Statement of Charles P. Blahous[1]

Before the U.S. House of Representatives Committee on Rules

April 30, 2019

Thank you, Chairman McGovern, Ranking Member Cole, and all of the members of the committee. I appreciate this opportunity to appear before you to discuss the estimated federal budget costs of enacting Medicare for All (M4A).

My testimony is based on research performed last year to estimate the cost of a specific bill from the 115th Congress, the Medicare for All Act of 2017 introduced by Senator Bernie Sanders (I-VT). Let me begin with a few caveats before summarizing these estimates and the assumptions that underlie them. The first caveat is that while there are strong similarities between Representative Jayapal's bill that is the subject of this hearing, and the Sanders bill that I analyzed, I have not developed estimates for the Jayapal bill, nor have I analyzed the revised Medicare for All bill introduced by Senator Sanders in the current Congress. Cost estimates for these current bills are expected to be somewhat higher due to their additions of long-term care benefits, but I can only provide quantitative estimates for the previous Sanders bill that I analyzed.

Second, the narrow purpose of this research was to estimate the federal budget costs of enacting M4A. The study does not offer opinions on whether such legislation would be good or bad policy, nor does it engage various important value judgments or difficult health policy calls that must be made in the course of any comprehensive health care legislation. While the study (as well as this testimony) does describe possible effects of various policy decisions associated with implementing M4A, it does so only to illuminate how the numerical estimates might be affected by them.

Third, although various incarnations of these proposals have titles that include the phrase "Medicare for All," the federal health care systems they would establish differ from current Medicare in fundamental ways. Instead of extending the current Medicare program to the population as a whole, these bills would move all Americans, including seniors currently on Medicare, into a new system offering different (generally more generous) benefits, while doing away with many of Medicare's current financing mechanisms such as patient deductibles and copays. Accordingly, while these estimates pertain to a specific bill known as M4A, I have not attempted to analyze an actual expansion of eligibility for traditional Medicare. Nor have I analyzed any of various proposals to allow other individuals to buy into the current Medicare program.

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Cost Estimates

The additional federal costs of enacting the Medicare for All Act of 2017 would likely be somewhere within the range of $32.6-$38.8 trillion over its first ten years of full implementation, which at the time the study was conducted would be 2022-2031. The $32.6 trillion projection was presented in the paper as a lower-bound estimate, representing an unlikely scenario in which the provisions of M4A that are intended to lower costs all produce the full amount of their potential savings, without regard for any accompanying adverse effects this might have on health care access, timeliness or quality. Alternatively, if after M4A's enactment, historical patterns of federal government behavior remained more consistent with past practice, the new federal costs would be closer to $38.8 trillion over the first ten years.

Such enormous numbers are difficult to grasp, and these particular numbers also appear especially large because they extend out to 2031. To provide context, the study also translates them into a share of GDP. The $32.6 trillion estimate equates to an addition to federal budget costs of roughly 10.7% of GDP in 2022, gradually increasing to 12.7% of GDP in 2031, and growing further afterward. If instead, new federal costs were $38.8 trillion over ten years, federal obligations would be increased by 12.6% in 2022 and by 15.1% in 2031, also growing larger over subsequent time. We have no experience with enacting federal cost assumptions of this magnitude, which renders these numbers especially difficult for many to conceptualize. To illustrate the general size of the cost increase, the study notes that even under the lower-bound estimate of $32.6 trillion, a doubling of all currently projected federal individual and corporate income taxes would be insufficient to finance the added federal costs of enacting M4A.

Table 1: Projected Federal Cost Increases under M4A

Scenario	**New Federal Costs, 2022-31 ($T)**	**New Federal Costs, 2022 (% of GDP)**	**New Federal Costs, 2031 (% of GDP)**
Lower-bound estimate	$32.6 T	10.7%	12.7%
Estimate assuming continuity in provider + drug payments	$38.8 T	12.6%	15.1%

It is especially important to understand that these estimates do not reflect the total federal costs of M4A, but rather just its addition to federal costs above and beyond currently projected federal health care outlays and tax subsidies, which include Medicare, Medicaid, the tax subsidy for employer-sponsored health insurance, Affordable Care Act exchange subsidies, and other health programs. The total projected federal costs under M4A would be substantially higher than the net cost increases shown in Table 1, with federal obligations for M4A being somewhere within the range of $54.6 trillion and $60.7 trillion over the first ten years. Under the lower-bound estimate, federal spending on M4A alone would be 20.8% of GDP by 2031. 20.8% of GDP also equals the total amount of all current federal spending projected for 2019 by the Congressional Budget Office. Further, these figures do not account for all national health-related spending under the M4A bill, as

for example they exclude long-term care spending that would remain the responsibilities of individuals and state governments.

