Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage:

Considerations for Policymakers

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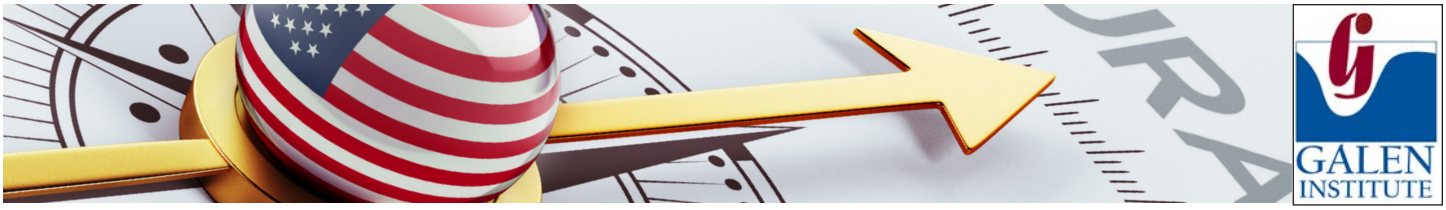

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By Doug Badger[1]

Critics of the way health care is financed in the United States often ask why it is the only highly developed country whose government has not established a universal health care system.[2]

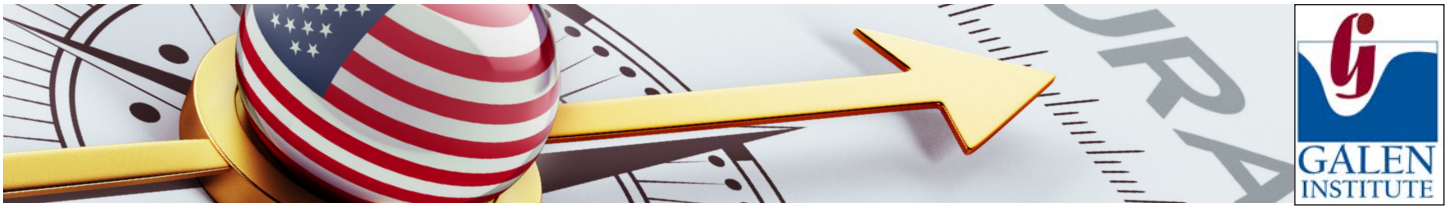
The question is generally posed rhetorically with the intention of ending debate. It suggests that the U.S. can and should adopt health care financing structures similar to those of other prosperous countries.

This paper will treat this as a genuine question and as a point of departure for debate, rather than its terminus. It will seek to inform that debate by examining the provenance, evolution, advantages and limitations of the leading source of coverage in the United States: employer-sponsored insurance (ESI). It will then examine some of the implications for health care financing and delivery were the U.S. government to supplant employers as the financer of medical care for most workers and their families. It will use the "Medicare For All Act" introduced by Senator Bernie Sanders (I-VT) as the point of comparison between a government-financed system that would replace the current one, using 2016 as the reference year.[3]

The paper is not intended as a cost estimate or predictive model but rather as a way to identify and, in a more general sense, to quantify the implications of replacing ESI with government financing.

The Evolution of ESI

The evolution of financing and delivering medical care in the United States and its reliance on ESI has often been described as an "accident of history."[4] In fact, while it is true that the U.S. government, unlike the governments of other highly developed countries, did not specifically devise or rationalize a system for financing medical care, the hybrid of public-private financing evolved through a series of



decisions deliberately taken by government, employers, private insurers, providers, labor unions and consumers.

Failure of Efforts to Establish National Health Insurance

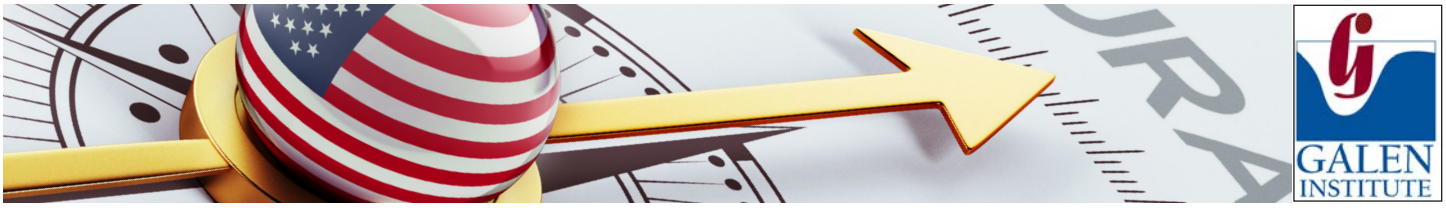
The first thread in the U.S. medical financing tapestry involves a long-standing policy of not centrally financing the provision of medical care. Despite more than a century of effort—efforts that once again have gained prominence—federal policymakers have repeatedly rejected national health insurance proposals.

Advocacy for national health insurance has been traced back to the early twentieth century.[5] Progressive activists called for the creation of what they called "sickness insurance," programs to compensate workers for loss of income due to illness, benefits similar to those provided by voluntary mutual aid programs that had sprung up in Europe and the U.S. during the late nineteenth century.[6] As hospitals began to evolve from refuges for the poor and those with contagious diseases into places of healing, the concept was broadened to include medical benefits.

The American Association for Labor Legislation is generally credited with advancing the first proposal for government-financed health insurance. In 1915, it laid out model state legislation that would provide workers with sick pay for up to 26 weeks, coverage of hospital and physician care, maternity benefits and a $50 burial benefit.[7] The program, estimated to cost four percent of wages, was to be financed with contributions from workers, employers and state governments.[8] Between 1915 and 1920, 16 bills were introduced in various state legislatures. No state established a program.[9]

The New Deal offered advocates a fresh opportunity to push for what was at that point called "national health insurance." President Roosevelt's Committee on Economic Security was charged with making recommendations for establishing programs to protect families from financial distress linked to age, illness and disability. Included in its mandate was to recommend a government program of medical care to insure "against misfortunes which cannot be wholly eliminated from this man-made world of ours."[10] But the committee's final report contained no such recommendations, instead promising a subsequent report on government medical insurance. President Roosevelt quashed that report after its authors concluded that the program would necessitate a doubling of the payroll deduction required by the creation of Social Security.[11]

Proposals for national health insurance emerged again during the 1940s. This



time advocates sought to establish a federally administered program, financed by payroll taxes, a proposal more akin to Social Security than to the state-administered programs that were a feature of earlier proposals.[12] Despite the urging of the Truman Administration, Congress declined to act. The Carter and Clinton administrations subsequently floated proposals to create universal, government-financed health insurance. All were unsuccessful.

In every case, opposition from segments of the health care industry helped doom these efforts. But it is also the case that Congress over this same timeframe vastly expanded government financing of medical care, as will be discussed below. One key difference between the successful efforts of the Johnson and Obama administrations and the series of failed proposals is that Medicare, Medicaid and the Affordable Care Act did not seek to replace ESI with public coverage, but rather affected it at most tangentially.

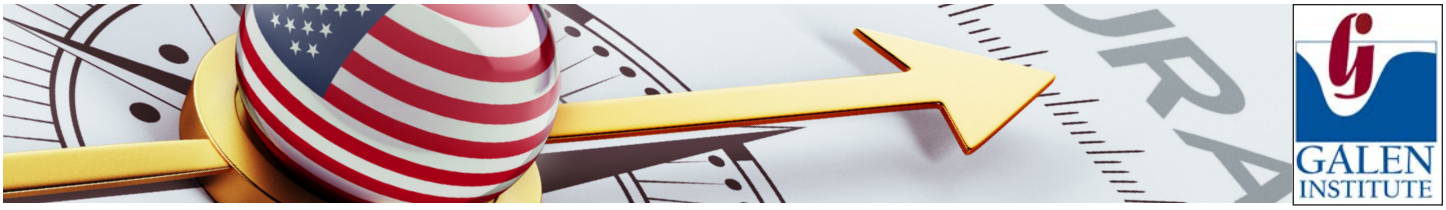
Emergence and Growth of Private Employment-Based Insurance

The rise and durability of private health insurance, with its close links to the employer setting, is a second evolutionary factor that distinguished the U.S. system from its European counterparts. Robust programs of private health insurance generally did not develop in Europe; they did in the U.S.

As in Europe, voluntary employee welfare arrangements had their antecedents in the nineteenth century. Statutory health insurance, first proposed during the 1880s by Otto Von Bismarck, took decades to develop throughout Europe, reaching full maturity only after World War II.[13]

The U.S. moved in a different direction. During the late nineteenth and early twentieth centuries, some labor unions and a handful of employers established what were called sick benefit programs.[14] As efforts to create government-sponsored coverage faltered in the early decades of the twentieth century, private arrangements began to emerge. The first Blue Cross plan, established in 1929, presented a unique approach that wedded employers, workers and hospitals in prepaid hospital care arrangements.[15]

At the time, employer-sponsored coverage was relatively rare. An estimated 1.2 million employees and a similar number of dependents participated in ESI in 1930.[16] But the Blue Cross model of voluntary non-profit, group hospitalization



coverage mushroomed during the Great Depression and the Second World War. By 1935, there were 15 Blue Cross plans in 11 states.[17] A decade later, 19 million people were enrolled in 80 Blue Cross plans.[18]

During this same period, Blue Shield plans covering physician services also appeared, along with physician group plans and other privately financed arrangements. Despite their many differences, these plans all predominantly emerged within the employer setting.

These arrangements multiplied because they worked. Employment-based groups of reasonable size offered risk pools that generally were broadly representative of their respective communities. Employment-based pools were in some respects ready-made for spreading medical risk, obviating the need for government to create pools at the state or federal level. By the time of the Second World War, the development of workplace-based private insurance was a distinguishing feature of health coverage in the United States.

The persistent growth in private health insurance coverage, which continued into the ensuing decades, was in part attributable to a decision of the National War Labor Board, which ruled that fringe benefits did not violate the federal wage freeze.[19] ESI thus provided companies with a means to compete for scarce labor. The Revenue Act of 1954 sealed this arrangement by codifying the treatment of employer contributions to health insurance premiums as not subject to income and payroll taxation.[20] Employer-sponsored health insurance became a tax-preferred form of compensation that remains widespread and popular more than 70 years after the government lifted wage controls.

Labor unions also helped fuel the growth of ESI. The Taft-Hartley Act, which became law in 1947, allowed collective bargaining over "conditions of employment."[21] The National Labor Relations Board ruled that health insurance benefits fell within this definition. The Supreme Court upheld the NLRB ruling in 1949.[22] Throughout the late 1940s and early 1950s, unions successfully negotiated (often as the result of strikes) the establishment and expansion of health benefits.[23] Between 1950 and 1965, health benefits tripled as a percentage of employee compensation.[24]

ESI thus became a firmly established source of health insurance in the U.S. at about the same time as government-financed plans came to prominence in other devel-

oped countries. ESI's growth in the U.S. is attributable to a variety of factors, some involving government, but many the work of private actors, including hospitals, employers and labor unions. Its growth and popularity were in that sense intentional, not accidental.

