report/the-health-care-choices-proposal-charting-new-path-down-payment-patient.
2. H.R. 1804, Medicare for All Act of 2017, 115th Cong., 1st Sess., September 13, 2017, https://www.congress.gov/bill/115th-congress/senate-bill/1804/text (accessed January 28, 2019).
3. H.R. 676, Expanded and Improved Medicare for All Act, 115th Cong., 1st Sess., January 24, 2017, https://www.congress.gov/bill/115th-congress/house-bill/676 (accessed January 28, 2019).

4. Kenneth E. Thorpe, "An Analysis of Senator Sanders Single Payer Plan," January 27, 2016, https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal (accessed January 28, 2019). Punctuation as in original.
5. John Holahan, Matthew Buettgens, Lisa Clemans-Cope, Melissa M. Favreault, Linda J. Blumberg, and Siyabonga Ndwandwe, "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending," Urban Institute, May 2016, https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending/view/full_report (accessed January 28, 2019).
6. Charles Blahous, 'The Costs of a National Single-Payer Healthcare System," *Mercatus Working Paper*, Mercatus Center at George Mason University, July 2018, https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf (accessed January 28, 2019).
7. Center for Health and the Economy, "Medicare for All: Leaving No One Behind," May 1, 2016, https://healthandeconomy.org/medicare-for-all-leaving-no-one-behind/ (accessed January 28, 2019).
8. Vilsa Curto, Liran Einav, Amy Finkelstein, Jonathan Levin, and Jay Bhattacharya, "Healthcare Spending and Utilization in Public and Private Medicare," National Bureau of Economic Research *Working Paper* No. 23090, January 2017, https://www.nber.org/papers/w23090.pdf (accessed January 28, 2019).
9. Direct Research, LLC, *Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly*, August 2014, http://medpac.gov/docs/default-source/contractor-reports/august2014_secondaryinsurance_contractor.pdf?sfvrsn=0#page=12 (accessed January 30, 2019).

London Calling: Don't Commit to Nationalized Health Care

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1. For a brief introduction to the world's health systems, see Mark Britnell, *In Search of the Perfect Health System* (London: Red Globe Press, 2015).
2. For more on 19th-century health and welfare services and the 1911 National Insurance Act, see David Green, *Working Class Patients and the Medical Establishment: Self-help in Britain from the Mid-Nineteenth Century to 1948* (New York: St. Martin's Press, 1985).
3. Hackney Museum, "The New National Health Service," public leaflet, February 1948, http://museum.hackney.gov.uk/object9232 (accessed January 9, 2019).
4. Robert Parker, "60 Years of the NHS," *The Observer*, June 21, 2008, https://www.theguardian.com/society/2008/jun/22/nhs60.nhs1 (accessed January 9, 2019).
5. Ibid.
6. Ibid.
7. Statista, "Infant Mortality Rate in the United Kingdom (UH) from 2000 to 2017," https://www.statista.com/statistics/281501/infant-mortality-rate-in-the-united-kingdom/ (accessed January 22, 2019).
8. NHS Digital, "General Practice Workforce: General and Personal Medical Services, England High-Level March 2017, Provisional Experimental Statistics, 2015 to 2017," May 23, 2017, https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/high-level-march-2017-provisional-experimental-statistics (accessed January 22, 2019).
9. NHS Digital, "NHS Workforce Statistics September 2017, Provisional Statistics," for September 30, 2009, to September 30, 2017, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/nhs-workforce-statistics-september-2017-provisional-statistics (accessed January 22, 2019).
10. Claire Milne, "The Number of Nurses and Midwives in the UK," Full Fact, January 23, 2018 https://fullfact.org/health/number-nurses-midwives-uk/ (accessed January 19, 2009).
11. NHS Leadership "About the NHS: Breast Screening Introduced: 1988," http://www.nhsgraduates.co.uk/about-the-nhs/history/1980s/breast-screening-is-introduced-1988/ (accessed January 9, 2019).
12. Ipsos MORI, "State of the Nation 2013," January 13, 2013, https://www.ipsos.com/ipsos-mori/en-uk/state-nation-2013 (accessed January 9, 2019).
13. Helen Evans, *Sixty Years On—Who Cares for the NHS?* (London: Institute of Economic Affairs, 2008), p. 35.
14. Ibid.
15. Ibid. Also see Henry J. Aron and William R. Schwartz, *The Painful Prescription: Rationing Hospital Care* (Washington, DC: Brookings Institution, 1984), p. 67.

16. Evans, *Sixty Years On*, pp. 43 and 44.
17. David Rose, "One in Eight Patients Still Waiting More than a Year But 'Targets Will Be Met,'" *The Times*, June 8, 2007, https://www.thetimes.co.uk/article/one-in-eight-patients-still-waiting-more-than-a-year-but-targets-will-be-met-gtgqcfvrkz8 (accessed January 9, 2019).
18. House of Commons Library, NHS Key Statistics: England, October 2018," October 2, 2018, pp. 12 and 13, https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7281 (accessed January 22, 2019). Also see Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, "Hospital Acquired Infections," *Research Briefing* No. 5, 2001.
19. The Malnutrition Advisory Group's report was released on November 11, 2003. For a more up-to-date overview, see Marinos Elia et al., "The 'MUST' Explanatory Booklet," British Association for Parenteral and Enteral Nutrition, 2011, https://www.bapen.org.uk/pdfs/must/must_explan.pdf (accessed January 22, 2019), and Rebecca Stratton, Trevor Smith, and Simon Gabe, "Managing Malnutrition to Improve Lives and Save Money," British Association for Parenteral and Enteral Nutrition, October 2018, https://www.bapen.org.uk/pdfs/reports/mag/managing-malnutrition.pdf (accessed January 22, 2019).
20. House of Commons Library, "NHS Key Statistics: England, October 2018," October 2, 2018, p. 12, https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7281 (accessed January 22, 2019).
21. Caroline Price, "How Private GP Services Are Expanding," Pulse, October 26, 2016, http://www.pulsetoday.co.uk/political/how-private-gp-services-are-expanding/20033098.article (accessed January 9, 2019).
22. Richard Smith, "Surely Time to Let the Private Sector Take Over Dental Care Completely," The BMJ Opinion blog, September 29, 2017, https://blogs.bmj.com/bmj/2017/09/29/richard-smith-surely-time-to-let-the-private-sector-take-over-dental-care-completely/ (accessed January 9, 2019).
23. Andrew Adonis and Stephen Pollard, *A Class Act: The Myth of Britain's Classless Society* (London: Hamish Hamilton, 1998), p. 171.
24. Nick Triggle, "NHS 'Poor' on Treating Deadly Illnesses," BBC News, June 26, 2018, https://www.bbc.co.uk/news/health-44567824 (accessed January 9, 2019).
25. Alex Matthews-King, "NHS Waiting Lists for Lung and Bowel Treatments Double Since Conservative-led Government Came to Power, Analysis Shows," *Independent*, December 12, 2018, https://www.independent.co.uk/news/health/nhs-waiting-list-lung-cancer-bowel-disease-arthritis-austerity-conservative-labour-a8678631.html (accessed January 9, 2019).
26. Ibid.
27. Ibid.
28. Triggle, "NHS 'Poor' on Treating Deadly Illnesses."
29. Mark Dayan, Deborah Ward, Tim Gardner, and Elaine Kelly, "How Good Is the NHS?" Institute for Fiscal Studies, June 25, 2018, https://www.ifs.org.uk/publications/13111 (accessed January 9, 2019).
30. Ruth Robertson, "How Does the NHS Compare Internationally?" The King's Fund, June 2, 2017, https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-international-comparisons (accessed January 9, 2019).
31. Ibid.
32. Ibid.
33. For a quick explanation of U.K. health cash plans, see Wikipedia, "Health Cash Plan," https://en.wikipedia.org/wiki/Health_cash_plan (accessed January 24, 2019).
34. Tim Evans, "General Election 2015: There's a Deafening Political Silence Around Those Who Opt to Go Private," *City A.M.*, April 10, 2015, http://www.cityam.com/213408/there-s-deafening-political-silence-around-those-who-opt-go-private (accessed January 9, 2018).
35. Benenden Health, "About Bendenden Health," http://benenden.co.uk (accessed January 1, 2019).
36. Evans, "General Election 2015."
37. For an introduction to the role that British trades unions play in private health care, see Daniel Kruger, "Why Half the Members of Trade Unions Have Private Health Care," *The Telegraph*, September 11, 2001, https://www.telegraph.co.uk/comment/4265527/Why-half-the-members-of-trade-unions-have-private-health-care.html (accessed January 9, 2019).
38. Unison, "Member Benefits: Health and Wellbeing," https://benefits.unison.org.uk/unison-living/wellbeing/ (accessed January 9, 2019); Unison, "Member Benefits: Health Plans," https://benefits.unison.org.uk/unison-living/wellbeing/health-plans/ (accessed January 9, 2019); and Unison, "Member Benefits: Dental Plans," https://benefits.unison.org.uk/unison-living/wellbeing/dental-plans/ (accessed January 9, 2019).

