



Answers to Questions for the Record Following a Hearing Conducted by the House Committee on the Budget: Key Design Components and Considerations for Establishing a Single-Payer Health Care System

On May 22, 2019, the House Committee on the Budget convened a hearing at which Mark Hadley, the Congressional Budget Office's Deputy Director, Jeffrey Kling, CBO's Associate Director for Economic Analysis, and Jessica Banthin, CBO's former Deputy Assistant Director in the Health, Retirement, and Long-Term Analysis Division testified about the agency's report Key Design Components and Considerations for Establishing a Single-Payer Health Care System.¹ After the hearing, Ranking Member Womack and Congressman Roy of the Committee submitted questions for the record. This document provides CBO's answers. It is available at www.cbo.gov/publication/55951.

Ranking Member Womack

Question. The CBO report states: "Government spending on health care would increase substantially under a single-payer system because the government (federal or state) would pay a large share of all national health care costs directly."

- How much of the spending on federal health programs is funded by: Taxes collected through the Treasury? Direct payments by beneficiaries in the form of premiums and out-of-pocket spending? Tax deductions for employer-sponsored health insurance? Other?
- What percentage of total health expenditures is NOT paid for by the federal government, which would likely be shifted to the federal government under a single-payer system?

Answer. In fiscal year 2018, federal spending on major health care programs totaled \$1.2 trillion, which consisted of spending on Medicare (excluding the effects of premiums and other offsetting receipts), Medicaid, and the Children's Health Insurance Program (CHIP), as well as subsidies for plans purchased through the marketplaces established by the Affordable Care Act (ACA).² Virtually all of the financing for the programs other than Medicare comes from the general fund of the Treasury. In 2018, combined funding for those programs amounted to \$456 billion.

In 2018, transfers from the general fund of the Treasury accounted for \$312 billion of the total funding for Medicare, revenues from payroll taxes accounted for \$265 billion, and

1. See Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System* (May 2019), www.cbo.gov/publication/55150.

2. See Congressional Budget Office, "10-Year Budget Projections" (August 2019), Table 1-4, www.cbo.gov/about/products/budget-economic-data#3. That estimate does not include other federal spending for health care, such as health insurance costs for federal employees, veterans' health care, and the military health care system.

beneficiaries' premiums accounted for \$99 billion. The remaining sources of financing for Medicare, which together account for less than 10 percent of the program's funding, include the following: revenues from a portion of the federal income taxes that Social Security recipients with income above a certain threshold pay on their benefits; interest credited to Treasury securities held in the Medicare trust funds (which in turn is financed by the Treasury's general fund); and payments from the states to help finance Medicare Part D.

The tax exclusion for employment-based health insurance reduces federal revenues and is therefore a federal subsidy for health insurance. The staff of the Joint Committee on Taxation (JCT) and CBO estimate that the tax exclusion cost the federal government about \$300 billion in forgone revenues in 2018.³ Altogether, that tax exclusion plus federal spending on major health care programs amounted to \$1.5 trillion in 2018.

Currently, national health care spending—which totaled \$3.5 trillion in 2017—is financed through a mix of public and private sources. Private sources paid more than half of that amount, and state or local governments paid about one-tenth. The federal government paid 37 percent of the total, or \$1.3 trillion.⁴ The percentage of national health expenditures that would be shifted to the federal government under a single-payer system would depend on the design of the system. Two key design features are the services that would be covered by the single-payer system and the amount of cost sharing that would be required. In a system covering a comprehensive set of benefits with little cost sharing, most national health expenditures would be made by the federal government. The total effect on the federal budget and the amounts individuals and organizations paid for health care coverage would depend on how the system was financed.

Question. The CBO report states: “In a federally administered single-payer system, the associated cash flows would be federal transactions, in CBO’s view, and the spending and revenues for the system would appear in the federal budget.”

- Please explain this statement further.
- How would CBO determine if this new spending would be considered mandatory or discretionary?
- What are the potential trade-offs and risks if the federal spending was mandatory or discretionary?

Answer. A single-payer system might be administered entirely by federal agencies, or private entities might play some role. CBO generally treats the transactions of nonfederal entities as federal if those entities act as agents of the federal government by using the sovereign power of the federal government, work to achieve a governmental purpose, or if they are subject to a significant degree of federal control. In CBO’s view, the spending and revenues of the system would be governmental even if the private sector played some role in administering

3. See Congressional Budget Office, “Reduce Tax Subsidies for Employment-Based Health Insurance,” *Options for Reducing the Deficit: 2019 to 2028* (December 2018), www.cbo.gov/budget-options/2018/54798.