The Growth of Public Insurance for Defined Populations

The final important trend in the evolution of U.S. health care financing is the growth of public programs for defined populations. This public policy strand preceded the other two. Government-backed health care for veterans is among its leading examples. The Department of Veterans Affairs traces the origins of government aid to veterans to 1636, when the Plymouth Colony waged war against the Pequot Indians.[25] The federal government established the first medical facility for veterans in 1811.[26] By the time Congress created the Veterans Bureau in 1921, medical care for veterans was a well-established federal priority. The new bureau undertook the construction of a network of federal hospitals.[27] That network has grown over the decades. Congress has approved a $50 billion budget for the Veterans Health Administration for fiscal year 2019.[28]

The real growth of government-financed medical coverage for specified populations began in the mid-1960s with the creation of Medicare and Medicaid. In some ways, this was a byproduct of the evolution of ESI during the post-World War II period. Since health insurance coverage was primarily linked to the workplace, advocates of government-financed medical care proposed public coverage for those whose attachment to the labor force was attenuated by age, disability and poverty.

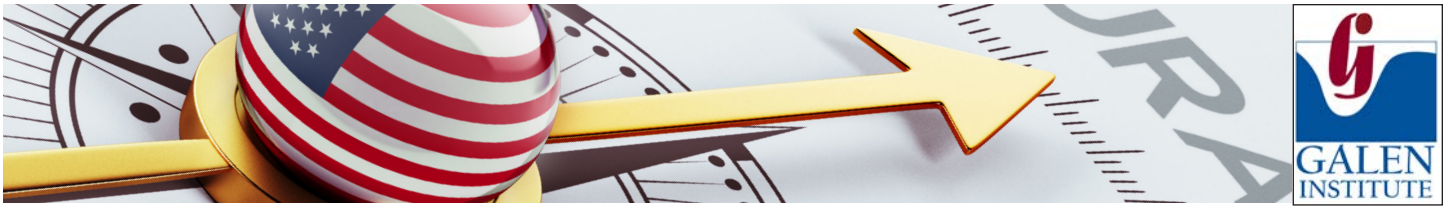
Financing of these programs resembles those in other developed countries in that they tax workers and corporations to cover the costs of medical services. The U.S. programs, however, are not universal, but targeted to specific populations.[29] Spending on these programs has grown rapidly, particularly with the creation of Medicare and Medicaid in the mid-1960s. The result, shown in Table 1, is that federal and state governments now finance the majority of personal health care expenditures.

Table 1 – Percentage of Personal Health Care Expenditures Financed by Federal and State Governments

1960	24.3%
1970	38.1%
1980	44.8%
1990	44.2%
2000	47.9%
2010	52.0%
2016	52.5%

Source: CMS, National Health Expenditures 2016, Table 6.[103]

The government share of health spending doubled between 1960 and 2000. By 2008, government had eclipsed the private sector as the dominant financer of personal health care expenditures.[30] The percentage of medical care financed by the

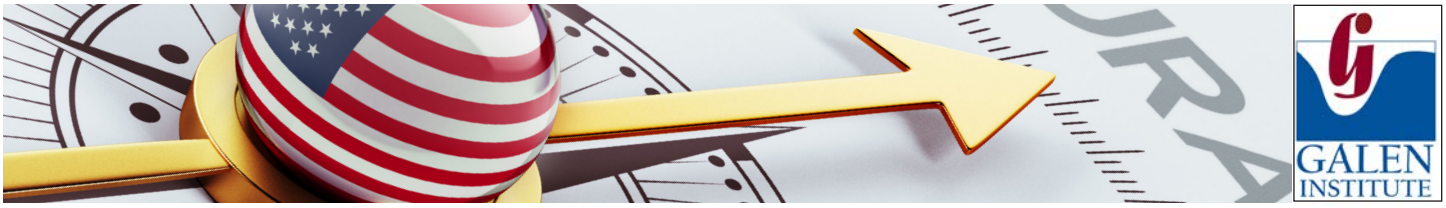


federal government is projected to continue growing. The Centers for Medicare and Medicaid Services projects that federal and state governments will pay for 56.4 percent of personal health care expenditures in 2026.[31]

This increase can be ascribed to numerous factors. First, the creation of Medicare, combined with the aging of the population, has led to massive growth in that program. In 1970, Medicare spending constituted 0.7 percent of GDP.[32] In 2016, it had nearly quintupled as a share of the economy to 3.3 percent.[33] With the program growing at an estimated 10,000 people per day, government sources forecast that it will consume 4.5 percent of GDP by 2026.[34]

Medicaid spending, too, has grown more than fivefold, from 0.5 percent of GDP in 1970 to 2.7 percent in 2016.[35] Unlike Medicare, Medicaid spending is not a product of change in the composition of the population but in changes to the program itself. Beginning in the 1980s, Congress has expanded eligibility standards, adding tens of millions of people to the rolls. In 1970, 14 million people, representing less than seven percent of the population, participated in Medicaid.[36] By 2016, an estimated 91.4 million people, representing nearly 29 percent of the U.S. population, were enrolled in either Medicaid or the related CHIP program at some point during the year.[37] The creation of new programs under the Affordable Care Act (ACA) and the Balanced Budget Act of 1997 contributed to this growth.[38]

The result is that federal and state governments finance more than half of personal health expenditures and will continue to do so for the foreseeable future even in the absence of further public policy changes.



The Current State of ESI

Although the government now finances the bulk of medical spending, ESI remains a source of insurance coverage for the majority of the population. In 2016, 173.1 million people had employer-sponsored health insurance.[39] Table 2 shows the breakdown in the number of workers in firms that offer coverage, the percentage of employees eligible for such coverage and the percentage of eligible employees who enrolled in that coverage in 2016.

Table 2 - Offer and Participation Rates of ESI, 2016

Percentage of workers in firms that offer coverage to at least some employees	89%
Percentage of workers in offering firms who are eligible to enroll in ESI	79%
Percentage of eligible workers in offering firms who enrolled in ESI	79%
Percentage of workers in offering firms who have ESI	62%
Percentage of workers in **all** firms who have ESI	55%

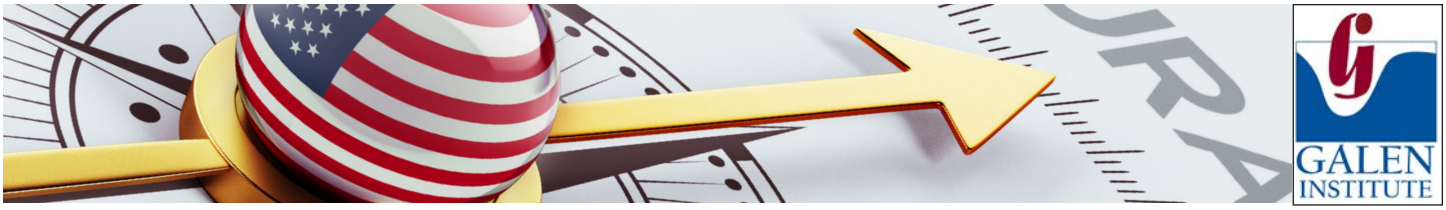
Kaiser Family Foundation, Employer Health Benefits Annual Survey, 2016, Exhibits 3.1 and 3.2

The table shows that, while access to ESI is broad, it is far from universal. There are several reasons for this, some involving decisions by employers and others due to choices made by workers themselves. Structural changes in the labor force also have contributed to the decline in the percentage of Americans with ESI.

The vast majority of workers—89 percent according to the Kaiser survey—worked for companies that sponsored health insurance coverage in 2016. An estimated 79 percent of those employees were eligible to enroll in their firm's plan. Companies may make certain employees, part-time workers for example, ineligible for coverage and they may not allow new employees to join their plans until they have completed a waiting period.

Among employees in offering firms who were eligible for ESI in 2016, 79 percent enrolled. Some may have chosen to remain uninsured despite exposure to tax penalties on the uninsured.[40] Others may have had other sources of coverage, through a working spouse, for example, a parent (in the case of those under 26), or through a public program like Medicare. In all, 62 percent of those working for employers that sponsor coverage enrolled in that coverage in 2016.

The percentage of workers in all firms—including those that offered coverage and



those that did not—enrolled in ESI was 55 percent in 2016. That figure has remained relatively stable over the past five years but is significantly lower than the 65 percent figure in 2001.[41]

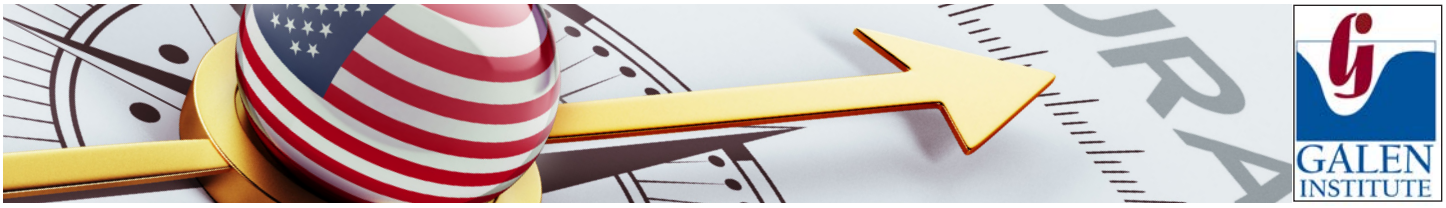
Many critics of ESI have faulted its lack of universality and noted the secular decline in the percentage of the population enrolled in such coverage. There are a number of reasons for this. First, ESI, unlike government-financed systems outside the U.S., was for many years voluntary both for companies and employees. The ACA instituted mandates on both, enforced by tax penalties.

Firms with fewer than 50 full-time equivalent workers are exempt from the employer mandate. The establishment of individual and employer mandates may have affected coverage at the margins, but the percentage of workers enrolled in ESI was largely unchanged by those mandates.

The likelihood that a firm offers coverage depends to a great extent on its size, as it did before the mandate took effect. The Kaiser survey found that nearly all firms with at least 200 workers in 2016 offered ESI.[42] Among firms with 50-199 workers, 91 percent offered coverage. That figure dropped to 80 percent for companies with 25-49 employees, 61 percent for those that employed 10-24, and 46 percent of companies with fewer than 10 workers.

In general, it appears that larger firms, which are subject to the mandate, sponsored health insurance coverage before the government required them to do so, while a fairly substantial percentage of smaller firms, which are generally exempt from the mandate, did not offer coverage to their employees. The employer mandate, in short, has not appreciably affected the practice of firms with respect to ESI. Participation rates are largely the same as they were under a purely voluntary system.