39. For an analysis of the agreement and how it emerged, see Allyson M. Pollock et al., *NHS plc: The Privatisation of Our Health Care* (London: Verso Books, 2004), pp. 66–68.
40. Declan Gaffney, Allyson M. Pollock, David Price, and Jean Shaoul, "NHS Capital Expenditure and the Private Finance Initiative—Expansion or Contraction," *British Medical Journal*, Vol. 319, No. 7201 (1999), pp. 48–51, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1116147/ (accessed January 9, 2019).
41. Pollock, *NHS plc*, pp. 68–71.
42. For an overview of the Bloomberg data, see Lee J. Miller and Wei Lu, "These Are the Economies with the Most (and Least) Efficient Health Care," Bloomberg, September 19, 2018, https://www.bloomberg.com/news/articles/2018-09-19/u-s-near-bottom-of-health-index-hong-kong-and-singapore-at-top (accessed January 23, 2019).
43. Laura Donnelly, "UK's Healthcare Plummets on Global Efficiency Tables," *The Telegraph*, October 9, 2018, https://www.telegraph.co.uk/news/2018/10/09/uks-healthcare-plummets-global-efficiency-tables/ (accessed January 9, 2019).
44. Ibid.
45. This includes taxes for the NHS and private health care spending.
46. Donnelly, "UK's Healthcare Plummets."
47. Milton Friedman, "Gammon's Law Points to Health-Care Solution," *The Wall Street Journal*, November 12, 1991.
48. Ibid.
49. Tom Bower, "How Blair Made the NHS a Black Hole That Wasted Billions: Former PM Tried to Transform the Health Service by Throwing Money at it—With Disastrous Results," *Daily Mail*, March 2, 2016, https://www.dailymail.co.uk/news/article-3473995/How-Blair-NHS-black-hole-wasted-BILLIONS-Former-PM-tried-transform-health-service-throwing-money-disastrous-results.html (accessed January 9, 2019).
50. Ibid.
51. Ibid.
52. Ibid.
53. Ibid.
54. Ibid.
55. Ibid.
56. Siva Anandaciva and James Thompson, "What Is Happening to Waiting Times in the NHS?" The King's Fund, November 8, 2017, https://www.kingsfund.org.uk/publications/articles/nhs-waiting-times?gclid=CjwKCAiAu_LgBRBdEiwAkovNsK8hV14kAlWtufNHCl28C-S_7Xhc1pdA6f2Hd23vTHVhE-3_u7eqsxoCpPAQAvD_BwE (accessed January 9, 2019).
57. NHS England, "Consultant-led Referral to Treatment Waiting Times," https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/ (accessed January 9, 2019).
58. Anandaciva and Thompson, "What Is Happening to Waiting Times in the NHS?"
59. Ibid.
60. Ibid., and NHS England, "A&E Attendances and Emergency Admissions 2017–18," https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2017-18/ (accessed January 9, 2019).
61. Anandaciva and Thompson, "What Is Happening to Waiting Times in the NHS?"
62. Rob Findlay, "Ambitions to Hold the Waiting List Steady this Financial Year Are Doomed," HSJ, December 13, 2018, https://www.hsj.co.uk/quality-and-performance/ambitions-to-hold-the-waiting-list-steady-this-financial-year-are-doomed/7024036.article (accessed January 23, 2019).
63. Maria Davies, "NHS Waits and Restrictions Driving Out-of-Pocket Spending," LaingBuisson, December 12, 2018, https://www.laingbuissonnews.com/healthcare-markets-content/nhs-waits-and-restrictions-driving-out-of-pocket-spending/?mxmroi=777-1-132299-0 (accessed January 9, 2019).
64. Brian Micklethwait, "How and How Not to Demonopolise Medicine," Libertarian Alliance *Political Notes* No. 56, 1991, http://libertarian.co.uk/lapubs/polin/polin056.pdf (accessed January 9, 2019).
65. Dayan, Ward, Gardner, and Kelly, "How Good Is the NHS?"

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1. "Bernie Sanders Announces 2020 Run: Full Transcript," CBS This Morning, February 19, 2019, https://mailchi.mp/cbsnews/bernie-sanders-on-ctm-545449?e=73ddddeb3a (accessed February 3, 2020).
2. MRI units per million inhabitants: Latvia: 13.9, Chile: 12.3, Turkey: 11.0, Canada: 10.2, Slovak Republic: 9.6. OECD, "Health at a Glance 2017: Indicators—Magnetic Resonance Imaging (MRI) Units," November 2019, https://data.oecd.org/healthcare/magnetic-resonance-imaging-mri-units.htm (accessed February 3, 2020).
3. Robert E. Moffit, "Total Control: The House Democrats' Single-Payer Health Care Prescription," Heritage Foundation *Backgrounder* No. 3423, July 19, 2019, https://www.heritage.org/health-care-reform/report/total-control-the-house-democrats-single-payer-health-care-prescription.
4. Physicians for a National Health Program, "Understanding the Medicare for All Act of 2019," https://pnhp.org/what-is-single-payer/senate-bill/ (accessed February 3, 2020).
5. Edmund F. Haislmaier and Jamie Bryan Hall, "How 'Medicare for All' Harms Working Americans," Heritage Foundation *Special Report* No. 219, November 19, 2019, https://www.heritage.org/health-care-reform/report/how-medicare-all-harms-working-americans, and "'Medicare for All' Might Be Hot Buzz Phrase These Days, But on Debate Stage Most Candidates Equivocate," Kaiser Health News *Morning Briefing*, June 28, 2019, https://khn.org/morning-breakout/medicare-for-all-might-be-hot-buzz-phrase-these-days-but-on-debate-stage-most-candidates-equivocate/ (accessed February 3, 2020).
6. Mohammad Ziaul Islam Chowdhury and Monsur Ahmed Chowdhury, "Canadian Health Care System: Who Should Pay for All Medically Beneficial Treatments? A Burning Issue," *International Journal of Health Services*, November 2, 2017, https://www.ncbi.nlm.nih.gov/pubmed/29095077 (accessed February 3, 2020).
7. Rabah Kamal, Daniel McDermott, and Cynthia Cox, "How Has U.S. Spending on Healthcare Changed Over Time?" Peterson-Kaiser Health System Tracker, December 20, 2019, https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-hospital-and-physician-services-represent-half-of-total-health-spending (accessed February 3, 2020).
8. Canadian Institute for Health Information, "National Health Expenditure Trends, 1975 to 2018," 2018, https://secure.cihi.ca/free_products/NHEX-trends-narrative-report-2018-en-web.pdf (accessed February 3, 2020).
9. Canadian Life and Health Insurance Association, *Canadian Life and Health Insurance Facts*, 2015 edition, http://clhia.uberflip.com/i/563156-canadian-life-and-health-insurance-facts/15 (accessed February 3, 2020).
10. Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, "Health Insurance Coverage in the United States: 2018," United States Census Bureau, November 8, 2019, https://www.census.gov/library/publications/2019/demo/p60-267.html (accessed February 3, 2020).
11. Kaiser Family Foundation, "State Health Facts: Health Insurance Coverage of the Total Population," 2018, https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed February 3, 2020).
12. Jon Greenberg, "Bernie Sanders Overplays Canada's Out-of-Pocket Health Care Costs," *PolitiFact*, February 22, 2019, https://www.politifact.com/truth-o-meter/statements/2019/feb/22/bernie-sanders/sanders-skips-canada-out-pocket-health/ (accessed February 3, 2020), and Centers for Medicare and Medicaid Services, "National Health Expenditures 2017 Highlights," December 11, 2018, https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2017-national-health-expenditures (accessed February 14, 2020).
13. Canadian Institute for Health Information, "How Does Canada's Health Spending Compare?" in "National Health Expenditure Trends, 1975 to 2019," https://www.cihi.ca/en/how-does-canadas-health-spending-compare (accessed February 4, 2020). Data for "How Does Canada's Health Spending Compare?" are through 2018.
14. Estimates of out-of-pocket spending as a percentage of U.S. health care costs vary. Estimated at 10 percent (Centers for Medicare and Medicaid Services, "National Health Expenditures 2017 Highlights," December 11, 2018); estimated at 11 percent (Peterson–Kaiser Family Foundation Health System Tracker, "Affordability: Out-of-Pocket Spending," https://www.healthsystemtracker.org/indicator/access-affordability/out-of-pocket-spending/ (accessed February 4, 2020)).
15. Ibid.