4. The estimates of national health care spending by source of payment are from Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, “National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960–2018” (accessed February 15, 2019), <https://go.usa.gov/xEUS6>. The estimates of national and federal spending on health care include spending on investment in the medical sector, which accounts for 5 percent of national spending on health care and 3 percent of federal spending on health care. The estimates of federal spending for Medicare exclude the effects of premiums and other offsetting receipts. The estimates do not account for tax subsidies, such as the federal tax exclusion for employment-based health insurance.

it. For example, the federal government could contract with one or more private insurers to administer the program, and the responsibilities of those insurers could include collecting premiums and paying providers. Because those insurers would be acting as agents of the federal government, CBO would classify the cash flows as governmental in its cost estimates.⁵

For a system in which private insurers delivered the benefits, key design choices would be as follows: how policymakers would structure the competition among private insurers, how private insurance might supplement a standard benefit, and how such supplemental benefits would relate to previously existing benefits. Such a system could be more akin to a multi-payer system than a single-payer system if private insurers paid providers. However, some analysts would consider such a system to be a single-payer system if the government defined the eligible population, specified the covered services, collected the resources needed for the plan, required the eligible population to contribute toward financing the system, and showed the receipts and expenditures associated with the plan in the government's budget. That type of system could retain previously existing benefits.

Mandatory Versus Discretionary Funding. The spending for a single-payer system would be considered mandatory if the authorization act that established the new program also controlled its funding. The spending would be considered discretionary if the authorization act established the new program but did not control its funding. In the latter case, the amount of funding for the new program would be determined through the annual appropriation process. Those appropriations are subject to a set of budget enforcement rules and processes that differ from those that apply to mandatory spending.

Advantages and Disadvantages of Each Type of Funding. Specifying the spending for a single-payer system as mandatory rather than discretionary would provide greater certainty in funding for the program, which would be helpful to beneficiaries, providers, and manufacturers of drugs and medical devices. If spending for the program was discretionary, its funding would lapse if the appropriation bill for the program was not passed by the start of the fiscal year. In that case, temporary funding could be provided through a continuing resolution. Specifying the spending for a single-payer system as discretionary would give the Congress a formal mechanism to review the program on a yearly basis and make modifications that Members deemed appropriate. The Congress also could use other mechanisms to encourage reviews at less frequent intervals, such as a sunset provision whereby the program would end on a specified date unless it was reauthorized. Keeping total costs within the appropriated amount and minimizing disruptions as total spending neared that amount would be challenging if the government's role was to pay private-sector providers for all services rendered.

Question. The CBO report states, "A standardized IT system could help a single-payer system coordinate patient care by implementing portable electronic medical records and reducing duplicated services....Establishing an interoperable IT system under a single-payer system would have many of the same challenges as establishing an interoperable IT system in the current health care system with its many different providers and vendors."

- What is the current status of the Affordable Care Act website? What does it do? How many people use it to verify eligibility? What is the scale of the ACA website compared to a centralized IT system CBO describes in the report? The ACA website is a verification

5. See Congressional Budget Office, *How CBO Determines Whether to Classify an Activity as Governmental When Estimating Its Budgetary Effects* (June 2017), www.cbo.gov/publication/52803, and *The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System* (May 2009), www.cbo.gov/publication/41185.

system and not a payment system, correct? How much has been spent on the ACA website to date? Did the ACA website ever have technical difficulties after its launch? What were some of these difficulties?

- What is the HITECH Act that was included in the stimulus package in 2009? How much was allocated to the project? What is the status of the project today? Is this an interoperable system, similar to what is described in the report?

Answer. The Centers for Medicare & Medicaid Services (CMS) was responsible for developing a federally facilitated marketplace for states without their own marketplaces. The federally facilitated marketplace includes a website—[HealthCare.gov](https://www.healthcare.gov)—that is currently operational. It serves as a portal for consumers and several supporting information technology (IT) systems.

In 2019, 32 states use the federally facilitated marketplace, and 12 states and the District of Columbia operate their own state-based marketplaces. The remaining 6 states perform some administrative functions for their marketplaces, but all rely on the federal website and supporting IT systems.⁶

Utilization of Marketplace Websites. Consumers can compare health insurance plans and purchase a plan through the state marketplace websites or [HealthCare.gov](https://www.healthcare.gov). The marketplaces verify that people are eligible for coverage before allowing them to enroll and provide people with an estimate of the cost of their coverage after accounting for any subsidies for which they are eligible. In some states, the marketplaces also can determine whether people are eligible for coverage through Medicaid or the Children’s Health Insurance Program. In other states, the marketplaces make an initial assessment of eligibility for those programs and transfer applicants’ information to state agencies for final determination. The marketplace websites are a verification and enrollment system, not a payment system. CMS uses supporting IT systems to review, approve, and generate financial assistance payments—such as premium tax credits and cost-sharing reductions—to insurers.

Over the course of the year, the average number of consumers who enrolled in the marketplaces and paid for their coverage across all states was about 5.5 million in 2014, 9.4 million in 2015, 10.0 million in 2016, 9.8 million in 2017, and 9.9 million in 2018. For 2019, that number is 9.5 million in CBO’s projections. In addition, some people who apply for coverage through the marketplaces are determined to be eligible for Medicaid or CHIP and enroll in one of those programs. For example, that was the case for 5.2 million people in 2016.