Gauging the effectiveness of the individual mandate is a more difficult undertaking. There undoubtedly are some people who have enrolled in health insurance coverage solely to avoid the tax penalty on the uninsured. How many is a matter of considerable uncertainty. The Congressional Budget Office has repeatedly reduced its estimate of the coverage effects of the mandate.[43] Beginning in January 2019, the government no longer will levy a tax penalty on the uninsured. That change in policy may improve our understanding of the mandate's coverage effects.

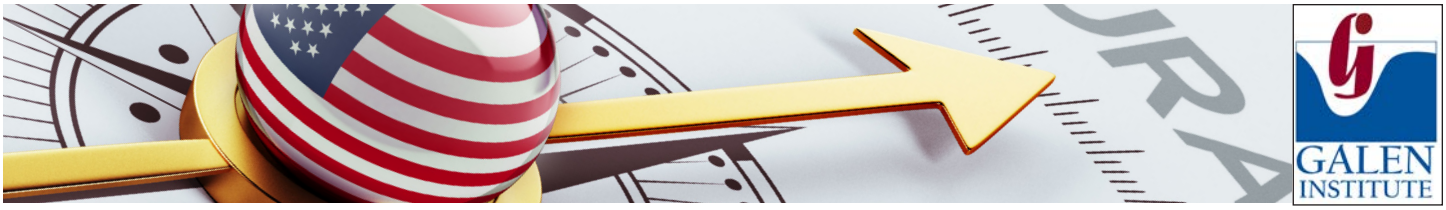


Structural changes in the labor force also may help explain the decline in ESI coverage. Assessing the effects of such changes is beyond this paper's scope, but they might include declines in the manufacturing sector, lower rates of labor union membership, temporary and part-time employment, increasing health care costs and a secular decline in workforce participation, most pronounced among males of prime working age.[44]

Despite the decline in the percentage of the population with ESI, job-based health coverage remains widespread. As a consequence, ESI offers considerable benefits to the government. Premiums for those with ESI totaled nearly $991.3 billion in 2016.[45] Of that amount, 73 percent was contributed by employers and 27 percent by workers.[46] Government does not tax health benefits. If it treated ESI the same as it does wages, federal income and payroll tax revenues would increase.[47] The Treasury Department estimates that, absent the tax exclusion, federal revenues would have been $348 billion higher in fiscal year 2016.[48]

By not taxing ESI, the government leveraged nearly $1 trillion in private health insurance spending at a net cost to the federal budget of less than $350 billion.[49] A very rough estimate of the benefit to the government in 2016 can be derived by subtracting the amount of federal revenue lost to the exclusion ($348 billion) from the total amount of ESI premiums ($991.3 billion), yielding $643.3 billion. That is a rough estimate of the net cost of supplanting ESI with direct government financing in 2016.[50] To finance that sum through payroll taxes in 2016 would have required raising the OASDI tax by 9.6 percentage points, from 12.4 percent to 22.0 percent of taxable payroll.[51]

This is not to suggest that the government would increase payroll taxes if it were to eliminate ESI. Congress might choose other means of offsetting costs and to at least partially finance the program through borrowing. Nor is this intended as a comprehensive estimate of the costs of replacing ESI with a government-funded system. Such an estimate would have to take into account a number of factors, some of which are discussed later in the paper – potential administrative savings, lower reimbursements for medical goods and services and increased consumption of such goods and services among them. Rather, it is an effort to illustrate the amount of private health insurance spending that the government leverages through the exclusion.[52]



That leverage, as we have seen, was not the sole reason that ESI became so widespread. Other developments in the marketplace and in government policy clearly contributed to its broad dissemination. The tax exclusion, however, undeniably serves as a powerful incentive to most employers to maintain health benefits plans for their workers.

The tax exclusion for ESI can be viewed as an efficient way for the government to increase health insurance coverage.[53] Instead of taxing workers and corporations and directly financing their medical care, the U.S. government exempts ESI from taxation, leveraging $2.85 in health insurance spending for every $1 in federal revenue losses.[54]

This efficiency takes on more importance in light of the fact that workers bear a large portion of the cost of financing public programs, including Medicare and Medicaid. The federal costs of those programs totaled $944.1 billion in 2016.[55] This money came from a variety of sources. Workers paid $253.5 billion in payroll taxes in 2016 to finance Part A of Medicare.[56] Since 89 percent of workers were in firms that offered ESI, one can allocate roughly $225.6 billion of the costs of providing hospital benefits to Medicare beneficiaries to these workers.

The bulk of federal health care spending is financed by general revenues and government borrowing. Workers in firms offering ESI supply the lion's share of these revenues. They finance their own care at a relatively modest cost to the federal government, and their income and payroll taxes contribute a substantial portion of the money that the federal government uses to provide medical benefits to others.

Workers in firms that offer ESI provide a potential third benefit to government by paying higher rates for medical care than do public programs. These higher payment rates may provide an often-overlooked benefit to public programs by supporting a supply of doctors and hospitals required to meet the medical care demands of those with both public and private insurance. Reducing these rates to Medicare levels could potentially have adverse consequences.

Table 3 compares private insurance reimbursement rates for hospitals and doctors with those paid by Medicare and Medicaid.

Table 3 – Medicare, Medicaid and Commercial Rates for Hospital and Physician Services, 2016

	Medicare	Medicaid	Commercial
Hospital*	1.00	1.01	1.67
Physician**	1.00	0.72	1.33

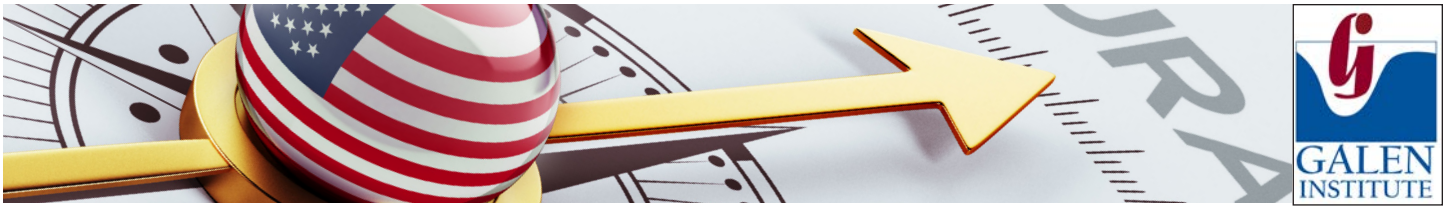
* AHA, 2018 Chartbook, Table 4-4. ** Medicare and Commercial figures are from MedPAC, March 2018, p. 115. Medicaid figures are from Kaiser https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

The table sets Medicare hospital and physician payments as the index rate, assigning it a value of 1.00. Medicaid and commercial payment rates are then assigned a value relative to average Medicare rates. Hospital rates are derived from the American Hospital Association's "Chartbook." Physician rates come from two sources. The Medicare Payment Advisory Committee (MedPAC), an advisory arm of Congress, supplied average physician payments for Medicare and private insurers. The physician payment rates for Medicaid relative to Medicare were compiled by the Kaiser Family Foundation.

The first and most obvious observation from the table is that private insurers—a market that is dominated by ESI—on average pay hospitals and doctors far more than do Medicare and Medicaid. Medicare and Medicaid pay roughly comparable rates for hospital care (1.00 and 1.01 respectively), while private insurers pay rates that average 67 percent more than does Medicare.

The numbers are a bit more complicated for physician payments. As with hospital payments, Medicare physician reimbursement rates are substantially lower than commercial rates, but substantially higher than for Medicaid.

These rate differentials are essential to evaluating proposals to supplant ESI with government financing. The Medicare For All bill, as will be discussed below, proposes to apply Medicare hospital and physician rates universally. This would have an uncertain effect on hospitals, which run consistently negative margins on Medicare patients.[57] This trend of running negative margins on Medicare patients has persisted over time. Moreover, current law would dampen the rate of growth in hospital payments in future years, a pattern that Medicare trustees warn could have ominous consequences.[58]



Private insurers also compensate doctors at higher rates than do Medicare and Medicaid. Paying Medicare rates to all physicians would result in lower overall compensation for their services, although that effect would to some extent be mitigated by raising Medicaid rates to Medicare levels.

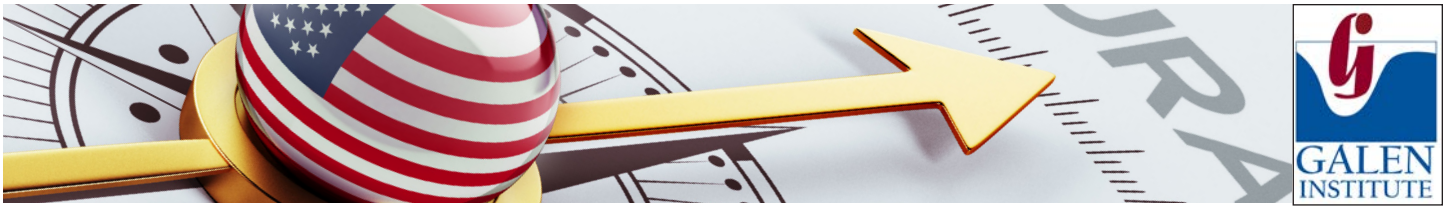
ESI evolved as the dominant source of health coverage in the U.S. through a series of decisions by government authorities, employers, labor unions and consumers. It is not the system an economist might have designed or a panel of experts might have proposed. Notwithstanding its shortcomings, ESI provides societal benefits that its critics rarely take into account. ESI pays rates that are far in excess of those paid by public programs and may therefore be helping sustain the supply of physicians and hospitals, its participants provide the bulk of financing for public programs through income and payroll taxes, and they fund their own coverage at a steeply discounted cost to the federal government.[59]

Medicare For All Act and ESI

Key provisions of the Medicare for All bill

Efforts to remake the U.S. health care system in the image of its European counterparts have persisted for more than a century. The leading current proposal is the Medicare For All Act, authored by Senator Bernie Sanders (I-VT).[60] As its name implies, the measure would enroll all U.S. residents in a federally-funded health care program called the "Universal Medicare Program" (UMP). The bill would:

- Replace all private health insurance (including ESI) and most public health insurance—including Medicare (sec. 901(a)), most of Medicaid (sec. 901(a)(3)), the Children's Health Insurance Program, the ACA and other government programs—with a single government-financed system that would cover "every individual who is a resident of the United States" (sec. 102).
- Cover a broad range of services, including hospital, physician, prescription drugs, mental health, rehabilitation and habilitation, dental and vision care (sec. 201(a)).[61]
- Eliminate cost-sharing, including deductibles, coinsurance and balance billing, for most covered services (sec. 202(a)).[62]
- Require providers to enter into a participating agreement with the Secretary in order to be eligible for reimbursement under the program (secs. 301-302).
- Reimburse providers in accordance with a fee schedule that appears to be similar to that of Medicare (sec. 611).
- Direct the HHS Secretary to establish national practice guidelines (sec. 501). In cases where such national guidelines are in place, payments may only be made if services "have been provided in accordance with such guidelines" (sec. 203(c)).[63]
- Direct the HHS Secretary to negotiate drug prices with manufacturers and establish a formulary for prescription drugs that would "promote the use of generic medications to the greatest extent possible" (sec. 614).
- Prohibit employers and insurers from covering any item or service covered by UMP (secs. 107 and 801).
- Permit individuals to privately contract with physicians and hospitals to pay privately for services that would otherwise be covered under the program (sec. 303(a)). Such contracts, however, require the provider to attest that he or she will not bill the program for any covered service provided to any beneficiary for a period of one year (sec. 303(c)).
- Require the HHS Secretary to "establish a national health budget, which specifies the total expenditures to be made for covered health care services under this Act" (sec. 601(a)(1)). The budget would include allocations for covered health services, quality assessment, health professional education, administrative costs, innovation, capital expenditures and public health (sec. 601(a)(2)).[64]



In sum, the bill proposes to ban ESI and private health insurance, expand the range of benefits that Medicare and ESI typically cover, and generally make care free at the point of service to all U.S. residents, all of which would require substantial increases in federal spending.[65]

Costs of the Medicare for All bill

Supplanting private health insurance spending with additional government spending on health care is, of course, the bill's central purpose. The magnitude of those spending increases and the extent to which they can be offset are matters of considerable controversy, and one into which this paper does not seek to wade. Independent analyses that have been produced to date put the net federal spending increases over the program's first decade of full implementation in the range of $24.7 trillion to $29.1 trillion.[66] Supporters of the measure believe these costs to be overstated.[67]

Although there is disagreement over its net federal costs, the bill's advocates and critics generally agree on the major factors that would affect those costs, as summarized in Table 4.

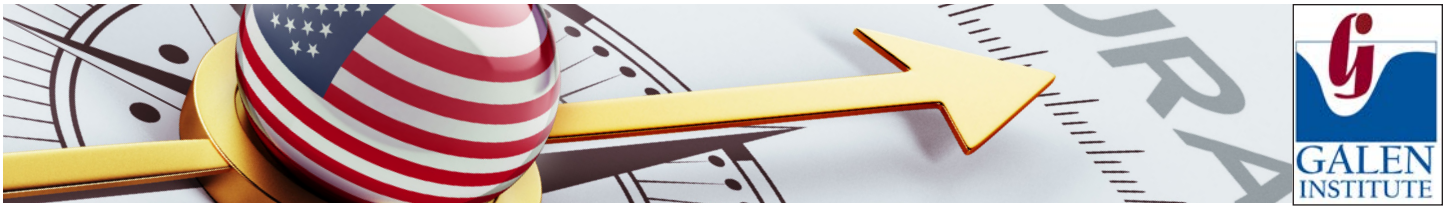
Table 4 – Major Factors Affecting the Costs of Medicare For All

Factors that would increase spending	Factors that would offset spending
Replace PHI with government financing (sec. 107)	Eliminate most existing government programs (sec. 901)
Provide universal coverage (sec. 102)	Reduce administrative costs[68]
Eliminate most cost-sharing (sec. 202)	Reduce payments for medical goods and services (sec. 611)
Expand benefits (sec. 201)	Establish a national health budget (sec. 601)
	Eliminate tax exclusion for ESI (sec. 701(b)(1))
	Recoup most state Medicaid spending[69]

In general, the bill would increase federal spending by putting nearly all personal health expenditures on the federal budget. It also would likely increase consumption by replacing private health insurance (including ESI) with a government program that finances a broader range of benefits than are generally financed under existing public and private programs,[70] eliminating cost-sharing for those benefits and covering virtually everyone in the country. It would offset these costs largely

by eliminating most existing government programs, setting payments for medical goods and services at Medicare rates, reducing administrative costs, and eliminating private health insurance and, consequently, the revenue effects of the tax exclusion. It also would establish a national health budget, although the bill does not specify whether or how the government would enforce that budget.

Estimating the net costs to the federal government of these and other factors is beyond the scope of this paper.[71] Instead, it seeks to identify factors that policymakers should consider as they contemplate supplanting ESI with government funding.



Replacing ESI with government financing – Policy considerations

Substituting government spending for private spending

The first factor has to do with the substitution of federal spending for private spending.[72] Federal revenues were $348 billion less in 2016, as we have seen, than they would have been had health benefits been subject to income and payroll taxation. Assuming employers converted 100 percent of health benefits to taxable wages, the government would recoup this entire sum. Spending on ESI health insurance premiums totaled $991 billion in 2016, leaving a gap of over $643 billion in health spending currently financed through employers. While other factors might affect this number in both directions, it is difficult to see how the other provisions of the bill would generate sufficient savings to close this gap. Substituting federal financing for ESI at least to some degree would seem to entail "buying out the base"—requiring taxpayers to finance goods and services to which millions already have access without government assistance.

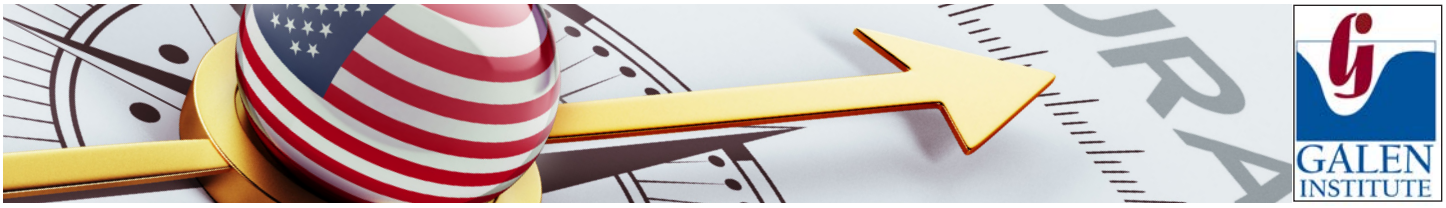
Potential administrative savings

Second, substituting government financing for ESI would reduce administrative spending, as Table 5 illustrates.

Table 5 - Potential Administrative Savings Of Shifting ESI Enrollees to M4A

	Admin Costs	Enrollees	Admin per Enrollee	ESI Enrollees	Admin Savings
PHI	$129.6B	216.2M[b]	$599		
Medicare[c]	$9.2B	56.8M	$162		
Admin Savings			$457	173.0M[d]	75.2B
	[a]NHE, Table 20. [b]Census, Table 1. [c]2017 HI Trustees, Table II.B.1 [d]NHE, Table 21				

CMS estimates the administrative costs of private health insurance in 2016 at $129.6 billion. Dividing that figure by the Census estimate of 216.2 million enrollees in private health insurance yields an average administrative cost per enrollee of $599. CMS actuaries report 2016 Medicare administrative spending of $9.2 billion for 56.8 million beneficiaries. That computes to per-capita administrative costs of $162, or $457 less than for private health insurance. Multiplying that figure by



the estimated 173.0 million ESI enrollees suggests that spending on administrative costs for ESI enrollees would have been $75.2 billion less in 2016 had the government financed their health insurance.

Once again, this is not intended as a point estimate of administrative savings, but rather to illustrate that such savings are likely and potentially substantial.[73]

Reimbursement of hospital and physician services

Shifting people with ESI to a federally financed program that pays Medicare rates also holds the potential for savings. Unlike with administrative costs, these savings come with greater potential for adverse consequences. Table 6 shows 2016 payments to hospitals by private insurers, Medicare and Medicaid and what those payments would have been—holding utilization constant—if all hospitals had been paid at Medicare rates.

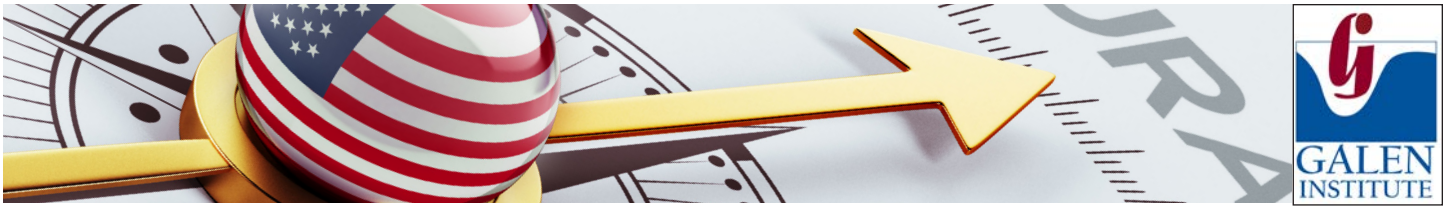
Table 6 -- 2016 Payments to Hospitals

	PHI	*Medicare*	*Medicaid*	*Total*
Current Law	$426.7	$267.5	$189.8	$884.0
M4A	$255.5	$267.5	$187.9	$710.9
Change	-$171.9	$0	-$1.9	-$173.1

Source: NHE, Table 7 and MedPAC

Using the ratios presented in Table 3, this table compares hospital financing in 2016 with what it would have been had Medicare rates applied to Medicare and private health insurance (including ESI). Assuming that utilization remained unchanged, hospitals would have received a total of $173.1 billion less in 2016 from the three major sources of revenue had Medicare reimbursement rates applied.

One might argue that hospitals could absorb a 40 percent reduction in payments on behalf of privately insured patients through greater efficiencies. It is also worth considering, however, that the rates paid by private insurers—predominantly through ESI—may be helping preserve access to medical care for those enrolled in public programs. As noted above, hospitals have consistently run negative margins on their Medicare patients. That margin in 2016 was -9.6%. Since Medicaid payments are only slightly higher than Medicare (and a smaller source of funds), it



is likely that the combined Medicare-Medicaid margins are very close to that negative margin. Putting all Americans on the Medicare payment scale would worsen those margins by sharply reducing reimbursement rates for services provided to those who currently have private insurance.

Other countries are able to sustain a socially acceptable supply of hospital care through publicly-financed systems.[74] But with a handful of exceptions, most countries with publicly-financed systems finance public hospitals to provide care for the bulk their citizenry.[75] Only 15% of U.S. hospitals are public, which is quite low compared to most countries with publicly-financed systems.

Moreover, most countries with government-financed systems permit the sale of private insurance to supplement public coverage. Voluntary health insurance can be sponsored by employers and often provides access to private hospitals and increased amenities at public hospitals, including private rooms and shorter wait times for non-emergency services. The Medicare for All Act would prohibit such private financing.[76]

It is unclear how an infrastructure that consists predominantly of private, not-for-profit hospitals and relies to a great extent on higher reimbursement levels from private insurers would adapt to large and abrupt payment reductions.

Physician payments would also have been lower in 2016 under Medicare reimbursement rates, as Table 7 shows.