16. Organization for Economic Co-operation and Development, "Health at a Glance 2017: OECD Indicators—Out-of-Pocket Medical Spending as a Share of Final Household Consumption, 2015 (or Nearest y=Year)," February 2018, https://read.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017/out-of-pocket-medical-spending-as-a-share-of-final-household-consumption-2015-or-nearest-year_health_glance-2017-graph58-en#page1 (accessed February 4, 2020).
17. The World Bank, "Out-of-Pocket Expenditure per capita, PPP (Current International $)," 2000–2016, https://data.worldbank.org/indicator/SH.XPD.OOPC.PP.CD (accessed February 4, 2020).
18. Peterson–Kaiser Family Foundation Health System Tracker; The World Bank, "GDP per Capita, PPP (Current International $)—Canada," 1990–2018, https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD?locations=CA (accessed February 4, 2020); and The World Bank, "GDP per Capita (Current US$)—United States," 1960–2018, https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=US (accessed February 4, 2020).
19. Kamal, McDermott, and Cox, "How Has U.S. Spending on Healthcare Changed Over Time?"
20. Canadian Institute for Health Information, "National Health Expenditure Trends, 1975 to 2018," Figure 7, https://secure.cihi.ca/free_products/NHEX-trends-narrative-report-2018-en-web.pdf (accessed February 14, 2020).
21. Claudia Sanmartin et al., "Trends in Out-of-Pocket Health Care Expenditures in Canada, by Household Income, 1997 to 2009," Statistics Canada, April 2014, https://www150.statcan.gc.ca/n1/pub/82-003-x/2014004/article/11924-eng.htm (accessed February 4, 2020).
22. Statistics Canada, "Average Household Out-of-Pocket Expenditures on Health Care as Percentage of After-Tax Income, by Household Income Quintile, Canada Excluding Territories, 1997 to 2009," November 27, 2015, Figure 1, https://www150.statcan.gc.ca/n1/pub/82-003-x/2014004/article/11924/c-g/desc/desc1-eng.htm (accessed February 4, 2020).
23. Edwin L. Weinstein, "Financial Life Stages of Older Canadians," prepared for the Ontario Securities Commission, Spring 2015, www.osc.gov.on.ca/documents/en/Investors/inv_research_20150601_report-life-stages-older.pdf (accessed February 4, 2020).
24. Ashra Kolhatkar et al., "Patterns of Borrowing to Finance Out-of-Pocket Prescription Drug Costs in Canada: A Descriptive Analysis," *Canadian Medical Association Journal Open*, Vol. 6, No. 4 (November 19, 2018), http://cmajopen.ca/content/6/4/E544.full (accessed February 4, 2020).
25. Brett Skinner and Mark Rovere, "Health Insurance and Bankruptcy Rates in Canada and the United States," Fraser Institute *Fraser Alert*, July 2009, https://www.fraserinstitute.org/sites/default/files/HealthInsuranceandBankruptcyRates.pdf (accessed February 14, 2020)
26. Angela Redish, Janis Sarra, and Margaret Schabas, "Growing Old Gracefully, An Investigation into the Growing Number of Bankrupt Canadians over Age 55," research project funded by the Office of the Superintendent of Bankruptcy, March 31, 2006, https://www.ic.gc.ca/eic/site/bsf-osb.nsf/vwapj/Redish-Sarra-Schabas-2006-ENG.pdf/$FILE/Redish-Sarra-Schabas-2006-ENG.pdf (accessed February 4, 2020).
27. Carlos Dobkin et al., "Myth and Measurement—The Case of Medical Bankruptcies," *The New England Journal of Medicine*, Vol. 378, No. 12 (2018), http://economics.mit.edu/files/14892 (accessed February 4, 2020).
28. Organization for Economic Co-operation and Development, "Tax Wedge Decomposition," https://stats.oecd.org/Index.aspx?DataSetCode=TXWDECOMP# (accessed February 4, 2020). Calculator set to family with two children and one earner.
29. For the average 2019 Canada Pension Plan (CPP) payment, see Government of Canada, "CPP Retirement Pension: How Much You Could Receive," https://www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-benefit/amount.html (accessed February 4, 2020). For a discussion on, and average of, Canada's Old Age Security (OAS), see Lisa MacColl, "CPP Pay Dates: How Much CPP Will I Get?" Wealthsimple, 2020, https://www.wealthsimple.com/en-ca/learn/how-much-cpp-retirement (accessed February 4, 2020). The U.S. average Social Security payment in 2019 was $1,470 per month: Center on Budget and Policy Priorities, "Policy Basics: Top Ten Facts About Social Security," August 14, 2019, https://www.cbpp.org/research/social-security/policy-basics-top-ten-facts-about-social-security (accessed February 4, 2020).
30. Organization for Economic Co-operation and Development, "Revenue Statistics 2019: Tax Revenue Trends in the OECD," 2019, https://www.oecd.org/tax/tax-policy/revenue-statistics-highlights-brochure.pdf (accessed February 5, 2020).
31. Ibid.
32. Canadian Institute for Health Information, "National Health Expenditure Trends, 1975 to 2018."

33. Bacchus Barua, Milagros Palacios, and Joel Emes, "The Sustainability of Health Care Spending in Canada 2017," Fraser Institute, March 14, 2017, https://www.fraserinstitute.org/studies/sustainability-of-health-care-spending-in-canada-2017 (accessed February 14, 2020).
34. Fraser Institute, "Canadian Health Care Insurance Isn't Free. Here's What You Pay," 2017, https://www.fraserinstitute.org/file/price-of-public-health-care-insurance-2017-infographicjpg (accessed February 5, 2020).
35. Christina D. Romer and David H. Romer, "The Macroeconomic Effects of Tax Changes: Estimates Based on a New Measure of Fiscal Shocks," NBER *Working Paper* No. 13264, July 2007, https://www.nber.org/papers/w13264 (accessed February 5, 2020).
36. The World Bank, "GDP per Capita (current US$)," 1960–2018, https://data.worldbank.org/indicator/NY.GDP.PCAP.CD (accessed February 5, 2020).
37. Josh Katz, Kevin Quealy, and Margot Sanger-Katz, "Would 'Medicare for All' Save Billions or Cost Billions?" *The New York Times*, October 16, 2019, http://nytimes.com/interactive/2019/04/10/upshot/medicare-for-all-bernie-sanders-cost-estimates.html?mtrref=www.google.com&gwh=A3476181BECA1ED751C283803C1DF4ED&gwt=pay&assetType=REGIWALL (accessed February 14, 2020).
38. Charles Blahous, "The Costs of a National Single-Payer Healthcare System," Mercatus Center *Working Papers* July 30, 2018, https://www.mercatus.org/publications/government-spending/costs-national-single-payer-healthcare-system (accessed February 4, 2020).
39. Chad Reese, "Medicare for All: $32 Trillion in New Costs or $2 Trillion in Savings?" *The Bridge*, Mercatus Center, August 9, 2018, https://www.mercatus.org/bridge/commentary/medicare-all-32-trillion-new-costs-or-2-trillion-savings (accessed February 6, 2020), and Chris Conover, "The #1 Reason Elizabeth Warren's Medicare-for-All Plan Is A Singularly Bad Idea," *Forbes*, November 25, 2019, https://www.forbes.com/sites/theapothecary/2019/11/25/the-1-reason-elizabeth-warrens-medicare-for-all-plan-is-a-singularly-bad-idea/#55feb8f41ed9 (accessed February 6, 2020).
40. Bacchus Barua and David Jacques, "Waiting Your Turn: Wait Times for Health Care in Canada," Fraser Institute, December 2018, https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2018.pdf (accessed February 6, 2020).
41. Canadian Institute for Health Information, "How Canada Compares: Results from the Commonwealth Fund's 2017 International Health Policy Survey of Older Adults in 11 Countries—Data Tables," Question 22, February 8, 2018, https://secure.cihi.ca/estore/productFamily.htm?pf=PFC3650&lang=en&media=0 (accessed February 6, 2020).
42. Merrit Hawkins, "2017 Survey of Physician Appointment Wait Times," September 22, 2017, pp. 5, 18, and 20, https://www.merritthawkins.com/news-and-insights/thought-leadership/survey/survey-of-physician-appointment-wait-times/ (accessed February 14, 2020).
43. Bacchus Barua and Sazid Hasan, "The Private Cost of Public Queues for Medically Necessary Care, 2018," Fraser Institute *Bulletin*, May 2018, https://www.fraserinstitute.org/sites/default/files/private-cost-of-public-queues-2018.pdf (accessed February 14, 2020).
44. Overall, 15 percent of Canadians did not have a regular health care provider in 2017. Statistics Canada, "Primary Health Care Providers, 2017," Health Fact Sheets, February 21, 2019, https://www150.statcan.gc.ca/n1/pub/82-625-x/2019001/article/00001-eng.htm (accessed February 6, 2020), and Robert E. Moffit and Meridian Baldacci, "Why Single-Payer Would Make Health Care Worse for Americans," Heritage Foundation *Commentary*, September 26, 2018, https://www.heritage.org/health-care-reform/commentary/why-single-payer-would-make-health-care-worse-americans.
45. Sonja Puzic, "'It's Insane': Ont. Patient Told She'd Have to Wait 4.5 Years to See Neurologist," CTV News, November 2, 2017, https://www.ctvnews.ca/health/it-s-insane-ont-patient-told-she-d-have-to-wait-4-5-years-to-see-neurologist-1.3661114 (accessed February 6, 2020).
46. Ariane Krol, "Le supplice de la liste" (The Torture of the List), in French, *La Presse*, December 6, 2018, https://www.lapresse.ca/debats/editoriaux/ariane-krol/201812/05/01-5206946-le-supplice-de-la-liste.php (accessed February 14, 2020).
47. Pamela Fayerman, "A Public Health System that Failed a Canadian Boy: The Saga of Walid Khalfallah," *Vancouver Sun*, November 18, 2012, https://vancouversun.com/news/staff-blogs/a-public-health-system-that-failed-a-canadian-boy-the-sad-saga-of-walid-khalfalla (accessed February 6, 2020).
48. Barua and Jacques, "Waiting Your Turn: Wait Times for Health Care in Canada."
49. Feixue Ren and Yanick Labrie, "Leaving Canada for Medical Care, 2017," Fraser Institute, June 29, 2017, https://www.fraserinstitute.org/studies/leaving-canada-for-medical-care-2017 (accessed February 6, 2020).