The scale of the websites and supporting IT systems that serve the ACA marketplaces is much smaller than the scale of a centralized IT system that would be needed under a single-payer system. To put that in perspective, the total U.S. population was about 327 million in 2018.⁷

Cost of Implementing the Health Insurance Marketplaces. Through 2014, CMS spent \$8.4 billion to set up the marketplaces. That figure includes about \$5 billion in grants to states and an additional \$3.4 billion in spending by CMS.⁸ Those amounts include spending to establish all functions of the marketplaces, not just spending devoted to the websites and supporting IT systems. Based on information from CMS, about \$2.1 billion was spent on

6. See Kaiser Family Foundation, “State Health Insurance Marketplace Types, 2020,” <https://tinyurl.com/yafjlgjn>.

7. See Census Bureau, “Quick Facts” (July 2018), www.census.gov/quickfacts/fact/table/US/PST045218.

8. Even states that run their own marketplaces rely on the federal IT infrastructure of [HealthCare.gov](https://www.healthcare.gov) and use the data hub built and maintained by the federal government. See Annie L. Mach and C. Stephen Redhead, *Federal Funding for Health Insurance Exchanges*, Report for Congress R43066 (Congressional Research Service, October 29, 2014), <https://fas.org/sgp/crs/misc/R43066.pdf> (479 KB).

IT infrastructure for the federally facilitated marketplaces from 2014 through 2018.⁹ (CBO does not have information on the amount spent on IT infrastructure for the state-based marketplaces.)

Technical Difficulties. The website for the federally facilitated marketplace experienced technical difficulties after it was launched. According to a report issued by the Government Accountability Office (GAO) in 2015, there were several problems with the development and rollout of [HealthCare.gov](https://www.healthcare.gov). People faced significant obstacles when they tried to create accounts and enroll in the system. Some of the issues that GAO highlighted included inadequate planning by CMS regarding the capacity needed for the system, software coding errors, and a failure to implement all planned functionality before the system was launched. Additionally, GAO concluded that CMS did not apply best practices for the system's development, which contributed to problems with the launch of [HealthCare.gov](https://www.healthcare.gov). After the website was launched, CMS took steps to address those problems by increasing capacity, requiring additional software quality reviews, and awarding a new contract to complete the development of the systems.¹⁰

The marketplace's supporting IT systems, which perform functions such as linking consumers' information to other systems to facilitate the enrollment process and payments to insurers, also experienced difficulties. Prior to 2016, for example, CMS used an interim process to calculate and authorize financial assistance payments. The federal marketplace fully transitioned to an automated system in 2016 and nearly all of the state marketplaces have transitioned.¹¹

The HITECH Act. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) encouraged health care providers to adopt health information technology. That act established a program that provided incentive payments early in the program and imposed penalties that came later. Eligible providers needed to demonstrate the ability to use a certified electronic health record (EHR) system in a meaningful way and meet other requirements. The legislation included a "certification" component that required EHRs to have certain common capabilities and a "meaningful use" component that required health care providers to meet certain criteria regarding their use of EHRs, such as using them for e-prescribing and reporting clinical quality measures.

According to CMS, the agency paid providers more than \$30 billion from 2011 to 2018 through the Medicare and Medicaid EHR incentive programs.¹² As of 2017, 80 percent of

9. See Centers for Medicare & Medicaid Services, *Justification of Estimates for Appropriations Committees, Fiscal Year 2020* (2019), p. 167, <https://go.usa.gov/xVJhs> (PDF, 4.5 MB); *Justification of Estimates for Appropriations Committees, Fiscal Year 2019* (2018), p. 166, <https://go.usa.gov/xVJhF> (PDF, 4.5 MB); *Justification of Estimates for Appropriations Committees, Fiscal Year 2018* (2017), p. 171, <https://go.usa.gov/xVJhJ> (PDF, 3.6 MB); *Justification of Estimates for Appropriations Committees, Fiscal Year 2017* (2016), p. 307, <https://go.usa.gov/xVSqQ> (PDF, 9.1 MB); and *Justification of Estimates for Appropriations Committees, Fiscal Year 2016* (2015), p. 88, <https://go.usa.gov/xVSqA> (PDF, 10.2 MB).

10. See Government Accountability Office, *CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices*, GAO-15-238 (March 2015), www.gao.gov/assets/670/668834.pdf (4.8 MB).

11. See Department of Health and Human Services, Office of Inspector General, *Initial Review of CMS's Automated System for Processing Financial Assistance Payments* (attachment to a letter to the Honorable Gus Bilirakis, May 8, 2017), <https://oig.hhs.gov/oas/reports/region2/21702001.pdf> (492 KB).