Table 7 -- 2016 PHI, Medicare and Medicaid Payments to Physicians

	PHI	*Medicare*	*Medicaid*	*Total*
Current Law	$239.8	$139.3	$40.0	$419.1
M4A	$180.3	$139.3	$55.6	$375.2
Change	-$59.5	$0	+$15.6	-$43.9

Source: NHE, Table 9 and MedPAC

Once again using the ratios presented in Table 3, this table shows that, assuming no change in utilization, physician payments would have been $43.9 billion lower had the Medicare fee schedule applied to Medicare, Medicaid and PHI. Reductions in physician payments would be relatively less than for hospitals, in part

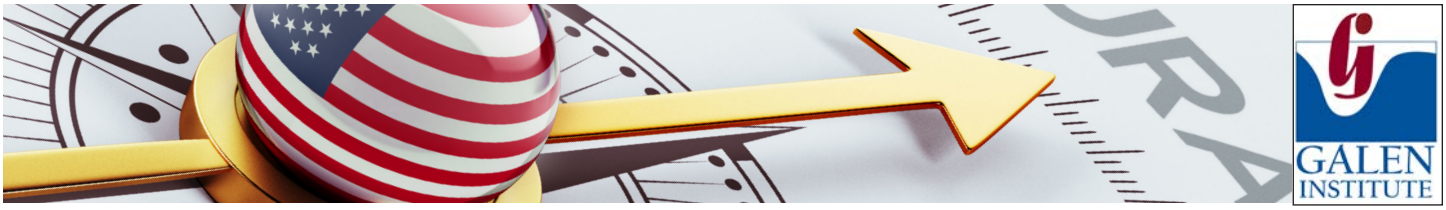
because Medicaid physician reimbursement rates would rise. Physicians would have collected $59.5 billion less in fees in 2016 had Medicare rates applied to privately insured patients. The overall reduction, net of the Medicaid adjustment, was -$43.9 billion, or -10.5 percent.

Reductions of this size also would have an uncertain effect on access to care, particularly since the expansion of coverage to additional people and the elimination of cost-sharing can be expected to induce greater demand for services.

It is difficult to sort through the potential implications of universal reductions in hospital and physician reimbursement rates in an environment with multiple public and private payors. Theoretically, there is a spectrum of possibilities. Medicare could be thought of as paying "correct" rates and private payors overpaying for services. If that were true, then the disruptions caused by abruptly reducing payments would be temporary, though no doubt troubling. But if Medicare rates are "too low," those consequences could be more enduring and severe.

Matters are almost certainly more complex, with Medicare theoretically "underpaying" for some services and private insurers "overpaying" for others. Government can, and no doubt will, adjust rates, but the current system Medicare uses for setting those rates, which the Medicare For All bill would retain, was not designed to reimburse providers at levels that create equilibrium between supply and demand for the nation as a whole.[77] Nor is it easy to imagine a government-administered methodology that would.

In short, the Medicare For All Act would put upward pressure on demand through virtually universal coverage, expanded benefits and the elimination of most cost-sharing, while applying downward pressure on supply by establishing universal reimbursement rates for doctors and hospitals that are significantly lower on average than rates now paid by private insurers.[78] Policymakers should take care to examine the potential effects of these cross-pressures on access to quality medical care.



Global health care budget

One way that other governments attempt to deal with this mismatch between supply and demand is to impose limits on the amount of medical care government will finance.[79]

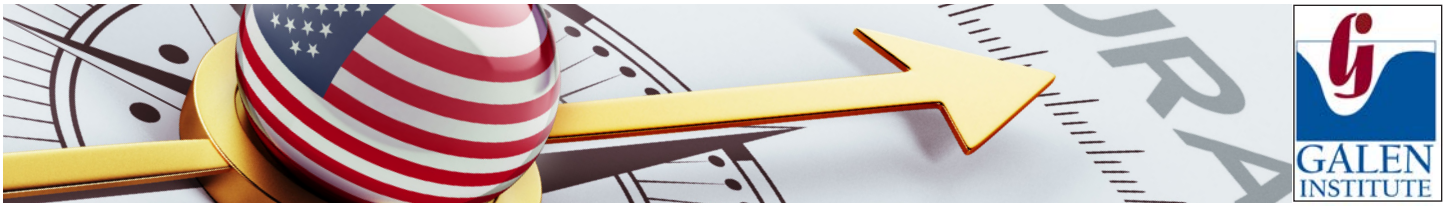
The Sanders bill makes a gesture in this direction. Section 601 requires the HHS Secretary to establish a national health budget that "specifies the total expenditures to be made for covered health care services under this Act." The bill does not, however, provide a mechanism for the Secretary to enforce compliance with the budget.

Elsewhere the bill provides that the government will, with certain exceptions, only pay for services that comport with "national practice guidelines" developed by the Secretary.[80] As with the national health budget, the effect of this limitation is not well articulated, although some savings would conceivably accrue from government's refusal to pay for covered services that are not provided in accordance with federally established practice guidelines.[81]

The House counterpart to the Sanders bill is much more descriptive and clear.[82] Congress would annually appropriate an amount for total health care spending.[83] The HHS Secretary would appoint a Director to enforce that budget.[84] The Director, in turn, would oversee 15 regional administrators, who would make disbursements to providers on a monthly basis in accordance with the congressionally established annual budget.[85]

The assumption behind both variants is that Congress and a federal agency can allocate medical goods and services more efficiently than our current mix of public and private payors. This, along with administrative efficiencies, government-established reimbursement rates and other provisions, will assure that proper amounts are paid for all medically appropriate care. The current system, by contrast, is suspected of wasteful outlays on unnecessary care and overtreatment.[86]

It may be that empowering Congress to set a national budget and conscripting HHS to enforce that budget will reduce health care spending and avoid supply shortages. The Director and a cohort of regional administrators may be assumed to possess keen negotiating skills coinciding with their plenary authority over health spending. They may substantially reduce inefficiencies, assuring that resources are more perfectly aligned with medical needs.



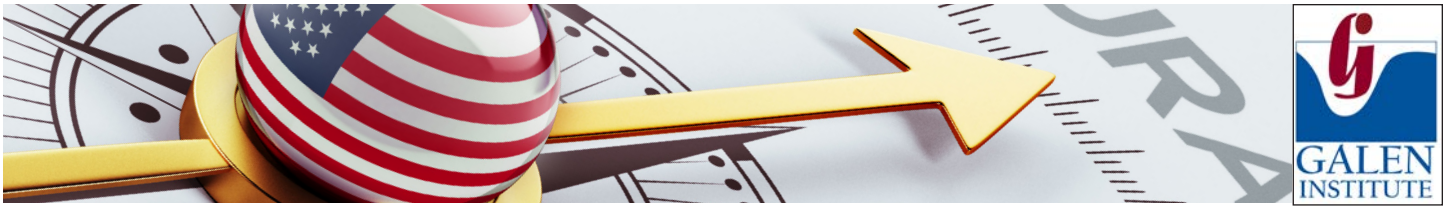
There is also reason for lawmakers to question these assumptions. Increasing efficiency and aligning reimbursement with value have been the preoccupation of public and private payors for decades. Private insurers and employers who sponsor coverage for their workers have fairly obvious incentives to avoid paying for unnecessary care. They have devised any number of programs, approaches and strategies, not only to root out waste, but also to incentivize employees to stay healthy. Employers have been especially active and innovative in this respect.[87] One can argue that these ongoing efforts have produced only marginal efficiencies, but it is quite another thing to suggest that efficiency would improve if the government were to eliminate these private efforts entirely.

That is especially true given the track record of government initiatives to enhance value. Public payors have pursued a panoply of proposals to improve efficiencies over a period of decades. These include scores of Medicare demonstration projects and payment reforms around myriad ideas for enhancing value. Programmatic changes have ranged from prospective payment systems to competitive bidding to bundled payments to accountable care organizations.

None of these has had much impact on Medicare spending, and none has diverted the program from the path to insolvency.[88] Much of that spending, as mentioned above, is due to increases in the number of enrollees. But spending also has risen on a per-capita basis, despite reductions in reimbursement rates and efforts to control the volume of services.

Medicare pays doctors far less, on average, than do commercial payers, as discussed above. Per capita Part B expenditures have nonetheless risen persistently. Congress clamped down on physician reimbursement when it enacted Medicare's Resource-Based Relative Value Scale (RBRVS) in 1989.[89] Under this system, the government assigns relative values to roughly 10,000 procedures, taking into account physician work, practice expenses and medical malpractice liability associated with each procedure.[90] The notion was that Medicare should reimburse physicians according to objective criteria that measure the resource costs of providing medical services.

When that failed to arrest spending growth, they overlaid the RBRVS system with a sustainable growth rate (SGR) modifier.[91] Under SGR, if total Medicare physician expenditures rose above specified levels in any year, the HHS Secretary would



be required to make across-the-board cuts in Medicare physician reimbursements in the subsequent year. RBRVS clamped down on the unit cost of services; SGR attempted to adjust those rates downward to account for increased volume.

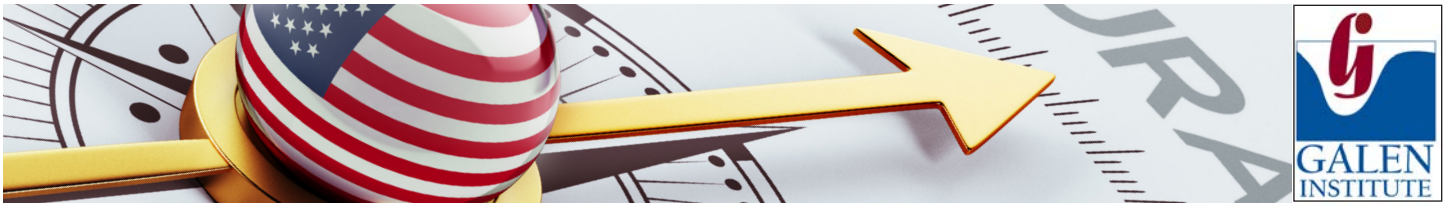
Adopted by Congress in 1997, SGR would have required cuts in Medicare reimbursement for physician services beginning in the early 2000s, something lawmakers were loath to do. So they repeatedly voted to prevent these cuts from taking effect. According to a March 2015 report by the Congressional Research Service, Congress on 17 separate occasions between 2003 and April 2014 enacted legislation to override scheduled reductions in Medicare physician payments.[92]

With enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, Congress replaced the SGR system with one that presumably will pay doctors based on the "value" their services provide rather than on the volume of those services.[93]

According to analyses and projections prepared by the CMS Actuary, per-capita Medicare Part B spending has risen—and will continue to rise—inexorably despite these reforms. In 1990, before implementation of the RBRVS system, Medicare Part B expenditures per beneficiary averaged $1,355.[94] By 2000, after enactment of both the RBRVS system and the SGR modifier, per-capita spending had nearly doubled to $2,496. A decade later, it had nearly doubled again to $4,907. By 2020, when the MACRA reforms will have reached full flower, actuaries project per-capita spending to reach $6,862, more than five times the rate that prevailed before three generations of physician payment reforms. Over that period, Medicare Part B per-capita spending outpaced medical inflation (to which the Medicare program itself greatly contributed) by more than 50 percent.[95]

Nor have larger and more expansive reforms shown much promise. The Affordable Care Act introduced the concept of the Accountable Care Organization (ACO), a group of medical providers willing to be held accountable for the quality, cost and overall care of the Medicare beneficiaries within its purview. ACO proponents predicted that the program would transform the delivery of medical care, introducing efficiencies never before seen in U.S. health care.