50. Colin Craig, "The Flight of the Sick," Second Street *Policy Brief*, March 2019, https://www.secondstreet.org/wp-content/uploads/2019/04/Policy-Brief-Flight-of-the-Sick.pdf (accessed February 6, 2020). For perspective: There are 3 million hospital admissions per year in all of Canada: Canadian Institute for Health Information, "Hospital Stays in Canada," April 25, 2019, https://www.cihi.ca/en/hospital-stays-in-canada (accessed February 6, 2020).
51. Ren and Labrie, "Leaving Canada for Medical Care, 2017."
52. Fiona Tapp, "Why Canadians Are Increasingly Seeking Medical Treatment Abroad," *Huffpost*, June 29, 2017, https://www.huffpost.com/entry/canadian-medical-tourism_n_5949b405e4b0db570d3778ff (accessed February 6, 2020).
53. Craig, "The Flight of the Sick," and Randi Druzin, "Crossing the Border for Care," *U.S. News & World Report*, August 3, 2016, https://www.usnews.com/news/best-countries/articles/2016-08-03/canadians-increasingly-come-to-us-for-health-care (accessed February 6, 2020).
54. Luigi Siciliani and Jeremy Hurst, "Explaining Waiting Times Variations for Elective Surgery across OECD Countries," *OECD Health Working Paper* No. 7, October 7, 2003, https://www.oecd.org/els/health-systems/17256025.pdf (accessed February 6, 2020).
55. Marcel Boyer and Julie Frappier, "Medical Specialists in Quebec: How to Unlock the Reserve Supply," Montreal Economic Institute *Economic Note*, April 2009, https://www.iedm.org/files/avril09_en.pdf (accessed February 6, 2020). For a recent case involving a grey-market surgery clinic, see Laura Kane, "Private Medical Clinics Win Injunction Against B.C. Law that Banned Them," CTV News, November 23, 2018, https://www.ctvnews.ca/canada/private-medical-clinics-win-injunction-against-b-c-law-that-banned-them-1.4190549 (accessed February 6, 2020).
56. ElizabethWarren.com, "Plans: Ending the Stranglehold of Health Care Costs on American Families," 2019, https://elizabethwarren.com/plans/paying-for-m4a (accessed February 6, 2020).
57. Physicians for a National Health Program, "Understanding the Medicare for All Act of 2019."
58. University of British Columbia, "Evidence and Perspectives on Funding Healthcare in Canada," https://healthcarefunding.ca/key-issues/current-funding/ (accessed February 6, 2020).
59. Ibid.
60. Robert Book, "Veterans Health Administration: A Preview of Single-Payer Health Care," American Action Forum, June 2, 2014, https://www.americanactionforum.org/research/veterans-health-administration-a-preview-of-single-payer-health-care/ (accessed February 6, 2020).
61. Michel Kelly-Gagnon, "Reasons to Resist a National Pharmacare Monopoly," *National Post*, October 8, 2019, https://www.iedm.org/fr/reasons-to-resist-a-national-pharmacare-monopoly/ (accessed February 7, 2020).
62. Bradley Sawyer and Nolan Sroczynski, "How Do U.S. Health Care Resources Compare to Other Countries?" Peterson–Kaiser Family Foundation Health System Tracker, September 30, 2016, https://www.healthsystemtracker.org/chart-collection/u-s-health-care-resources-compare-countries/ (accessed February 7, 2020).
63. Ibid.
64. Barua and Jacques, "Waiting Your Turn: Wait Times for Health Care in Canada."
65. Bacchus Barua, Sazid Hasan, and Ingrid Timmermans, "Comparing Performance of Universal Health Care Countries, 2017," Fraser Institute, 2017, https://www.fraserinstitute.org/sites/default/files/comparing-performance-of-universal-health-care-countries-2017.pdf (accessed February 7, 2020).
66. Peter St. Onge and Germain Belzile, "Pharmaceuticals: Life-Saving Benefits that Pay for Themselves," Montreal Economic Institute, February 5, 2020, https://www.iedm.org/pharmaceuticals-life-saving-benefits-that-pay-for-themselves/ (accessed February 14, 2020).
67. Ali Shajarizadeh and Aidan Hollis, "Delays in the Submission of New Drugs in Canada," *Canadian Medical Association Journal*, Vol. 187, No. 1 (January 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4284192/ (accessed February 7, 2020), and Canadian Health Policy Institute, "Coverage of New Medicines in Private Versus Public Drug Plans in Canada 2009–2018," *Annual Report*, https://www.canadianhealthpolicy.com/products/coverage-of-new-medicines-in-private-versus-public-drug-plans-in-canada-2009-2018.html (accessed February 7, 2020).
68. Eric C. Schneider et al., "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care," The Commonwealth Fund, July, 2017, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2017_jul_schneider_mirror_mirror_2017.pdf (accessed February 7, 2020).

69. Steven Globerman, Bacchus Barua, and Sazid Hasan, "The Supply of Physicians in Canada: Projections and Assessment," Fraser Institute, January 18, 2018, https://www.fraserinstitute.org/sites/default/files/supply-of-physicians-in-canada.pdf (accessed February 7, 2020).
70. Sawyer and Sroczynski, "How Do U.S. Health Care Resources Compare to Other Countries?"
71. "Doctor Shortage 'Critical,'" *The Guardian*, September 25, 2003, https://www.theguardian.pe.ca//news/local/doctor-shortage-critical-278242/ (accessed February 7, 2020).
72. Marcel Boyer and Julie Frappier, "Medical Specialists in Quebec: How to Unlock the Reserve Supply," Montreal Economic Institute *Economic Note*, April 2009, https://www.iedm.org/files/avril09_en.pdf (accessed February 14, 2020).
73. Jasmin Guénette and Patrick Déry, "Slashing Med School Admissions Isn't How You Deal with a Doctor Shortage," Ideas for a More Prosperous Society, March 19, 2018, https://www.iedm.org/78401-slashing-med-school-admissions-isnt-how-you-deal-doctor-shortage/ (accessed February 7, 2020).
74. Organization for Economic Co-operation and Development, "Health at a Glance 2017: OECD Indicators," p. 95, chart 5.10, https://www.oecd-ilibrary.org/docserver/health_glance-2017-en.pdf (accessed February 14, 2020).
75. Sandra Banner and Hamilton Spectator, "The Solution for Canada's Doctor Shortage Is Abroad," *The Hamilton Spectator*, November 28, 2018, https://www.thespec.com/opinion-story/9055996-the-solution-for-canada-s-doctor-shortage-is-abroad/ (accessed February 7, 2020); Breanna Karstens-Smith, "'It's a Crisis': Patients in Need of Family Doctor Wait Hours in Line," CTV News Vancouver, July 4, 2018; Glen Whiffen and Nancy King, "Atlantic Canada Needs More Doctors: Where Are They?" *The Chronicle Herald*, January 25, 2019.
76. Schneider et al., "Mirror, Mirror 2017."
77. Canadian Institute for Health Information, "How Canada Compares: Results from the Commonwealth Fund's 2017 International Health Policy Survey of Older Adults in 11 Countries—Data Tables," Question 22.
78. Ibid.
79. Brian H. Rowe et al., "Characteristics of Patients Who Leave Emergency Departments without Being Seen," *Academic Emergency Medicine*, Vol. 13, No. 8 (August 2006), pp. 848–852, https://onlinelibrary.wiley.com/doi/abs/10.1197/j.aem.2006.01.028?sid=nlm%3Apubmed (accessed February 7, 2020).
80. Organization for Economic Co-operation and Development, "Health at a Glance 2017: OECD Indicators," Chart 6.1, p. 101.
81. Fiona MacDonald and Karine Levasseur, "Medical Errors Are Too Common But Patients Are Paving the Way for Change," CBC News, June 22, 2018, https://www.cbc.ca/news/canada/manitoba/opinion-levasseur-macdonald-patient-safety-1.4718545 (accessed February 7, 2020).
82. Vik Adhopia, "Canadian Health Care's 'One Issue per Visit' Problem," CBC News, March 20, 2019, https://www.cbc.ca/news/health/second-opinion-one-problem-visit-1.5061506 (accessed February 7, 2020).
83. Organization for Economic Co-operation and Development, "Surgical Complications" in "Health at a Glance 2017," https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017/surgical-complications_health_glance-2017-37-en (accessed February 14, 2020).
84. Canadian Institute for Health Information, "How Canada Compares: Results from the Commonwealth Fund's 2017 International Health Policy Survey of Older Adults in 11 Countries—Data Tables."
85. Ashley Kirzinger, Cailey Muñana, and Mollyann Brodie, "KFF Health Tracking Poll—January 2019: The Public on Next Steps for the ACA and Proposals to Expand Coverage," Kaiser Family Foundation, January 23, 2019, https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/ (accessed February 7, 2020).