12. See Centers for Medicare & Medicaid Services, "Data and Program Reports" (May 2019), <https://go.usa.gov/xVSqD>. In 2018, CMS changed the name of its EHR incentive programs to the Medicare and Medicaid Promoting Interoperability Programs to focus on improving interoperability and patients' access to health information.

office-based physicians had adopted a certified EHR system, and 96 percent of all nonfederal acute care hospitals had a certified health IT system.¹³

Although interoperability of EHRs was an important goal of the HITECH Act, that goal has not been achieved.¹⁴ (Interoperability is the ability of two or more systems to exchange information and the ability of those systems to use the information that has been exchanged without special effort.) The Office of the National Coordinator (ONC) at CMS has reported that electronic health information is often spread across multiple providers that use different systems that are not interoperable.¹⁵ In 2017, just over 40 percent of hospitals engaged in all four domains of interoperability defined by the ONC: sending, receiving, finding, and integrating electronic patient records from external sources.¹⁶

Question. The CBO report states: “Under the current system, CBO estimates, an average of 29 million people per month—11 percent of U.S. residents under age 65—were uninsured in 2018.”

- The report found that 243 million people under the age of 65 had health insurance. Where does this group of people get their insurance? How many of these individuals obtain their insurance from companies or businesses? Unions? Self-employment?
- Would the individuals who currently have coverage, roughly 300 million Americans, be affected if we moved to a single-payer system? How many people who currently have coverage would be disrupted by the potential effects of such a massive overhaul?
- What is the breakdown of the uninsured population near retirement, 50–64 years old? What is their general health status? What are their overall health conditions?

Answer. People under the age of 65 obtain health insurance coverage from various sources. A majority of those people have employment-based coverage—in 2019, an estimated 159 million people, or 58 percent of the total nonelderly population.¹⁷ Of that total, roughly 6 million people are covered by multiemployer union plans.

On average, another 69 million people under the age of 65 obtain coverage through Medicaid or CHIP, 14 million obtain insurance through private nongroup plans, 1 million (who live in Minnesota and New York) are covered by the Basic Health Program, 8 million are covered by Medicare, and 3 million have coverage from other sources, such as student health plans or foreign sources.

13. See Office of the National Coordinator for Health Information Technology, “Health IT Dashboard” (updated June 17, 2019), <https://dashboard.healthit.gov/quickstats/quickstats.php>.

14. See Julia Adler-Milstein, “Moving Past the EHR Interoperability Blame Game,” *NEJM Catalyst* (July 2017), <https://catalyst.nejm.org/ehr-interoperability-blame-game/>.

15. See Government Accountability Office, *Health Information Technology: HHS Should Assess the Effectiveness of Its Efforts to Enhance Patient Access to and Use of Electronic Health Information*, GAO-17-305 (March 2017), www.gao.gov/assets/690/683388.pdf (6.6 MB).

16. See Office of the National Coordinator for Health Information Technology, *Variation in Interoperability Among U.S. Non-federal Acute Care Hospitals in 2017*, ONC Data Brief 42 (November 2018), <https://go.usa.gov/xppxG> (PDF, 647 KB).

17. The responses to this question are based on CBO’s estimates for 2019. All of those estimates reflect average monthly enrollment over the course of the year. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085. That report was published shortly after the release of *Key Design Components and Considerations for Establishing a Single-Payer Health Care System*.

CBO and JCT estimate that in 2019 between 4 million and 5 million people are enrolled in health insurance that is subsidized by the income tax deduction for health insurance premiums that is available to people who are self-employed.¹⁸ Many of those people purchase insurance on an individual basis instead of as part of a group; their coverage is categorized as nongroup rather than employment-based even though their subsidies are work-related.

Effects of a Single-Payer System on People Who Currently Have Coverage. In CBO's estimation, if private insurance was eliminated under a single-payer system, the following people under age 65 would need to switch their coverage to the single-payer plan: 159 million with employment-based insurance, 14 million with nongroup coverage, and 1 million with coverage through the Basic Health Program. Those estimates cannot be added to yield an estimate of the total number of people with private insurance because some people report more than one type of coverage. The role of private insurance under a single-payer system would depend on its design. For example, the system might eliminate private insurance, or it could retain a role for private insurance, such as offering benefits that supplement the public plan.

If current public programs were eliminated, people of all ages who participated in those programs would need to switch their coverage: an estimated 75 million enrolled in Medicaid, 7 million enrolled in CHIP, and 61 million enrolled in Medicare. (Those numbers count people with two sources of coverage, such as Medicare and Medicaid, in both categories.) Depending on the system's design, some people who now have public coverage could continue to have such coverage under a single-payer system, but their covered benefits and cost sharing might change.