Factors Affecting the Cost Estimates

The vast majority of new federal costs under M4A would result from the federal government's assuming responsibility for most national health spending currently financed by other entities, including private insurance, state and local governments, and individuals. By itself, and before considering possible offsetting savings, M4A's expansion of coverage while shifting from privately-financed to federally-financed insurance would not only cause federal budget obligations to increase, but national health expenditures as well. This is partially because of increased expenditures on health services for the currently uninsured, and partially because of M4A's coverage of some services not now covered by traditional Medicare, such as dental, vision and hearing benefits. Additional expenditure increases would also occur because M4A would offer complete first-dollar coverage of all individuals' health services, unlike traditional Medicare and most current private insurance. It is well established in the economics literature that the more of an individual's health services that are covered by insurance, the more they tend to consume, irrespective of the services' efficacy or value. M4A's first-dollar coverage of health services would therefore fuel substantial additional demand. As the study explains in greater detail:

> "Finally, the plan's requirement that "no cost-sharing, including deductibles, coinsurance, copayments, or similar charges, be imposed on an individual" would also significantly increase healthcare utilization. As a general rule, the greater the percentage of an individual's healthcare that is paid by insurance (i.e., the insurance's actuarial value, or AV), the more healthcare services an individual tends to buy. There is an extensive literature devoted to estimating how much individuals increase their use of healthcare as the AV of their insurance increases—which, in the case of M4A, would be to an AV of essentially 100 percent. Providing this first-dollar coverage is estimated to induce 11 percent additional demand for those currently covered by private insurance and 16 percent for those now in traditional Medicare without supplemental coverage."

The M4A bill seeks to offset these additional costs through various means. One is through the replacement of private health insurance by a federally-administered system that sponsors intend to have lower administrative costs. The study makes an aggressive assumption that over half of the administrative costs currently borne by private insurance would be eliminated. These assumed administrative cost savings would offset roughly 4% of the additional federal costs arising from the federal government's becoming the financier of nearly all US health care. For another comparison, these assumed administrative cost savings would offset roughly 28% of the additional national health spending expected to arise from increased health service demand under M4A. In other words, health insurance administrative costs would be lowered, but this would offset only a fraction of the additional national health expenditures projected as a result of M4A's expanded and enhanced coverage.

Another means by which M4A would attempt to contain costs is by having the Secretary of Health and Human Services negotiate drug prices with a particular emphasis on replacing brand-name medications with less expensive generics. To understand the cost projections, it is important to distinguish between potential savings and likely savings. 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.

History provides reason for skepticism that this level of savings would actually be achieved. Historically the federal government has tended to prioritize health benefits for those dependent on federal programs over the interests of taxpayers in restraining cost growth. Though it is theoretically possible that under M4A the federal government would switch its emphasis from allowing patients full access to the fruits of pharmaceutical and other health care innovation, to protecting the interests of taxpayers through cost containment, the political economy incentives under M4A make this unlikely. Under M4A, the lack of deductibles, copayments and cost-sharing would largely eliminate consumer (and thus voter) sensitivity to health care prices, including drug prices. Dramatic drug price savings under M4A should therefore be considered an aspirational goal rather than the basis for an intermediate cost projection. This is one of multiple reasons why actual costs under M4A would likely exceed the study's lower-bound projection scenario.

The most significant variable affecting M4A cost projections is that of provider payment rates. The study's lower-bound projection assumes that all provider payment rates would immediately be set to Medicare rates, which are roughly 40% lower than private insurance rates over the time window in the study, with the exact percentage reduction varying by year and by type of provider. Other studies performed before the introduction of the Sanders bill assumed that higher payment rates than this would be required, because Medicare payment rates are substantially below providers' reported costs of providing services. The CMS Medicare actuary, for example, projected at the time of the study that 80% of hospitals would experience negative margins in 2019 when treating Medicare patients, a situation M4A would extend to the population as a whole. See Figures 1 and 2, reproduced from a memorandum from the CMS Medicare actuary's office.[2]

[2] The figures shown here are reproduced from CMS Office of the Actuary, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2018TRAlternativeScenario.pdf. These figures from the 2018 memorandum were chosen for inclusion here because they illustrate data cited in the study. CMS has recently published a 2019 update of these figures that is broadly similar.