Lessons from the Canadian Health Care System

BACCHUS BARUA *and* STEVEN GLOBERMAN, PHD

1. Margot Sanger-Katz, "What Did Bernie Sanders Learn in His Weekend in Canada?" *The New York Times*, November 2, 2017, https://www.nytimes.com/2017/11/02/upshot/bernie-sanders-went-to-canada-and-learned-a-few-things.html (accessed May 30, 2019).
2. President Trump famously referred to Canada's health care system as "so slow it's catastrophic in certain ways." See Andrew Russell, "Presidential Debate: Trump Calls Canadian Health Care 'Slow' and 'Catastrophic,'" *Global News*, October 11, 2016, https://globalnews.ca/news/2993439/presidential-debate-trump-calls-canadian-healthcare-slow-and-catastrophic/ (accessed May 30, 2019).

3. The CHA defines extra-billing as: "the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province."
4. For a comprehensive overview of cost sharing in other countries, see Steven Globerman, "Select Cost Sharing in Universal Health Care Countries," Fraser Institute, January 21, 2016, https://www.fraserinstitute.org/studies/select-cost-sharing-in-universal-health-care-countries (accessed October 16, 2019).
5. For a primer on activity-based funding, see Canadian Institute for Health Information, "A Primer on Activity-Based Funding," Discussion Paper, October 2010, https://www.cihi.ca/en/primer_activity_based_fund_en.pdf (accessed May 30, 2019).,
6. Edmund F. Haislmaier, "Why Global Budgets and Price Controls Will Not Curb Health Costs," Heritage Foundation *Backgrounder* No. 929, March 8, 1993, https://www.heritage.org/health-care-reform/report/why-global-budgets-and-price-controls-will-not-curb-health-costs.
7. Organization for Economic Co-operation and Development, "Health Care Resources," 2018, https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC (accessed October 30, 2019). Calculations by authors.
8. The provincial prohibition on acquiring private medical insurance was successfully challenged in Quebec in 2005. See Supreme Court of Canada, *Chaoulli v. Quebec*, 2005, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2237/index.do (accessed October 16, 2019).
9. Colin Craig, "The Flight of the Sick: A Closer Look at Waiting Lists and Medical Tourism," Second Street *Policy Brief*, March 2019, https://www.secondstreet.org/wp-content/uploads/2019/04/Policy-Brief-Flight-of-the-Sick.pdf (accessed May 30, 2019).
10. Government of Canada, "Canada Health Act," section 92(7), https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act.html (accessed October 16, 2019).
11. See, for example, the Hospital Insurance and Diagnostic Services Act of 1957 and the Medicare Act of 1966. Odette Madore, "The Canada Health Act: Overview and Options," Government of Canada, June 16, 2003, http://publications.gc.ca/collections/Collection-R/LoPBdP/CIR/944-e.htm (accessed May 30, 2019).
12. For a comprehensive analysis of the CHA, see Jason Clemens and Nadeem Esmail, "First, Do No Harm: How the Canada Health Act Obstructs Reform and Innovation," MacDonald–Laurier Institute, June 2012, https://www.macdonaldlaurier.ca/files/pdf/How-the-Canada-Health-Act-Obstructs-Reform-and-Innovation-June-2012.pdf (accessed May 30, 2019).
13. Canada Health Act, chapter 6, section 3.
14. See Revised Statutes 1985, chapter C-6, section 4; 1995, chapter 17, section 35.
15. Government of Canada, Department of Finance, "Federal Support to Provinces and Territories," 2019, https://www.fin.gc.ca/fedprov/mtp-eng.asp (accessed May 30, 2019).
16. This evolutionary process contrasts with current proposals by "single payer" advocates in the U.S., which would impose a universal government-run health care regime from the federal level.
17. Nadeem Esmail and Bacchus Barua, "Is the Canada Health Act a Barrier to Reform?" The Fraser Institute, 2018, https://www.fraserinstitute.org/sites/default/files/is-the-canada-health-act-a-barrier-to-reform.pdf (accessed May 30, 2019).
18. Ibid.
19. Saskatchewan, which successfully used contracted private clinics to reduce wait times, is a notable exception.
20. For example, a patient named Jacques Chaoulli and his physician successfully challenged Quebec's provincial ban on private medical insurance with the Supreme Court of Canada ruling that such a ban violates the Quebec Charter of Rights. *Chaoulli v. Quebec (Attorney General)*, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2237/index.do (accessed May 30, 2019). However, Quebec's charter is unique to the province, and this ruling does not apply to other provinces. More recently, Dr. Brian Day, former head of the Canadian Medical Association, is challenging British Columbia's provincial restrictions on private health care, which (arguably) go beyond what is required by the CHA. Charter Health, "Canadians Deserve Better Health Care," 2019, https://www.charterhealth.ca/ (accessed May 30, 2019).
21. All conversions to U.S. dollars are made using the Bank of Canada's annual exchange rate for 2018 between the two currencies: 1 USD = 1.2957 CAD. See Bank of Canada, "Annual Exchange Rates," https://www.bankofcanada.ca/rates/exchange/annual-average-exchange-rates/ (accessed October 16, 2019).
22. This works out to about 11.3 percent of Canada's GDP, roughly C$6,839 (U.S. $5,278) per person. Authors' calculations based on National Health Expenditure Trends, 1975 to 2018, Canadian Institute of Health Information, 2018.
23. This ratio has remained relatively stable since 1997. Ibid.

24. Authors' calculations based on 2018 data from the Canadian Institute of Health Information. The Canadian single-payer system does not currently cover outpatient pharmaceuticals and specific services that in total comprise about 30 percent of total health care expenditures in Canada.
25. Authors' calculations based on 2018 data for program spending from provincial budgets in conjunction with provincial-territorial health care spending data from the Canadian Institute of Health Information.
26. These include dentists, denturists, chiropractors, optometrists, massage therapists, osteopaths, physiotherapists, podiatrists, psychologists, nurses, and naturopaths (among others).
27. Authors' calculations based on 2018 data from the Canadian Institute of Health Information.
28. Colleen M. Flood and Tom Archibald, "The Illegality of Private Health Care in Canada," *Canadian Medical Association Journal*, Vol. 164, No. 6 (March 2001), pp. 825–830, https://www.cmaj.ca/content/164/6/825.short (accessed October 16, 2019).
29. Office of the Parliamentary Budget Officer, Federal Cost of a National Pharmacare Program," September 29, 2017, http://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/2017/Pharmacare/Pharmacare_EN_2017_11_07.pdf (accessed October 30, 2019).
30. Bill Casey, "Pharmacare Now: Prescription Medicine Coverage for all Canadians," Report of the Standing Committee of Health, House of Commons, Canada, 2018, https://www.ourcommons.ca/Content/Committee/421/HESA/Reports/RP9762464/hesarp14/hesarp14-e.pdf (accessed May 30, 2019).
31. Milagros Palacios and Bacchus Barua, "The Price of Public Health Care Insurance, 2018," Fraser Institute *Research Bulletin*, August 2018, https://www.fraserinstitute.org/sites/default/files/price-of-public-health-care-insurance-2018.pdf (accessed October 16, 2019).
32. The Fraser Institute used the 2017 OECD classification of countries with "universal" or near-universal health care coverage, which excludes Chile, Greece, Mexico, Poland, the Slovak Republic, and the United States (for not meeting the "universal" criteria). The Fraser Institute also excluded Turkey from the analysis, since Turkey was not classified as a high-income country by the World Bank at the time.
33. The OECD definition of universal coverage—ensuring that essentially 100 percent of the population has health insurance and medically necessary services regardless of ability to pay— is not synonymous with the notion of single-payer (government-financed) health care. Most of the countries classified by the OECD as providing universal coverage or maintaining a universal health care system rely on a combination of government and private insurance.
34. See Bacchus Barua and David Jacques, "Comparing Performance of Universal Health Care Countries, 2018," Fraser Institute, 2018, https://www.fraserinstitute.org/sites/default/files/comparing-performance-of-universal-health-care-countries-2018.pdf (accessed October 16, 2019).
35. Ibid., Table A1, p. 42.
36. Ibid., p. 8.
37. Canada's performance on this indicator must be interpreted with extreme caution. The OECD (2017) notes a number of methodological differences between countries for this indicator—particularly Canada. For more information, please see Barua and Jacques, "Comparing Performance of Universal Health Care Countries, 2018."
38. Ibid., p. 43.
39. Ibid., Table 3, p. 12.
40. Ibid., p. 44.
41. Ibid., Table 4, p. 16.
42. Ibid., p. 45.
43. Ibid., Table 5, p. 21.
44. Ibid., Table 7, p. 24.
45. The Fraser Institute's estimates measure the wait time in two sequential segments. The first segment estimates the time between referral by a general practitioner to consultation with a specialist: 8.7 weeks. The second segment measures the wait from consultation with a specialist to receipt of treatment: an additional 11 weeks. See Bacchus Barua and David Jacques, "Waiting Your Turn: Wait Times for Health Care in Canada, 2018 Report," Fraser Institute, December 4, 2018, https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2018.pdf (accessed October 16, 2019).
46. Brian Day, "The Consequences of Waiting," in Steven Globerman, *Reducing Wait Times for Health Care: What Canada Can Learn from Theory and International Experience* (Vancouver, Canada: Fraser Institute, 2013), https://www.fraserinstitute.org/sites/default/files/reducing-wait-times-for-health-care.pdf (accessed October 29, 2019)