Under the ACO shared savings demonstration program, the government devises a bespoke budget for each participating entity to provide medical care to a subset of Medicare beneficiaries. Entities that come in under budget share the savings with



the federal government, which would continue to bear the burden of cost overruns.

Pioneer ACOs, by contrast, entered into a two-sided risk arrangement, sharing in any savings but also going at risk for any Medicare spending in excess of the benchmark. In that sense, they would function under arrangements similar to those envisioned under a system of global budgets.

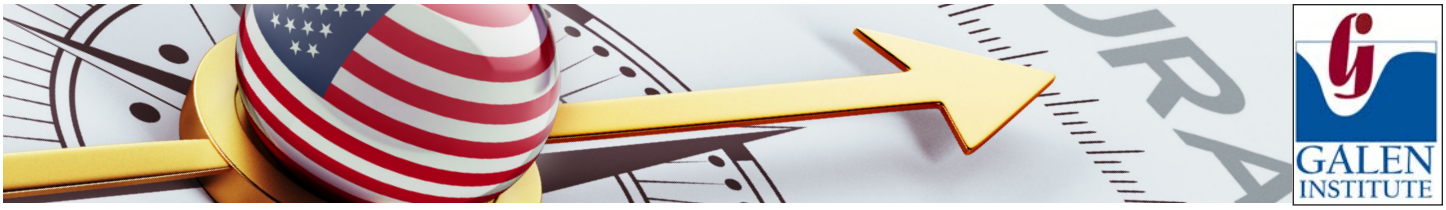
The results have been less than transformative. Only 32 organizations signed up to become Pioneer ACOs.[96] By the end of the second performance year (2013), nine of those organizations had dropped out of the program.[97] Ultimately, only nine of the original Pioneer ACOs remained in the program through 2016, with just seven achieving Medicare savings.[98] Aggregate savings totaled $61 million against a $3.4 billion benchmark, a margin of 1.8 percent.[99]

Seven of those Pioneer ACOs transitioned into "Next Generation Accountable Care Organizations," which CMS defines as "groups of doctors, hospitals and other health care providers and suppliers who come together voluntarily to provide coordinated, high-quality of care at lower costs to their original Medicare patients." Those entities generated negligible savings. The 18 active programs covering 477,197 patients in the first year reduced Medicare spending by only 1.1 percent.[100]

Although very few entities have agreed to accept the risk of something akin to global budgets, even these self-selected health systems were unable to achieve appreciable Medicare savings.

Other ACO models have produced even more disappointing results. Advanced Payment Accountable Care Organizations, a group of 36 physician-based organizations, received up-front payments to invest in resources to improve care delivery. An evaluation of the program over its first three years (2012-2014) found no statistically significant savings in 2012 and 2013, a statistically significant increase in spending in 2014, and no statistically distinguishable differences in medical care quality.[101]

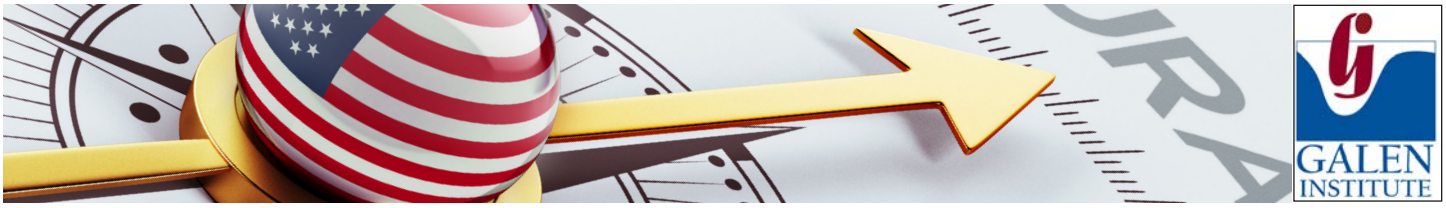
None of this inspires confidence in the ability of the government to improve the efficiency of health care delivery. Through more than half a century, successive waves of reform that policymakers hoped would extract greater value from the



health care system have fallen short. Congress and a succession of administrations have lacked the means and, at times, the political will to control federal health care spending.

It is certainly possible that this time will be different. Perhaps government has heretofore not had sufficient authority to make health care financing more efficient. Perhaps conferring on a small group of public employees plenary control over $4 trillion in annual spending will produce a system that functions with something approximating perfect efficiency. To achieve this, policymakers have first to devise a budget allocating the resources necessary to provide medical care to all Americans—not so much as to subsidize inefficiency but not so little as to create shortages—distribute that money correctly and muster the political will not to exceed its budget.

This is, of course, a theoretical possibility. But there is ample reason for caution, given government's long and undistinguished track record in this area.



Conclusion

Answering the question of why the U.S. has not adopted a centrally financed universal health care system similar to those of other developed countries is neither simple nor straightforward. The short answer is that the American system evolved very differently, with the path diverging most sharply in the aftermath of the Second World War. Its private health insurance market became viable and robust, fueled in part by the spread of ESI which, in turn, benefited from government decisions to treat health benefits differently from wage compensation and to allow collective bargaining over such benefits. That pattern was not replicated in other developed countries.

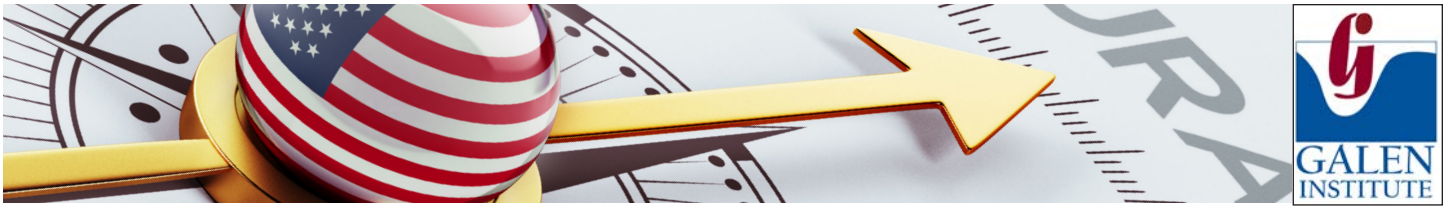
Nor is it clear what the effects of shifting to a government-financed system would have on patients. This paper has raised some important considerations of such a policy change on ESI. Specifically, it finds that substituting government financing for ESI would:

1. Place fiscal burdens on taxpayers that the private sector now voluntarily bears. In other developed countries, the government taxes workers to finance public spending on their health benefits. The U.S. exempts employer-sponsored health benefits from taxation, leveraging private spending on health benefits. Putting this private spending, along with the costs of richer coverage, on the government's ledger would have profound fiscal consequences.

2. Require workers with ESI to pay more to finance care for others. Estimates of the cost of establishing a new system vary, but all forecast a major increase in federal spending, which would to a large extent be borne by workers and employers.

3. Eliminate the higher reimbursement rates that private insurers typically pay for medical care. It may be that hospitals, physicians and other providers will be able to perform more efficiently and meet the increased demand for services that the Medicare for All Act would induce. It also is possible that a new system could not sustain the level of access to quality care that Americans now enjoy.

ESI has legions of critics on the Right and Left. Conservatives lament, among



other things, that it insulates consumers from the true cost of health insurance and, more importantly, from the true cost of care. They also note the inequity of tax preferences for ESI that do not extend to the individual purchase of health insurance and to out-of-pocket spending on medical care. And while ESI advocates view it is a valuable tool to attract and retain employees, many conservatives believe that tying health coverage to a job creates economic distortions and hampers worker mobility.

Those on the Left complain that ESI, even in combination with public programs like Medicare and Medicaid, has not achieved universal coverage, that the tax exclusion is regressive and of little value to people of modest means, and that administrative costs (especially profits), waste and unnecessary services make coverage and care more expensive and less accessible than if government alone paid for all medical care.

Both sets of critics cite the high cost and inefficiencies of the U.S. health care system, although they offer very different remedies. The Right would address these problems through market forces; the Left by putting the government in charge of allocating medical goods and services.[102]

It may very well be that the health care financing systems in other countries are superior to ours. Coverage is virtually universal in other highly developed nations, per-capita costs are lower and, at least by some measures (e.g., life expectancy at birth), outcomes are better. But even if we were to concede that point, it does not follow that adopting a government-financed system similar to those used by other countries would produce similar results in the United States.

Replacing our admittedly inelegant health care financing system with single payer is not like swapping U.S. customary units for metric measurements. It could have profound and unforeseeable consequences on the capacity of doctors, hospitals and other providers to deliver quality care. Displacements, even if temporary, carry potentially grave consequences.

Planting a new financing system requires uprooting another, one that has grown, adapted and evolved over decades. Policymakers should carefully weigh the risks of scuttling an employer-based system that provides health security to the majority of Americans and that largely finances public programs that provide coverage to others.

Endnotes

[1] Doug Badger is a Senior Fellow at the Galen Institute and a visiting fellow at the Heritage Foundation.

[2] See, for example, "America is a Healthcare Outlier in the Developed World," The Economist, April 26, 2018. https://www.economist.com/special-report/2018/04/26/america-is-a-health-care-outlier-in-the-developed-world

[3] S. 1804, introduced September 13, 2017. https://www.congress.gov/bill/115th-congress/senate-bill/1804/text?q=%7B%22search%22%3A%5B%22s+1804%22%5D%7D&r=1

[4] See, for example, Alex Blumberg and Adam Davidson, "Accidents of History Created U.S. Health System," NPR, October 22, 2009. https://www.npr.org/templates/story/story.php?storyId=114045132

[5] A succinct summary of these efforts can be found in Edward Berkowitz, "Medicare and Medicaid: The Past As Prologue," Health Care Financing Review, 2008, pp. 81-93. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195036/pdf/hcfr-29-03-081.pdf

[6] Marilyn J. Field and Harold T. Shapiro (editors), *Employment and Health Benefits*: A Connection At Risk, National Academies Press, 1993, pp. 51-53. https://www.nap.edu/read/2044/chapter/1

[7] Field and Shapiro, pp. 58-59.

[8] Field and Shapiro, p. 59.

[9] Berkowitz, pp. 81-82.