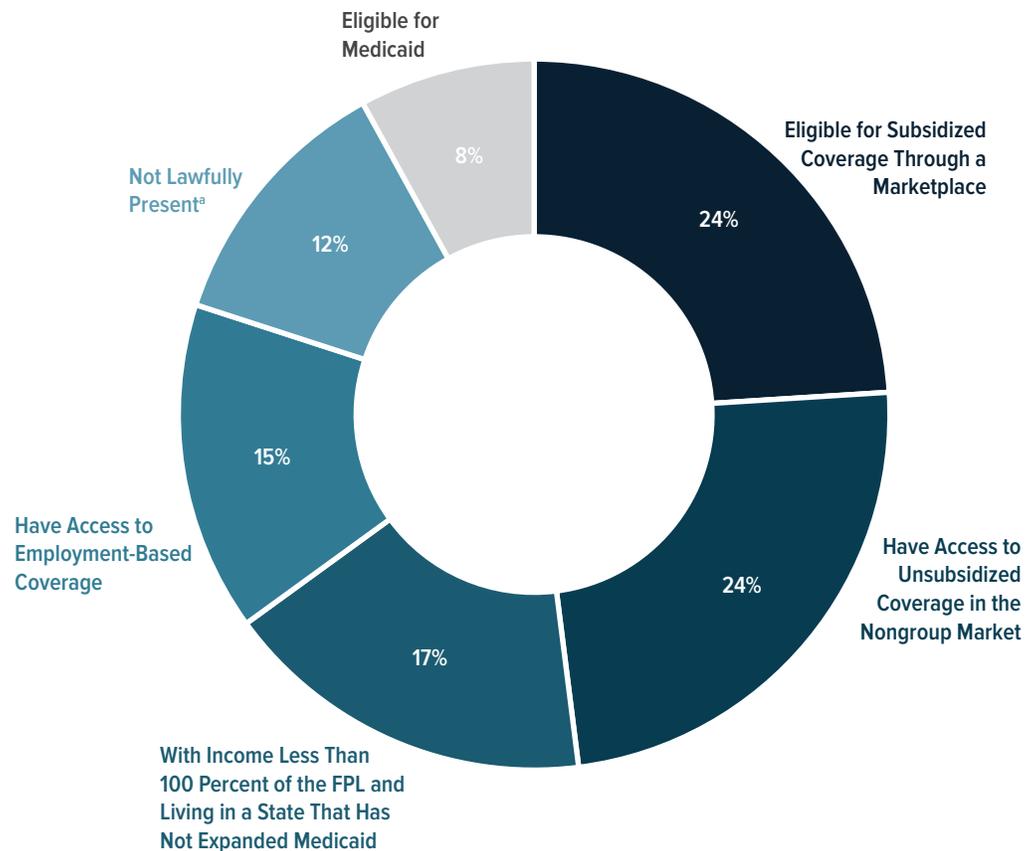
The Uninsured Population 50 to 64 Years Old. Among people ages 50 to 64 who are uninsured, CBO estimates, 24 percent are eligible for subsidized coverage through a marketplace, 24 percent have access to unsubsidized coverage in the nongroup market but choose not to purchase it, 17 percent have income less than 100 percent of the federal poverty guidelines (commonly referred to as the federal poverty level, or FPL) and live in a state that did not expand Medicaid, 15 percent have access to employment-based coverage, 12 percent are non-citizens who are not lawfully present in this country, and 8 percent are eligible for Medicaid but are not enrolled (see Figure 1).

According to CBO's analysis of data from the 2018 National Health Interview Survey, people between the ages of 50 and 64 who were uninsured had worse self-reported health status than people in the same age category who were insured. Among people ages 50 to 64 who were uninsured, 45.4 percent reported that they were in excellent or very good health, 34.0 percent were in good health, and 21.0 percent were in fair or poor health. By contrast, among people ages 50 to 64 who had health insurance, 54.4 percent reported that they were in excellent or very good health, 29.2 percent were in good health, and 16.3 percent were in fair or poor health. However, among people ages 50 to 64, the uninsured were less likely than those with insurance coverage to report having ever been told by a medical professional that they had certain medical conditions, such as diabetes (12.6 percent versus 14.1 percent), hypertension (35.7 percent versus 43.6 percent), or coronary heart disease (2.3 percent versus 4.9 percent). Those differences in reported health conditions might reflect differences between people with and without insurance coverage—specifically, differences in the nature and amount of their contact with the medical system—and thus differences in the opportunity for certain conditions to be diagnosed.

18. This estimate includes policyholders plus their dependents.

Figure 1.

Composition of the Uninsured Population Ages 50 to 64, 2019



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

FPL = federal poverty level.

a. Noncitizens who are not lawfully present in this country are ineligible for marketplace subsidies and for most Medicaid benefits.

Question. The CBO report states: “An expansion of insurance coverage under a single-payer system would increase the demand for care and put pressure on the available supply of care.... If the number of providers was not sufficient to meet demand, patients might face increased wait times and reduced access to care.”

- What factors led CBO to state: “...patients might face increased wait times and reduced access to care”?
- In a single-payer system with little or no cost sharing relative to our current system, would demand for medical services increase? If provider payments decreased, would a single-payer system have the capacity to meet the demand? Please explain these trade-offs and risks.
- What does “reduced access to care” mean in CBO’s view?
- What do wait times in other countries with single-payer health systems currently look like compared to the United States?

- What about systems within the United States that the government administers? The VA is primarily a government-run health care system. Were wait times ever a problem at the VA? What are recent examples?

Answer. A single-payer system with little cost sharing for medical services would lead to increased demand for care in the United States because more people would have health insurance and because those already covered would use more services. The extent to which the supply of care would be adequate to meet that increased demand would depend on various factors, such as the payment rates for providers and any measures taken to increase supply. If coverage was nearly universal, cost sharing was very limited, and the payment rates were reduced compared with current law, the demand for medical care would probably exceed the supply of care—with increased wait times for appointments or elective surgeries, greater wait times at doctors’ offices and other facilities, or the need to travel greater distances to receive medical care. Some demand for care might be unmet.