Figure 1: CMS Medicare Actuary Comparisons of Hospital Payment Rates

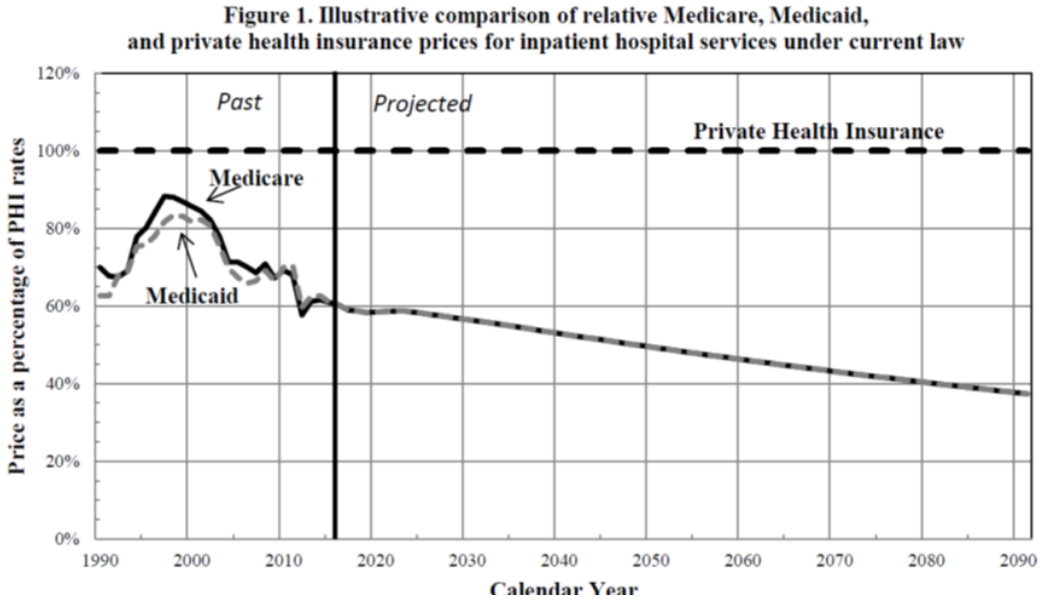
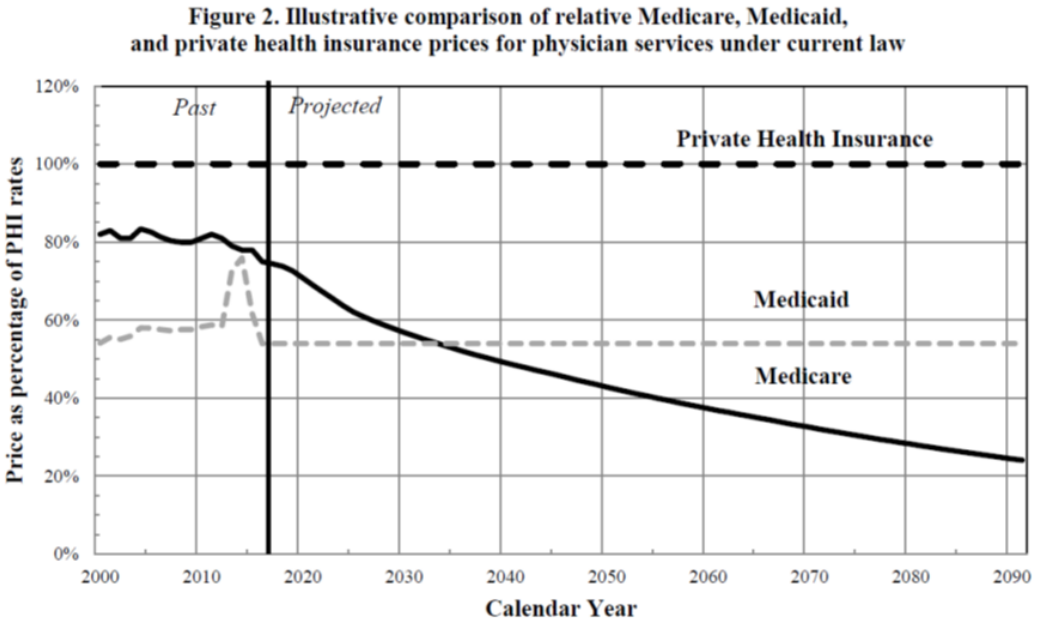


Figure 2: CMS Medicare Actuary Comparisons of Physician Payment Rates



We do not know how providers would respond to payment reductions of this magnitude for treatments now covered by private insurance, concurrent with a simultaneous increase in patient demand for health services under M4A. It is likely that there would be some disruptions in the availability, timeliness and quality of health care services, but no one can say what they would be. The study does not attempt to model the extent to which the supply of health care services may be

insufficient to meet expanded demand under M4A. In a scenario of insufficient supply, the amount of services would be lower than projected, but prices per service would increase.