[10] Field and Shapiro, p. 63.

[11] Field and Shapiro, p. 64.

[12] Berkowitz, p. 84.

[13] Field and Shapiro, p. 57.

[14] Field and Shapiro, pp. 54-55.

[15] Field and Shapiro, pp. 65-66.

[16] Field and Shapiro, p. 66.

[17] Field and Shapiro, p. 66.

[18] Field and Shapiro, p. 68.

[19] "History of Health Insurance Benefits," Employee Benefit Research Institute, March 2002. https://www.ebri.org/publications/facts/index.cfm?fa=0302fact It should be noted that the board's ruling did not create ESI, which existed in some professions dating to at least the late nineteenth century.

[20] PL 83-591.

[21] Taft-Hartley Act, PL 80-101. https://www.historycentral.com/documents/Tafthatley.html

[22] Field and Shapiro, p. 71.

[23] Field and Shapiro, p. 71.

[24] Field and Shapiro, p. 71.

[25] "VA History," Department of Veterans Affairs. https://www.va.gov/about_va/vahistory.asp

[26] Ibid.

[27] Ibid.

[28] H. Rept. 115-929, p. 282. https://www.congress.gov/115/crpt/hrpt929/CRPT-115hrpt929.pdf. In addition to programs for veter-

ans, the federal government also operates the Indian Health Service (IHS) to provide medical care to Native Americans and Alaska Natives. "About IHS," U.S. Department of Health and Human Services. https://www.ihs.gov/aboutihs/

[29] These programs are financed differently. Medicare Part A is financed by the Health Insurance (HI) payroll tax. Medicare Parts B and D are financed by general revenues. Medicaid and CHIP are jointly financed by the federal government and the states, with the federal share paid out of general revenue.

[30] CMS, National Health Expenditures 2016, Table 6.

[31] CMS, National Health Expenditures 2016, Projection Table 5.

[32] Medicare spending source: CMS, National Health Expenditures 2016, Table 6. GDP Source: Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/GDP

[33] Medicare spending source: CMS, National Health Expenditures 2016, Table 6. GDP Source: Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/GDP

[34] Medicare spending source: CMS, National Health Expenditures 2017, Spending Projections, Table 5. GDP Source: CBO Economic Outlook, August 2018.

[35] For sources, see footnote 31.

[36] Statista, Total Medicaid Enrollment, 1966-2017. https://www.statista.com/statistics/245347/total-medicaid-enrollment-since-1966/

[37] MACStats, Medicaid and CHIP Payment and Advisory Committee, December 2017, Exhibit 1. https://www.macpac.gov/publication/medicaid-and-chip-enrollment-as-a-percentage-of-the-u-s-population/

[38] BBA 97 created the Children's Health Insurance Program (CHIP).

[39] CMS, National Health Expenditures 2016, Table 22. The figure includes all participants, including those over age 65, most of whom also participate in Medicare. The figure also Includes plans that cover federal, state and local employees, which largely resemble the health insurance arrangements used by private employers and which exempt employer contributions from income and payroll taxes.

[40] 26 USC 5000A. https://www.law.cornell.edu/uscode/text/26/5000A

[41] The employer mandate instituted by the ACA appears to have had very little effect on the percentage of workers enrolled in ESI. In general, it appears that larger firms, which are subject to the mandate, sponsored health insurance before the government required them to do so, while a fairly substantial percentage of smaller firms, which are generally exempt from the mandate, did not offer coverage to their employees.

[42] Kaiser, Exhibit 2.3.

[43] The Congressional Budget Office's theories on the coverage and premium effects of the individual mandate continue to evolve. As of November 2017, it was continuing to rely on the decade-old experience of Massachusetts and quantitative analysis of uncertain value in its speculations. (Alexandra Minicozzi, "Modeling the Effects of the Individual Mandate on Health Insurance Coverage," CBO, November 2017. https://www.cbo.gov/system/files?file=115th-congress-2017-2018/presentation/53310-presentation.pdf) After Congress repealed the tax penalty on the uninsured, effective January 2019, CBO continued to believe that the mandate exerted a fairly strong behavioral effect. In particular, the agency predicted the premiums would rise on average by 15 percent in 2019, with two-thirds of that increase attributable to repeal of the tax penalty. ("Federal Subsidies for Health Insurance Coverage For People Under Age 65," CBO, May 2018, p. 7. https://www.cbo.gov/system/files?file=2018-06/53826-healthinsurancecoverage.pdf) Average premiums for 2019 coverage actually went down slightly, suggesting that CBO still hasn't gotten it quite right. ("Premiums on Federally-Facilitated Exchanges Drop in 2019," CMS, October 11, 2018. https://www.cms.gov/newsroom/press-releases/premiums-federally-facilitated-exchanges-drop-2019), More recently, CBO has said that it plans to update its Health Insurance Simulation Model. (Letter to Honorable Mike Enzi from the CBO Director, November 14, 2018. https://www.cbo.gov/system/files?-file=2018-11/54668-HISIM-Letter.pdf)

[44] The labor force participation rate among males aged 25-54 declined from over 97 percent in 1964 to less than 89 percent in September 2018, a decline that has persisted through both recessions and periods of economic growth. "Activity Rate: Aged 25-54: Males for the United States," FRED, St. Louis Federal Reserve. https://www.cbo.gov/system/files?file=2018-11/54668-HISIM-Letter.pdf

[45] CMS, National Health Expenditures, Table 24.

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

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

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

[49] This paper is concerned largely with federal expenditures and consequently makes no effort to estimate the effects of the exclusion on state tax revenues.

[50] This assumes that employers would convert 100 percent of tax-preferred health benefit compensation to wages, which are subject to federal income and payroll taxes. Under that assumption, federal revenues would have been $348 billion higher in 2016, partially covering the cost of financing public coverage of individuals whose insurance is now privately financed.

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

[52] This ratio in some sense understates the relationship between the tax exclusion and job-based health insurance coverage. Since it is linked to health insurance premiums, it does not take into account out-of-pocket spending by employees when they obtain medical goods and services. Consider, for example, a physician office visit, for which a worker's job-based plan has negotiated a rate of $100. If the coverage requires a $15 co-payment for an office visit, insurance would pay $85. The $15 copay is thus excluded from the calculation. Assessing the effect of out-of-pocket spending for covered services is difficult to do. It is likely that in some cases, an individual who lost their ESI would not have any insurance at all. Such a person might pay a higher rate for the physician visit, because the uninsured do not have access to negotiated rates. Or they might forego the visit altogether, since they are unwilling or unable to pay the final rate. Lacking the capacity to model that behavior, this paper simply compares that amount of insurance premiums paid for ESI with the revenue loss associated with the tax exclusion.

[53] That is not to suggest that this is the most efficient means of achieving this end. Many argue that tax-preferred treatment of health insurance premiums should be extended outside the workplace and that it should apply equally to both health insurance premiums and health insurance expenditures. Others have argued in favor of tax credits, rather than deductions, to avoid providing the greatest benefit to those who pay the highest marginal rates. The Affordable Care Act created refundable tax credits for people with incomes between 100 and 400 percent of the federal poverty level who purchase nongroup policies and placed a 40 percent excise tax on employer contributions to worker premiums in excess of specified amounts. The latter provision, whose enforcement Congress has repeatedly delayed, effectively functions as a cap on the tax exclusion.

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

[55] CMS, National Health Expenditures, Table 5-3.

[56] 2017 HI Trustees Report, Table II.B1.

[57] As discussed further below, MedPAC estimates that hospitals ran a margin of -9.6 percent on Medicare patients in 2016. Medicare Payment Advisory Committee, March 2018 Report to Congress, Figure 3-6, p. 81.

[58] 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, pp. 104f. The Trustees examined the effect of reductions in Medicare reimbursement for physician and hospital services under current law. They project that hospital payment rates would be less than 37 percent of rates paid by private insurers and that

physician rates would decline substantially as well. Even assuming that private health insurance is preserved and that these insurers continue to pay at inflation-adjusted rates, the Medicare cuts already in law "would result in 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" in 2040. They similarly expect "access to Medicare-participating physicians to become a significant issue in the long term." Those assessments almost certainly would worsen if all hospitals and physicians were paid at Medicare rates.

[59] Disentangling the interplay between reimbursement rates paid by government and private insurers is a difficult business and one this paper does not attempt. The paper does not suggest that Medicare and Medicaid pay less for medical services because private health insurers pay more, or vice-versa. Policymakers have undeniably reduced Medicare payments to doctors and hospitals over the course of recent decades and have set in place future payment cuts (which may or may not materialize). That does not suggest that Medicare payment reductions have led to providers exacting higher rates from commercial insurers. What is clear is that private insurers pay higher rates to physicians and hospitals and that applying Medicare rates universally to these providers would have uncertain effects on access to medical care and its quality.

[60] S. 1804, September 2017. https://www.congress.gov/bill/115th-congress/senate-bill/1804?q=%7B%22search%22%3A%5B%22s+1804%22%5D%7D&r=1 The bill had 16 Senate sponsors in September 2018. Rep. Keith Ellison (D-MN) is the lead sponsor of the House counterpart (H.R. 676), which had 123 cosponsors in September 2018. https://www.congress.gov/bill/115th-congress/house-bill/676/text

[61] Section 201(c) also gives the Secretary authority to include coverage of "complementary and integrative medicine."

[62] Some cost-sharing would be permitted for prescription drugs (sec. 202(b)) and of long-term care, which would continue to be covered by Medicaid (sec. 204). Experimental services and drugs would not be covered (sec. 203(b)).

[63] That section also permits payments if the "health care provider providing the service exercised appropriate professional discretion to deviate from the guideline in a manner authorized or anticipated by the guideline" (sec. 203(c)).

[64] It is unclear whether this is merely a ministerial function or whether these budgets are binding. The section does not include any enforcement mechanism in cases where expenditures for covered health services exceed the budget.

[65] See, for example, Charles Blahous, "The Costs of a National Single-Payer Health Care System," Mercatus Working Paper, July 2018. https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf John Holahan et al., *The Sanders Single-Payer Healthcare Plan: The Effect on National Health Expenditures and Federal and Private Spending* (Washington, DC: Urban Institute, 2016), tables 1 and 9. https://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000785-The-Sanders-Single-Payer-Health-Care-Plan.pdf Center for Health and Economy, "Medicare for All: Leaving No One Behind," *HealthAndEconomy.org*, May 1, 2016, table 6. http://healthandeconomy.org/medicare-for-all-leaving-no-one-behind/ Kenneth E. Thorpe, "An Analysis of Senator Sanders Single Payer Plan," *Healthcare-Now.org*, January 27, 2016. https://www.healthcare-now.org/296831690-Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal.pdf

[66] Charles Blahous, "Questions and Answers About Medicare For All's Costs," E21, August 21, 2018. https://economics21.org/charles-blahous-responds

[67] See, for example, Steffie Woolhandler, David U. Himmelstein and Adam Gaffney, "Single Payer Is Actually A Bargain," The Nation, August 10, 2018. https://www.thenation.com/article/single-payer-actually-huge-bargain/

[68] As discussed later in the paper, the bill's sponsors assume that replacing private insurance with federal financing will achieve substantial administrative savings.