Certain government policies could increase supply in the short run. For example, states could ease restrictions on the responsibilities that nurse practitioners and physicians’ assistants are allowed to assume.

Over the longer term, the federal government could implement policies to encourage investment in the health care system. Examples include investing in both physical infrastructure (for instance, subsidizing the cost of additional hospital beds) and human capital (for instance, more heavily subsidizing medical education). Without sufficient investment over the long term, wait times could lengthen as providers’ costs rise with other costs in the economy and the population grows.

Wait Times in the United States and Other Countries. In 2016, wait times in the United States were comparable to those in other countries for routine care, but wait times tended to be shorter for treatment by specialists or elective surgeries. A much larger share of the U.S. population reported barriers to obtaining care because of costs rather than wait times.¹⁹ The reverse would be the case under a single-payer system in the United States that had little or no cost sharing.

Access to Care in Public Programs in the United States. The federal government administers health insurance for the elderly and the disabled through the Medicare program. It provides coverage for that population to receive care from private providers and contracts with private insurers to offer coverage. Medicare beneficiaries generally do not report issues with access to care.²⁰ Almost all providers accept Medicare patients.

Medicaid is a health insurance program for the low-income population that is administered jointly by the federal and state governments. Because of the relatively low payment rates set by state governments, Medicaid beneficiaries report more access issues—such as difficulty obtaining appointments—than privately insured patients do.²¹

Rather than administering an insurance plan, the Department of Veterans Affairs (VA) operates an integrated health care system in which most of the veteran beneficiaries receive

19. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.4 MB).

20. See Medicare Payment Advisory Commission, “Chapter 4: Physician and Other Health Professional Services,” *Report to the Congress: Medicare Payment Policy* (March 2019), pp. 100–108, <https://go.usa.gov/xVhWU> (PDF, 367 KB).

21. See Medicaid and CHIP Payment and Access Commission, “Key Findings on Access to Care,” <https://go.usa.gov/xV4X7>.

only a portion of their health care (with few or no out-of-pocket expenses). According to the March 2018 VA Inspector General Report, access to health care—including wait times, scheduling practices, and the distance to facilities—continues to be an issue for VA.²² To address those issues, the VA MISSION Act of 2018 (which went into effect in June 2019) expanded VA's capacity to provide health care at non-VA facilities for eligible veterans.

Question. The CBO report states: “Public spending would increase substantially relative to current spending if everyone received long-term services and supports benefits.”

- What are long-term services and supports (LTSS) benefits and who receives them under the current system?
- How are these benefits covered now? What is the role of the states in funding the benefits?
- How would utilization change if these benefits were made free for patients?
- Please discuss the Community Living Assistance Services and Supports (CLASS) program. What was the program? What was the CBO cost estimate (both within the 10-year window and beyond)? Why did this program never go into effect? Was this program repealed?

Answer. Long-term services and supports include a range of health services and other types of assistance to people who have difficulty completing self-care tasks because of disabling conditions or chronic illnesses. LTSS care is provided in nursing homes and other institutional settings, in people's homes, and in community-based settings. LTSS includes care furnished by paid providers and by unpaid family members and friends.²³

Funding for LTSS. Public and private entities spent an estimated \$366 billion on LTSS in 2016.²⁴ Public sources accounted for 70 percent of that total spending. Medicaid (including both federal and state payments) accounted for 42 percent, Medicare accounted for 22 percent, and other public sources (such as the Veterans Health Administration) accounted for 6 percent. Many of the people who receive Medicaid benefits for LTSS use their own funds to pay for such services before they qualify for Medicaid. Out-of-pocket payments accounted for 16 percent of spending on LTSS in 2016. Payments by private insurance and other private sources make up a small portion of LTSS spending.

Changes in Utilization of LTSS Care If It Was Free. Utilization of LTSS would increase if those benefits had little or no cost sharing. Demand for such care would increase among those who would otherwise use their own funds to pay for it. Much of LTSS is unpaid (or informal) care currently provided by family members and friends. If a single-payer system covered LTSS with little or no cost sharing, a substantial share of unpaid care might shift to paid care. That effect could be particularly large if the single-payer plan covered home- and community-based services, which many people prefer to care in an institution.

22. See Department of Veterans Affairs, Office of Inspector General, “Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15” (March 13, 2018), <https://go.usa.gov/xV4kc>.

23. See Erica L. Reeves and MaryBeth Musumeci, *Medicaid and Long-Term Services and Supports: A Primer* (Kaiser Family Foundation, December 2015), <https://tinyurl.com/y45ybqnr>.

24. See Congressional Research Service, *Who Pays for Long-Term Services and Supports?* (August 2018), <https://fas.org/sgp/crs/misc/IF10343.pdf> (340 KB). Experts disagree on whether skilled nursing facility care and home health care covered under Medicare should be classified as LTSS. In the estimates presented in this response, spending on those services under Medicare is included in the total estimated spending on LTSS.