For the purpose of producing accurate cost estimates, the relevant question is whether Medicare payment rates or higher payment rates are more likely to be implemented. The study's lower-bound estimates assume the universal application of Medicare payment rates as indicated in the Sanders bill. It should be noted, however, that lawmakers have repeatedly balked at applying payment reductions that are far smaller, less sudden, and applicable to a lesser number of payments, than is called for in the Sanders bill. For example, lawmakers began annual overrides of the Medicare physician payment Sustainable Growth Rate formula when the pending cuts were only 4-5% and pertained only to Medicare treatments. By contrast, hospital payment cuts under M4A would start at over 40% and apply to the larger number of treatments now covered by private insurance. The study does not attempt to predict what would happen in legislative practice; it simply quantifies the magnitude of the provider payment cuts called for under the M4A bill, as well as how the overall cost estimates would change in a (possibly more likely) scenario in which they are not applied.

Table 2 summarizes how the M4A cost estimates are affected by these various assumptions.

Table 2: Effect of Various Assumptions upon M4A Cost Projections

Scenario	**Additional Federal Costs, 2022-2031 ($T)**
= Added federal costs from coverage increase	= $40.368 T
- Administrative cost savings	- $1.572 T
= Estimate assuming administrative savings	= $38.797 T
- Potential drug cost savings	- $0.846 T
= Estimate assuming drug and admin. savings	= $37.950 T
- Lowering provider payments to Medicare rates	- $5.307 T
= Lower-bound estimate	= $32.644 T

Other Perspectives on Estimated Costs

An occasional question about such estimates is whether they reflect a particular policy viewpoint or instead reflect broader agreement among experts as to the likely costs of M4A. The answer is that cost estimates produced by experts from a wide range of policy perspectives and institutional affiliations arrive at roughly the same place, after adjusting for different years estimated, as well as assumptions regarding provider payment rates, drug prices, and whether long-term services and supports (LTSS) are included. The following table translates my estimates into what they would have been for M4A's implementation during 2017-2026, as assumed in studies published by the Urban Institute, the Center for Health and Economy, and Emory University professor Ken Thorpe.

Table 3: Alternative Estimates for Added Federal Costs under M4A, if Effective 2017-2026

Estimate	**New Federal Costs over 2017-2026 ($T)**
Center for Health and Economy, Alternative Estimate	$40.2
Blahous (w/o provider cuts or drug savings)	$29.5
Urban Institute (w/o LTSS benefit)	$29.1
Blahous (w/drug savings, w/o provider cuts)	$28.9
Center for Health and Economy, Primary Estimate	$27.3
Blahous (w/provider cuts & drug savings)	$25.2
Thorpe	$24.7

As Table 3 shows, my estimates are generally within the range of those produced by other experts, the differences between them largely attributable to differences in key assumptions. The Urban Institute study produced an estimate of $32.0 trillion, which included LTSS coverage based on information available during the 2016 Sanders presidential campaign. Adjusting for the fact that the 2017 Sanders M4A bill did not include this coverage brings the Urban Institute's estimate down within the range of my own. My lower-bound estimate is generally smaller than those of other experts because it assumes (per the language of the Sanders bill) the application of Medicare provider payment rates, which are lower than the payment rates the Urban Institute, CHE and Thorpe studies all assumed would be the minimum necessary, prior to the bill's introduction. The Thorpe study estimates higher total national health spending than mine, but mine assumes the federal government would pay for a higher percentage of the whole. In general, however, the estimates are qualitatively similar regardless of who makes them, and provide the same general picture of the scale of federal government expansion M4A would bring about.

My study focused on federal cost projections under M4A, in part because such cost estimates play a key role in Congress's legislative procedures and are thus critical information for lawmakers. Many have correctly noted, as also described earlier in this testimony, that the vast majority of these projected costs are not new to the US economy as a whole, are currently being shouldered by others, and would be shifted to the federal government under M4A. Lawmakers should be cognizant that just as with other major national expenditures such as what Americans spend on food or housing, the fact that we are already bearing most of these costs does not necessarily imply that the federal government would find it easy or even practicable to assume them, nor does it necessarily suggest that the federal government can readily provide these goods and services free of charge to every American while satisfying their diverse needs and preferences. While total national health spending under M4A is an important piece of policy information, federal lawmakers would not be able to avoid the central question of how to finance its costs to the federal budget.

I hope this information is useful to committee members as Congress considers the various implications of enacting M4A legislation.