47. Bacchus Barua and David Jacques, "The Private Cost of Public Queues for Medically Necessary Care, 2019," Fraser Institute, March 2019, https://www.fraserinstitute.org/sites/default/files/private-cost-public-queues-medically-necessary-care-2019.pdf (accessed May 30, 2019).
48. Barua and Jacques, "Comparing Performance of Universal Health Care Countries, 2018," p. 33.
49. Ibid., p. 32.
50. Ibid.
51. Ibid.

How "Medicare for All" Harms Working Americans

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1. S. 1129, Medicare for All Act of 2019, 116th Cong., 1st Sess., and H.R. 1384, Medicare for All Act of 2019, 116th Cong., 1st Sess. See also Robert E. Moffit, "Government Monopoly: Senator Sanders' 'Single-Payer' Health Care Prescription," Heritage Foundation *Backgrounder* No. 3261, July 27, 2018, https://www.heritage.org/sites/default/files/2018-08/BG3261.pdf, and Robert E. Moffit, "Total Control: The House Democrats' Single-Payer Health Care Prescription," Heritage Foundation *Backgrounder* No. 3423, July 19, 2019, https://www.heritage.org/sites/default/files/2019-07/BG3423.pdf.
2. Atthar Mirza, "Would Bernie Sanders's Medicare-for-All Save Americans Money?" *The Washington Post*, June 3, 2019, https://www.washingtonpost.com/politics/2019/06/03/would-bernie-sanderss-medicare-for-all-save-americans-money/ (accessed November 4, 2019).
3. No proponent of this idea has provided a complete plan to pay for this proposal. Senator Sanders and Senator Warren have each offered plans to partially fund Medicare for All through combinations of payroll taxes imposed on employers and increased income taxes. We have chosen to model the full tax burden to pay for Medicare for All, and we used a higher payroll tax rate on employees because it is the standard measure for projecting the tax burden of a social insurance program. Moreover, this approach avoids the significant behavioral response effects of other possible tax increases. Additionally, the Committee for a Responsible Federal Budget (CRFB) recently provided several pay-for options. See Committee for a Responsible Federal Budget, "Choices for Financing Medicare for All: A Preliminary Analysis," http://www.crfb.org/papers/choices-financing-medicare-all-preliminary-analysis (accessed October 31, 2019). The CRFB highlights a 32 percent payroll tax split evenly between the employer and the employee, and notes that it would raise the same revenue as a 23 percent payroll tax paid solely by the employee. That latter figure is very similar to what we derived (21.2 percent). We modelled a payroll tax paid solely by the employees because imposing a tax on employers (all or in part) would produce additional adverse effects on cash compensation, employment, and business profitability—particularly for employers with workers near the statutory minimum wage, whose hourly wage cannot be reduced to offset the cost of the new tax. The resulting smaller tax base would, in turn, necessitate even higher tax rates to collect the same amount of revenue.
4. We assume that, should Medicare for All legislation pass, employers will convert funds they spend on health benefits today into higher wages. Appendix A includes a more detailed discussion of this assumption and resulting changes to the tax base.
5. Kenneth E. Thorpe, "An Analysis of Senator Sanders [sic] Single Payer Plan," Emory University, January 27, 2016, https://www.healthcare-now.org/296831690-Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal.pdf (accessed November 4, 2019); Center for Health and Economy, "Medicare for All: Leaving No One Behind," May 1, 2016, http://healthandeconomy.org/wp-content/uploads/2016/05/Medicare_For_All_20160501.pdf (accessed November 4, 2019); John Holahan et al., "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending," Urban Institute *Research Report*, May 9, 2016, https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending (accessed November 4, 2019); Charles Blahous, "The Costs of a National Single-Payer Healthcare System," Mercatus Center *Working Paper*, July 30 2018, https://www.mercatus.org/publications/federal-fiscal-policy/costs-national-single-payer-healthcare-system (accessed November 4, 2019); Jodi L. Liu and Christine Eibner, "National Health Spending Estimates Under Medicare for All," RAND Corporation, 2019, https://www.rand.org/pubs/research_reports/RR3106.html (accessed November 4, 2019); and Linda J. Blumberg et al., "From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs," Urban Institute and The Commonwealth Fund, October 2019, https://

www.urban.org/sites/default/files/2019/10/15/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_options_compare_on_coverage_and_costs.pdf (accessed November 4, 2019).
6. The exception is that Thorpe does offer a general estimate for the level of taxation that would be needed to fund such a program fully.
7. See Appendix A for details.
8. Household work status is significant for two reasons. First, the largest effects would come from shifting the U.S. health system from one that is half privately financed and employment-based to one that is fully government financed and detached from employment. The people who would directly experience that shift are, by definition, in households with workers. Second, we assume that the new taxes to fund a government-run health care program would be imposed exclusively on income from labor. Under that scenario, households with workers would bear the cost through higher taxes, while households without workers, by definition, would not pay higher taxes to fund the new program. It is important to note, however, that under some Medicare for All proposals, some non-working households would pay higher taxes under alternative financing scenarios that relied more on increasing income taxes and less on increasing payroll taxes. See Appendix A for an explanation of our reasons for assuming financing through payroll taxes and a discussion of the results from applying alternative assumptions of partial or full financing through higher income taxes.
9. See Appendix A for a discussion of the results from applying alternative assumptions of partial or full financing through higher income taxes.

Conclusion: The Truth About Government-Controlled Health Care

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1. These estimates do not include current enrollment in the more specialized government health programs, such as the Federal Employees Health Benefits Program (FEHBP), the Veterans Administration health program, Tricare, the Indian Health Service, or the state and local employee and retire health programs.
2. Sean P. Keehan et al., "National Health Expenditures Projections, 2019–28: Expected Rebound in Prices Drives Rising Spending Growth," *Health Affairs*, Vol. 39, No. 4 (April 2020), Exhibit 3, p. 707, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00094 (accessed September 8, 2020).
3. Mark V. Pauly, "Will Health Care's Immediate Future Look a Lot Like the Recent Past?" American Enterprise Institute, June 2019, p. 9, https://www.aei.org/research-products/report/health-care-public-sector-funding/ (accessed September 8, 2020).
4. Rachel Fehr, Rabah Kamal, and Cynthia Cox, "Insurer Participation on ACA Marketplaces 2014–2020," Kaiser Family Foundation *Issue Brief*, November 21, 2019, https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-aca-marketplaces-2014-2020/ (accessed September 8, 2020).
5. Micah Hartman et al., "National Health Care Spending in 2018: Growth Driven by Accelerations in Medicare and Private Insurance Spending," *Health Affairs*, December 5, 2019, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01451?journalCode=hlthaff (accessed December 17, 2019).
6. Representative Jan Schakowsky, Health Care for America Rally, 2009, video, timestamp 5:25, https://www.youtube.com/watch?v=W_MtLyDfXJA&feature=youtu.be&t=327 (accessed June 22, 2020).
7. Charles Blahous, "The Unanswered Questions of Medicare for All," American Enterprise Institute *Economic Perspectives*, February 15, 2019, p. 6, https://www.aei.org/research-products/report/the-unanswered-questions-of-medicare-for-all/ (accessed September 8, 2020).
8. Charles Blahous, "The Costs of a National Single-Payer Healthcare System," Mercatus Center Working Paper, George Mason University, 2018, https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf (accessed September 8, 2020).
9. The 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds, April 22, 2019, p. 180, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf (accessed September 8, 2020).
10. Blahous, "The Unanswered Questions of Medicare for All," p. 5.
11. Linda J. Blumberg, John Holohan, and Michael Simpson, "Don't Confuse Changes in Federal Health Spending with National Health Spending," Urban Institute Urban Wire blog, October 16, 2019, https://www.urban.org/urban-wire/dont-confuse-changes-federal-health-spending-national-health-spending (accessed September 8, 2020).