The CLASS Program. The ACA authorized a national, voluntary insurance program—known as the Community Living Assistance Services and Supports program—that was intended to help people cover the cost of LTSS. The CLASS program, which was never implemented, would have allowed working adults to make premium contributions for five years before being eligible to claim benefits under the program. They would have been required to be actively employed or to have earned an income for at least three of the first five years of enrollment in the program. In addition, eligible workers could not have been excluded because of their health status or preexisting conditions. The program would have provided a daily cash benefit if a person had difficulty with at least two activities of daily living.²⁵

CBO estimated that the difference between the premiums and costs in the initial years of the CLASS program would result in net federal savings of \$70 billion over the first 10 years because no benefits would have been paid out in the first five years of the program. However, CBO also reported that the program would increase budget deficits in later years by far more than the savings in the first 10 years.²⁶

Designing a program that would have been actuarially sound proved to be a challenge because it would have needed to attract enough relatively healthy enrollees to ensure that the program's premiums and the interest on those premiums were adequate to pay for future benefits. But the program would have been most appealing to people with the greatest likelihood of needing care, and people might have postponed enrolling in the program until they became at risk for being disabled. Because of those challenges, the Secretary of Health and Human Services announced in 2011 that she did not “see a viable path forward for CLASS implementation,” and the program was later repealed in January 2013.²⁷

Question. The CBO report highlights several issues hospitals might face if there was a shift to single-payer health care: “A single-payer system could retain current ownership structures, or the government could play a larger role in owning hospitals and employing providers. In one scenario, the government could own the hospitals and employ the physicians, as it currently does in most of the VHA system.”

- What is the hospital ownership structure in the United States today?
- How would the quality of care change during a transition if the government takes more of a responsibility in the ownership of hospitals?
- What other changes could hospitals see if we change to a single-payer system?

25. See Joanne Kenen, “The CLASS Act (Updated),” *Health Affairs*, Health Policy Brief (November 2011), www.healthaffairs.org/doi/10.1377/hpb20111117.188451/full/.

26. See Congressional Budget Office, *Measuring the Costs of Federal Insurance Programs: Cash or Accrual?* (December 2018), www.cbo.gov/publication/53921, and “Estimating the Budgetary Effects of the Affordable Care Act,” *CBO Blog* (June 17, 2014), www.cbo.gov/publication/45447.

27. See Joanne Kenen, “The CLASS Act (Updated),” *Health Affairs*, Health Policy Brief (November 2011), <https://www.healthaffairs.org/doi/10.1377/hpb20111117.188451/full/>.

Answer. Currently, there are 6,210 hospitals in the United States. Of that total, 5,262 (or 85 percent) are community hospitals, which are nonfederal, short-term general and specialty hospitals.²⁸ Both private and public entities own hospitals. Specifically:

- 48 percent are privately owned not-for-profit community hospitals;
- 21 percent are privately owned for-profit community hospitals;
- 16 percent are state and local government community hospitals;
- 3 percent are federal government hospitals;
- 10 percent are nonfederal psychiatric hospitals; and
- 2 percent include nonfederal long-term care hospitals and hospital units within an institution, such as prison hospitals or school infirmaries.²⁹

Among community hospitals, 56 percent are private not-for-profit hospitals, 25 percent are for-profit hospitals, and 18 percent are owned by a state or local government.

The quality of care delivered in a hospital is not necessarily determined by its form of ownership. Depending on other features of a single-payer system, such as hospital payment rates, publicly owned hospitals under a single-payer system might provide better or worse care on average than privately owned hospitals under the current system. The transfer of ownership from private to public might be disruptive to the daily operation of hospitals, however. Such disruption might negatively impact the quality of care for patients.

The effects of a single-payer system on hospitals would depend on the system's design. A key design feature would be the method of determining payments to hospitals. Under one approach that has been discussed, hospital payment rates would be set to equal Medicare rates, which are much lower on average than the rates that private insurers pay hospitals for their commercial plans and much higher than the "base rates" paid by Medicaid. However, after accounting for additional payments from state Medicaid programs to hospitals that are not tied to particular admissions, Medicaid payment rates are similar to—and may even be greater than—Medicare rates.³⁰

On balance, CBO expects that a single-payer system that paid hospitals using Medicare rates would result in a substantial decline in hospitals' average payment rates. Such a system would place considerable financial pressure on hospitals, particularly those that derive a substantial share of their business from commercially insured patients.

28. According to the definition developed by the American Hospital Association, the specialty hospitals captured in the definition of community hospitals include those that focus on areas such as obstetrics and gynecology; eye, ear, nose, and throat; long-term acute care; rehabilitation; and orthopedics. Excluded are psychiatric hospitals and hospitals not accessible by the general public, such as prison hospitals and college infirmaries.

29. See American Hospital Association, "Fast Facts on U.S. Hospitals, 2019" (accessed June 13, 2019), <https://tinyurl.com/y8nquhjs>.