[69] States would be required to help finance long-term care and related services (sec. 204), but no longer would have to finance their portion of covering other Medicaid services. This paper assumes that Congress would require states to remit to the federal government the amounts they would otherwise have spent on Medicaid. If not, the bill would be a windfall to the states at the expense of the federal government.

[70] Estimating the effect of consumption is a perilous undertaking that is beyond this paper's scope. Consider dental services. The bill stipulates that UMP would cover those services (sec. 201(a) without cost-sharing. In 2016, Americans spent an estimated $124.4 billion on dentistry. Out-of-pocket spending accounted for $49.9 billion. Private health insurance financed $57.7 billion, while Medicare spending on dental services was estimated at $0.5 billion. (CMS, National Health Expenditures, Table 12). Theoretically,

UMP would have covered the entire $124.4 billion. There are several caveats. First, dental benefits are not defined in the bill. It would presumably cover preventive screenings and things like crowns, fillings and root canals. But would it cover orthodontia, dental implants and cosmetic services? Then there is the question of how much UMP would pay for such services. Unlike physician, hospital and other services, there is no Medicare fee schedule for dental services, since the program offers only very limited coverage. There is also the question of consumption. If the government picked up most or all of the $50 billion that consumers spent out of their own pockets for dentistry in 2016, would they consume more than $124.4 billion in services? That, in turn, raises the question of supply. Would the current supply of dentists—both nationally and in particular geographic areas—be sufficient to meet additional demand? Would reimbursement rates be sufficient for dentists to supply services or would some limit their practices to patients able to pay cash?

[71] As referenced above, there have been a number of estimates of the net federal costs of the Medicare For All bill and more are likely to be forthcoming.

[72] Substituting public for private spending would have macroeconomic effects that are beyond this paper's scope. Some economists have suggested that shifting from private insurance premiums to tax-based financing would likely yield a less efficient financing mechanism, which would dampen future economic growth. See, for example, Robert Graboyes, "Medicare for All: Explaining the Math," Mercatus Center, August 23, 2018. https://www.mercatus.org/bridge/commentary/medicare-all-explaining-math

[73] Estimating the magnitude of administrative savings is, as with other estimates on this subject, fraught with uncertainty. One advocate of single-payer systems has concluded that it would have reduced annual administrative spending on insurance by $220 billion in 2017. Additional administrative savings for doctors and hospitals would increase this figure to $500 billion. http://annals.org/data/Journals/AIM/936177/M170302tt1_Table_Estimated_Administrative_and_Prescription_Drug_Savings_Under_Single-Payer_Refor.jpeg The $220 billion estimate compares Medicare administrative costs as a percentage of total claims with the percentage associated with private insurance. In comparing administrative costs of private insurance with Medicare, the paper uses per-capita administrative costs as the unit of measurement. Basing an estimate on administrative costs as a percentage of claims yields a higher estimate of administrative savings, in part because average Medicare claims are much higher than average private insurance claims. The problem with this methodology is that it assumes a linear relationship between claim size and administrative costs. It is not clear, however, that the cost of administering a $1,000 medical claim is ten times as great as for a $100 claim. For that reason, this paper adopts the per capita approach. Both approaches paper over the difficulty of making apples-to-apples comparisons of public and private administrative costs. Some have argued that official government statistics on the administrative costs of Medicare are understated and that the comparison with private insurance administrative cost rates are consequently misleading. Merrill Matthews, "Medicare's Hidden Administrative Costs," Council for Affordable Health Insurance, January 2006. http://mforall.net/files/CAHI_Medicare_Admin_Final_Publication.pdf It is also worth noting that lower administrative costs are not an unalloyed good. The Comptroller General has included Medicare on its "high risk" list since 1990, because of its "size, complexity, and susceptibility to mismanagement and improper payments." Additional administrative expenditures might arguably reduce the level of mismanagement and the amount of improper payments. This paper will not seek to adjudicate these issues but will instead note that shifting insurance coverage of workers with ESI to a government program would likely achieve substantial administrative savings.

[74] What is socially acceptable in other countries – for example, longer waiting times for hospital procedures – may not be socially acceptable to Americans.

[75] "International Profiles of Health Care Systems," Commonwealth Fund, May 2017, Table 4.

[76] S. 1804, section 107.

[77] S. 1804, section 611 requires the Secretary to establish reimbursement rates "in a manner that is consistent with processes for determining payments for items and services under title XVIII of the Social Security Act" (i.e., Medicare).

[78] The bill also would seek to reduce payments for other goods and services, including prescription drugs. Since there is no Medicare fee schedule for drugs, it is difficult to quantify (even in the highly qualified sense that this paper has used) these savings. The bill directs the Secretary to negotiate drug prices (section 614(a)) and to "promote the use of generic medications" (section 614(b)). The former provision leaves considerable room for speculation over whether the savings would be modest or substantial; the latter provision would likely have a negligible effect, since generics accounted for 89 percent of prescriptions in 2016. "2017 Generic Drug Access and Savings in the U.S. Report," Association for Affordable Medicines. https://accessiblemeds.org/resources/blog/2017-generic-drug-access-and-savings-us-report

[79] Most systems allow escape valves from these limits, generally through private insurance. As noted elsewhere in this paper, the Medicare For All bill does not (see sections 107 and 801).

[80] Section 203(c) of the bill provides that "a service shall be considered to have been provided in accordance with a practice guideline if the health care provider providing the service exercised appropriate professional discretion to deviate from the guideline in a manner authorized or anticipated by the guideline." That stipulation appears to allow payment for services that deviate from a guideline only in cases where such deviation is "authorized and anticipated by the guideline."

[81] If a provider were to administer a test or treatment for which the government refused to pay, it is unclear whether the patient would be responsible for the payment or if the provider would go uncompensated. Alternatively, the sponsors may envision that the provider seek the government's permission before providing any test or service. In that case, the ambiguity would be resolved by denying patients any test or treatment for which the government declined to pay.

[82] HR 676, sections 201 et seq.

[83] Section 201(a).

[84] Section 301.

[85] Section 202.

[86] A 2012 Institute of Medicine study estimated that "unnecessary health spending" totaled $750 billion in 2009 alone." CMS estimates that health care spending totaled $2.495 trillion in that year, leading to the widely broadcast factoid that 30 percent of medical care is unnecessary. The remedy prescribed by the report was to "chart a transition to a system that learns, in real time and with new tools, how to better manage problems." Such a "continuously learning health care system" would be one that "continuously and reliably captures, curates and delivers the best available evidence to guide, support, tailor and improve clinical decision making and care safety and quality." It is safe to say that the U.S. has not advanced very far toward this ambitious goal in the six years that have passed since it was articulated and that the federal government seems uniquely ill-equipped to design and implement a "continuously learning health care system." *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, Institute of Medicine of the National Academy, September 2012. http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2012/Best-Care/BestCareReportBrief.pdf

[87] American Benefits Legacy, p. 53.

[88] The most recent Trustees report warns: "Current-law projections indicate the Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation. Such legislation should be enacted sooner rather than later to minimize the impact on beneficiaries, providers and taxpayers." (*2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 2018, p. 4. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf) Similarly worded warnings have been contained in trustees reports filed by both Democratic and Republican administrations. They have so far gone unheeded.

[89] Omnibus Budget Reconciliation Act of 1989, PL 101-239, https://www.congress.gov/bill/101st-congress/house-bill/3299

[90] "RBRVS Overview," American Medical Association. https://www.ama-assn.org/rbrvs-overview

[91] Balanced Budget Act of 1997, PL 105-33, https://www.gpo.gov/fdsys/pkg/PLAW-105publ33/content-detail.html

[92] "The Sustainable Growth Rate and Medicare Physician Payments: Frequently Asked Questions," Congressional Research Service, March 16, 2015, p. 1. https://www.everycrsreport.com/files/20150316_R43430_a81ad39199b03381319ab08f9bee28dd6804badc.pdf

[93] Medicare Access and CHIP Reauthorization Act, PL 114-10. https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf

[94] All figures in this paragraph are taken from *2018 Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 5, 2018, Table V.D1, p. 194. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf It is worth noting that, while payments to physicians comprise the vast majority of Part B spending, there are other components as well. These include Medicare reimbursement for physician-administered drugs. Congress has repeatedly revised the formula for paying for such drugs as well and two successive administrations have now proposed demonstration projects designed to reduce spending on these products. As with payments for physician services, these various payment reforms have not arrested Medicare Part B spending growth.

[95] The St. Louis Fed index for the medical portion of CPI-U (medical) was 156,000 in January 1990. In January 2018, it had risen to 481,437. The CMS actuary forecast that it would increase by 4.3 percent in 2019 and by 4.2 percent in 2020. Applying those in-

creases to the January 2018 CPI-U (medical) reported by the St. Louis Fed yields 523,029. That figure is 3.35 times the January 1990 rate. Medicare Part B per-capita expenditures, meanwhile, increased by a factor of 5.06 over that same period, outstripping medical inflation by 51 percent. The St. Louis Fed data through January 2018 can be found at: https://fred.stlouisfed.org/series/CPIMEDSL The CMS Actuary's estimates of CPI-U (medical) for 2019 and 2020 are at *2017 Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 2017, Table V.B2, p. 179. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf

[96] *Evaluation of CMMI Accountable Care Organization Initiatives*, L&M Policy Research, December 2, 2016, p. xi. https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf

[97] Ibid, p. xi.

[98] Ibid, Table 15, p. 75.

[99] These figures are taken from the Performance Year Five spreadsheet, which is linked at "Pioneer CMO Model," Center for Medicare and Medicaid Services. https://innovation.cms.gov/initiatives/Pioneer-aco-model/

[100] Kristina Hanson Lowell, "Next Generation Accountable Care Organization Model Evaluation," NORC at the University of Chicago, August 27, 2018. https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf That does not mean that spending was 1.1 percent lower than in the prior year, but 1.1 percent less than the program would have spent on this population in 2016.

[101] "Evaluation of CMMI Accountable Care Organization Initiatives: Advance Payment ACO Final Report," L&M Policy Research, LLC, November 25, 2016. https://innovation.cms.gov/Files/reports/advpayaco-fnevalrpt.pdf

[102] The author's sympathies lie decidedly on the pro-market side of this theological divide.

[103] This table includes the category of "other third party payers and public health activity" in its calculation of government expenditures. This category includes some private third party payment, although a range of government programs (e.g., VA, IHS, workers compensation, MCH, VR, SAMHSA, school health and an unspecified list of "other" federal, state and local programs) account for the bulk of spending.

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