12. See, for example, Alison P. Galvani et al., "Improving the Prognosis of Health Care in the USA," *The Lancet*, February 15, 2020, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)33019-3/fulltext (accessed September 8, 2020).
13. John Holohan et al. "The Sanders Single payer Health care Plan," Urban Institute *Research Report*, May 2016, https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending (accessed September 8, 2020).
14. Blahous, "The Costs of a National Single-Payer Healthcare System,"
15. The Center for Health and the Economy, "Medicare for All: Leaving No One Behind," May 1, 2016, https://healthandeconomy.org/medicare-for-all-leaving-no-one-behind/ (accessed September 8, 2020).
16. Jodi L. Liu and Christine Eibner, "National health Spending Estimates Under Medicare for All," The Rand Corporation, 2019, https://www.rand.org/pubs/research_reports/RR3106.html (accessed September 8, 2020).
17. The Congressional Budget Office would have to posit a set of assumptions to make reasonable projections for the tax impact of the House and Senate bills because neither contains any tax or financing provisions. In a 2016 version of the House bill (H.R. 676) the legislative text of the financing provisions were so mysterious as to be almost laughable—specifying, for example, that the new national health insurance program would be funded by "small" or "modest" tax increases. Nothing substantive or empirically verifiable.
18. Edmund F. Haislmaier and Jamie Bryan Hall, "How 'Medicare for All' Harms Working Americans," Heritage Foundation *Special Report* No, 218, November 19, 2019, https://www.heritage.org/sites/default/files/2019-11/SR219.pdf.
19. Sally Pipes, "UK's Healthcare Horror Stories Ought to Curb Dems' Enthusiasm for Single Payer," *Forbes*, October 1, 2018, https://www.forbes.com/sites/sallypipes/2018/10/01/u-k-s-healthcare-horror-stories-ought-to-curb-dems-enthusiasm-for-single-payer/#21022c303099 (accessed September 8, 2020).
20. Irene Papanicolas, Liana E. Woskie, and Ashish K. Jha, "Health Spending in the United States and Other High Income Countries," *Journal of the American Medical Association*, March 13, 2018, p. 1032, https://jamanetwork.com/journals/jama/article-abstract/2674671 (accessed September 8, 2020).
21. Ibid., p. 1033.
22. King's Fund, "NICE and Herceptin," Policy Position, November 2005, https://www.kingsfund.org.uk/sites/default/files/Herceptin%20policy%20position.pdf (accessed September 8, 2020).
23. For a comparative analysis of international drug pricing and access, see Doug Badger, "Examination of International Drug Pricing Policies in Selected Countries Shows Prevalent Government Control over Pricing and Restrictions on Access," The Galen Institute, March 2019, Appendix 2, p. 20, https://galen.org/assets/Badger-Report-March-2019.pdf (accessed September 8, 2020).
24. Papanicolas, Woskie, and Jha, "Health Spending in the United States and Other High Income Countries," p. 1032.
25. For an overview of the professional literature, see Kevin Dayaratna, "Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured," Heritage Foundation *Backgrounder No. 2740*, November 9, 2012, https://www.heritage.org/health-care-reform/report/studies-show-medicaid-patients-have-worse-access-and-outcomes-the.
26. For an excellent, detailed discussion of these issues, see Chapter 26 in this book by Louis Brown, "Health Care: The Greatest Pro-Life Political Battle of Our Time." (The original version appeared in *The Public Discourse*, December 2, 2019, https://www.thepublicdiscourse.com/2019/12/58579/ (accessed September 8, 2020).
27. Kevin Pham, "Doctors were Not Meant to Treat Their Computers," The Daily Signal, September 28, 2018, https://www.heritage.org/health-care-reform/commentary/doctors-were-not-meant-treat-their-computers.
28. Kevin Pham, "Medicare for All Will Further Lower Physician Morale," The Daily Signal, August 9, 2019, https://www.dailysignal.com/2019/08/09/medicare-for-all-will-further-lower-physician-morale/.
29. Kevin Pham, "American Health Care Treats Canadians Who Cannot Wait," The Daily Signal, July 15, 2019, https://www.dailysignal.com/2019/07/15/american-health-care-treats-canadians-who-cannot-wait/.

1. Projections become more uncertain the more distant they are from data on actual experience. Also, assuming full implementation avoids the uncertainties and complexity entailed in trying to account for different possible implementation schedules over some period of time.
2. H.R. 1384, Medicare for All Act of 2019, 116th Cong., 1st Sess., and S. 1129, Medicare for All Act of 2019, 116th Cong., 1st Sess.
3. Blumberg et al., "From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs," estimate that a national health program would increase federal spending in 2020 by $2,687 billion—$300 billion more than our estimate of $2,387 billion. The difference appears to be primarily attributable to their projection that increased demand under the program will be $250 billion greater than we assume ($719.7 billion versus $470 billion).
4. Centers for Medicare and Medicaid Services, Office of the Actuary, "NHE Projections 2018–2027," Table 4. Health Consumption Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2011–2027, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html (accessed November 5, 2019). The figures for out-of-pocket spending are reduced by the amounts projected in Table 12. Other Non-Durable Medical Product Expenditures (spending on non-prescription drugs and medical sundries).
5. Congressional Budget Office, "Medicaid—CBO's May 2019 Baseline," https://www.cbo.gov/system/files/2019-05/51301-2019-05-medicaid.pdf (accessed November 8, 2019); "Children's Health Insurance Program—CBO's May 2019 Baseline," https://www.cbo.gov/system/files/2019-05/51296-2019-05-chip.pdf (accessed November 8, 2019); and "Medicare—CBO's May 2019 Baseline," https://www.cbo.gov/system/files/2019-05/51302-2019-05-medicare_0.pdf (accessed November 8, 2019). We adjusted the CBO's fiscal-year figures to calendar-year figures.
6. Thorpe, "An Analysis of Senator Sanders [sic] Single Payer Plan," p. 6, and Liu and Eibner, "National Health Spending Estimates Under Medicare for All."
7. In theory, Congress could try to capture state Medicaid savings either by directly taxing the states, or by eliminating an equivalent amount of other, non-health-related federal transfer payments to states, or by structuring the new program like Medicaid, as a federal-state partnership with federal funding conditioned on states paying part of the costs.
8. Elizabeth Warren, "Paying for Medicare For All," October 2019, https://medium.com/@teamwarren/ending-the-stranglehold-of-health-care-costs-on-american-families-bf8286b13086 (accessed November 5, 2019).
9. 42 U.S. Code § 1396u–5(a) and (c)(1)(C).
10. The estimates in Appendix Table 1 for increased acute care spending are from Blahous, "The Costs of a National Single-Payer Healthcare System," Table 3, which are smaller than those in Holahan et al., Table 5. The estimates in Appendix Table 1 for increased long-term-care spending are from Holahan et al., "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending," Table 9 (updated using data from 2018 NHE, Tables 10 and 13), which are smaller than those in Liu and Eibner, Table 2.
11. Congressional Budget Office, "Medicare—CBO's May 2019 Baseline." We adjusted the CBO's fiscal year figures to calendar-year figures.
12. Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO's May 2019 Projections," May 2, 2019, https://www.cbo.gov/system/files/2019-05/51298-2019-05-healthinsurance.pdf (accessed November 5, 2019). We adjusted the CBO's fiscal year figures to calendar-year figures.
13. H.R. 1384 § 107 and S. 1129 § 107.
14. Authors' calculations based on Congressional Budget Office, "CBO's 2019 Long-Term Projections for Social Security: Additional Information," Tables A-1 and A-2, September 12, 2019, https://www.cbo.gov/publication/55590 (accessed November 5, 2019).
15. Consensus academic analysis supports the view that employer-sponsored insurance offers reflect aggregate employee preferences to receive some portion of their compensation in this form and that the costs to the employer of providing this insurance are fully passed through to employees in the form of reduced wages. See, for example, Jonathan Gruber, "The Tax Exclusion for Employer-Sponsored Health Insurance," *National Tax Journal*, Vol. 64, No. 2 (2011), pp. 511–530, http://www.ntanet.org/NTJ/64/2/ntj-v64n02p511-30-tax-exclusion-for-employer.pdf (accessed October 30, 2019), and Jonathan Gruber, "Taxes and Health Insurance," *Tax Policy and the Economy*, Vol. 16 (2002), https://www.nber.org/chapters/c10862.pdf (accessed October 30, 2019). Three of

the studies estimating the cost of Medicare for All explicitly reference this standard expectation that employer spending on private health insurance would be converted into additional income (or other benefits) to employees. See Blahous, "The Costs of a National Single-Payer Healthcare System," p. 19; Thorpe, "An Analysis of Senator Sanders [sic] Single Payer Plan," p. 4; and Holahan et al., "The Sanders Single-Payer Health Care Plan," p. 24.

16. "Bernie will require that resulting healthcare savings from union-negotiated plans result in wage increases and additional benefits for workers during the transition to Medicare for All." See "The Workplace Democracy Plan," Bernie 2020, https://berniesanders.com/issues/the-workplace-democracy-plan/ (accessed November 5, 2019). Such a requirement applied to unionized workers would create competitive pressures for other employers to raise wages in a similar manner.
17. The CBO does not publish specific estimates of either the total Medicare tax base or of the amount of self-employment income subject to Medicare taxes. We estimated the total Medicare tax base by dividing the CBO's forecast of Medicare tax revenues by the statutory tax rate of 2.9 percent. We then subtracted from the resulting estimate of the Medicare tax base the CBO's baseline forecast of total wage and salary income. The result is an estimate of the amount of self-employment income subject to Medicare taxes, or in other words, the amount of self-employment labor-income.
18. Authors' projection derived by applying the 2017 ratio of total spending (employer and employee) on employer-sponsored health insurance to total spending on all private health insurance to future years, using data from: Centers for Medicare and Medicaid Services, "NHE Historical Tables, Calendar Years 1987–2017," Tables 21 and 24, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (accessed November 5, 2019).
19. Thorpe, "An Analysis of Senator Sanders [sic] Single Payer Plan," pp. 1 and 5 estimated a tax burden of 20 percent of income. Unlike the legislation used as the basis for our analysis, the earlier version of the proposal modeled by Thorpe did not include coverage for long-term-care services. The CRFB, "Choices for Financing Medicare for All: A Preliminary Analysis," estimated a 23 percent payroll tax if the tax was paid entirely by workers—the same parameter that we applied in our analysis.
20. The CBO projects that, under current law, federal debt will continue to grow relative to GDP—that is, faster than the economy—for the indefinite future. "Federal debt held by the public is projected to reach $16.6 trillion at the end of 2019. Relative to the size of the economy, that amount—at 78 percent of GDP—would be nearly twice its average over the past 50 years. By 2029, debt is estimated to reach $28.7 trillion, or 93 percent of GDP—a higher level than at any time since just after World War II. It would continue to grow after 2029, reaching about 150 percent of GDP by 2049." Congressional Budget Office, *The Budget and Economic Outlook: 2019 to 2029*, January 2019, p. 2, https://www.cbo.gov/publication/54918 (accessed November 8, 2019). Moreover, public health care programs and Social Security are the main drivers of the unsustainable federal budget. See Paul Winfree, "Causes of the Federal Government's Unsustainable Spending," Heritage Foundation *Backgrounder* No. 3133, July 7, 2016, https://www.heritage.org/budget-and-spending/report/causes-the-federal-governments-unsustainable-spending.
21. See the discussion of the effects of imposing payroll taxes on employers in Committee for a Responsible Federal Budget, "Choices for Financing Medicare for All: A Preliminary Analysis," p. 3.
22. It is unlikely that all states would cut their taxes in response, and it is even more unlikely that the states that did respond by cutting taxes would do so dollar for dollar to match the reductions in state spending exactly. Consequently, our assumption makes households appear somewhat better off than they would likely be under a Medicare for All program. If, however, we assume that states do not reduce taxes, we must make highly speculative assumptions regarding how they spend the revenues and regarding the effects of those decisions on household finances.
23. As noted, both S. 1804 and H.R. 676 would redirect all current federal spending on health coverage programs into paying for the new program. Thus, this analysis assumes that the current payroll tax of 2.9 percent on all wages that is now dedicated to funding Medicare Part A would remain in place to fund the new program, though presumably the tax would be renamed and the rate increased.
24. Senator Bernie Sanders, "Options to Finance Medicare for All," undated, https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all (accessed October 10, 2019).
25. After adjusting for the conversion of employer-sponsored insurance to taxable income, we project that total adjusted gross income (AGI) for calendar year 2020 will be $13,859 billion, of which taxable income (AGI minus deductions) will be $9,813 billion, and that the payroll tax base will be $11,274 billion. Thus, the payroll tax base (wages and salaries) comprises 81 percent of the personal income tax base (AGI), but because of standard and itemized deductions, only 70 percent of the income tax base is actually taxed.

26. Committee for a Responsible Federal Budget, "Choices for Financing Medicare for All: A Preliminary Analysis," pp. 3 and 4.
27. Total compensation includes any employer-paid share of payroll taxes and the value of any fringe benefits that are not included in employee taxable income.
28. Tax Policy Center, "Effective Federal Tax Rates—All Tax Units, by Expanded Cash Income Income [sic] Percentile, 2017," preliminary results, T18-0081, August 23, 2018, https://www.taxpolicycenter.org/file/178967/download?token=hbWelEY8 (accessed November 5, 2019).
29. Institute on Taxation and Economic Policy, *Who Pays? A Distributional Analysis of the Tax Systems in All 50 States*, 6th ed., October 2018, https://itep.org/whopays/ (accessed July 11, 2019).
30. U.S. Census Bureau, "2019 Quarterly Summary of State & Local Tax Revenue Tables," Table 1. "National Totals of State and Local Tax Revenue, by Type of Tax, 2019," 2019, https://www.census.gov/data/tables/2019/econ/qtax/historical.html (accessed July 24, 2019).
31. H.R. 676 § 202.
32. S. 1804 § 611. See also Charles Blahous, "The Costs of Medicare for All Are Rising Already," E21 Blog, The Manhattan Institute, August 26, 2019, https://economics21.org/medicare-for-all-costs-rising-already (accessed November 5, 2019).
33. Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2018, p. 115, http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0 (accessed November 5, 2019), and American Hospital Association, "TrendWatch Chartbook 2018," Table 4.4, "Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1995–2016," https://www.aha.org/system/files/2018-05/2018-chartbook-table-4-4.pdf (accessed November 5, 2019).
34. Holahan et al., "The Sanders Single-Payer Health Care Plan," assume hospital payment rates at 100 percent of cost "because Medicare hospital payment rates are estimated to be 89 percent of costs, on average." Thorpe, "An Analysis of Senator Sanders [sic] Single Payer Plan," specifies: "Since private insurance pays providers above treatment costs and Medicare and Medicaid pay below, we assume that a blended payment rate would be at 105% of costs." Liu and Eibner, "National Health Spending Estimates Under Medicare for All" scored the House bill, which would pay hospitals based on global budgets, and they assumed payments at a level equal to an "all-payer average" of current rates, which equates to "124 percent of current Medicare rates for hospital payments and 107 percent of current Medicare rates for physician payment."
35. Blahous, "The Costs of a National Single-Payer Healthcare System," pp. 10–13 and Table 3, estimates that paying providers at Medicare rates, as implied by the Senate bill, could theoretically reduce the cost of the program by $337 billion in 2020, but noted that "it is not precisely predictable how hospitals, physicians, and other healthcare providers would respond to a dramatic reduction in their reimbursements under M4A, well below their costs of care for all categories of patients combined." Yet, even that big a reduction in provider payments would only lower the projected amount of new federal spending by 14 percent (from $2,387 billion to $2,050 billion) and the associated payroll tax rate by three percentage points (from 21.2 percent to 18.2 percent).
36. Vilsa Curto et al., "Healthcare Spending and Utilization in Public and Private Medicare," *American Economic Journal: Applied Economics*, Vol. 11, No. 2 (2019), pp. 1–31, https://scholar.harvard.edu/vcurto/publications/health-care-spending-and-utilization-public-and-private-medicare (accessed November 5, 2019).
37. Blahous, "The Costs of a National Single-Payer Healthcare System," pp. 14–16; Holahan et al., "The Sanders Single-Payer Health Care Plan," p. 9; and Liu and Eibner, "National Health Spending Estimates Under Medicare for All." Blahous notes that "this is an aggressive estimate of administrative savings." Holahan et al. state: "We do not believe that administrative costs can fall far below this level; far too many administrative functions must be conducted."
38. Blahous, "The Costs of a National Single-Payer Healthcare System," Table 3.
39. Katharine London et al., "State of Vermont Health Care Financing Plan Beginning Calendar Year 2017 Analysis," *Commonwealth Medicine Publications*, January 24, 2013, Table 42, p. 64, https://escholarship.umassmed.edu/commed_pubs/76/ (accessed November 5, 2019).
40. Jodi L. Liu et al., "An Assessment of the New York Health Act: A Single-Payer Option for New York State," RAND Corporation, 2018, https://www.rand.org/pubs/research_reports/RR2424.html (accessed November 5, 2019).
41. Association for Accessible Medicines, "Generic Drug Access & Savings in the U.S," 2018, https://accessiblemeds.org/sites/default/files/2018_aam_generic_drug_access_and_savings_report.pdf (accessed November 5, 2019).
42. Blahous, "The Costs of a National Single-Payer Healthcare System," pp. 13 and 14 and Table 3.

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