30. For analyses of how Medicaid hospital payment rates compare with Medicare rates, see Devin A. Stone, Bridget A. Dickensheets, and John A. Poisal, "Comparison of Medicaid Payments Relative to Medicare Using Inpatient Acute Care Claims From the Medicaid Program: Fiscal Year 2010–Fiscal Year 2011," *Health Services Research*, vol. 53, no. 1 (February 2018), pp. 326–340, <http://doi.org/10.1111/1475-6773.12645>; Medicaid Payment Advisory Commission, *Medicaid Hospital Payment: A Comparison Across States and to Medicare*, Issue Brief (April 2017), <https://go.usa.gov/xp5sf> (PDF, 250 KB); and Thomas M. Selden and others, "The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care," *Health Affairs*, vol. 34, no. 12 (December 2015), pp. 2147–2150, <http://doi.org/10.1377/hlthaff.2015.0706>.

A single-payer system could also yield some financial benefits for hospitals. They would not have the administrative costs associated with multiple insurers for billing and prior authorizations. If the single-payer system required no cost sharing, hospitals would no longer incur the administrative expense of billing patients for their portion of the bill. Hospitals would treat fewer uninsured patients and provide less uncompensated care, although the decline in the number of uninsured patients would depend on who was eligible for coverage under the single-payer system. The reduction in the amount of uncompensated care would be particularly beneficial for hospitals that currently provide a substantial amount of such care.

Question. The CBO report states: “The number of hospitals and other health care facilities might also decline as a result of closures, and there might be less investment in new and existing facilities.” CBO produced a report in 2016 entitled *Projecting Hospitals’ Profit Margins Under Several Illustrative Scenarios*.³¹ In the report CBO found that “about 27 percent of [hospitals] had negative profit margins (in other words, they lost money) in that year.”

- According to the 2016 CBO report, what were the future projections of hospital margins in the U.S.?
- What were the major factors that were driving more hospitals into financial distress?
- What would happen if all hospitals received only the Medicare reimbursement rate?
- Would the shift to universal Medicare reimbursement rates have a different impact on urban and rural hospitals?
- How many hospitals are closing in the United States? Is there a differential rate between urban and rural hospital closures? What factors are hurting rural hospitals?
- In other countries, has the government had to save hospitals by buying them?
- If CBO were to score a single-payer proposal, could CBO provide a dynamic score? What elements does CBO use to do a dynamic score? Would CBO look at the effect of such a plan on jobs? Would CBO look at hospital closures? Would CBO look at the effect on the economy?

Answer. CBO’s 2016 analysis of hospital margins was intended to demonstrate the financial pressures that hospitals will face in the future as a result of various changes, including the provisions of the ACA that reduced Medicare payment updates and expanded insurance coverage. Hospitals’ actual financial experience will depend on their responses to those financial pressures.

The Results of CBO’s 2016 Analysis. To illustrate possible outcomes, CBO projected hospitals’ profit margins under several scenarios.³² Under one scenario, CBO assumed that hospitals would increase their productivity at the same rate as productivity growth in the economy as a whole and that they would use all of those productivity gains to reduce their costs. Under that scenario, CBO projected, 41 percent of hospitals would have a negative margin in 2025, and the average margin of hospitals in that year would be 3.3 percent. By comparison, in the base year for the analysis (2011), 27 percent of hospitals had a negative margin, and the

31. See Tamara Hayford, Lyle Nelson, and Alexia Diorio, *Projecting Hospitals’ Profit Margins Under Several Illustrative Scenarios*, Working Paper 2016-04 (Congressional Budget Office, September 2016), www.cbo.gov/publication/51919.

32. A hospital’s profit margin is equal to its revenues minus its costs, expressed as a percentage of its revenues.

average margin was 6.0 percent. Under the other scenarios CBO examined, the financial performance of hospitals was projected to be worse.

CBO found that the main factor contributing to smaller or negative margins for hospitals in the future was the ACA's reduction in Medicare payment updates. Under current law (as specified by the ACA), Medicare's annual update to hospital payment rates is equal to the percentage change in the average price of hospitals' inputs (such as labor and supplies) minus the estimated growth in productivity in the economy overall.

The analysis focused on about 3,000 hospitals that provide acute care and are subject to the cuts in Medicare's payment updates; thus, it excluded most rural hospitals. Most rural hospitals are designated as critical access hospitals, and Medicare pays 101 percent of their reasonable costs for inpatient and outpatient care.

The Effects of Paying All Hospitals Using Medicare Rates. On average, a shift to a single-payer system that paid all hospitals using Medicare rates would reduce payment rates to hospitals substantially compared with the rates that private insurers pay in their commercial plans. A working paper produced by CBO in 2017 found that the rates paid by private insurers for their commercial plans for hospital inpatient care were nearly 90 percent higher than Medicare rates on average.³³ The reduced payment rates would lower the total revenue of hospitals substantially and cause many to change their structure to lower costs. If all hospitals were paid 100 percent of Medicare fee-for-service rates, some would close unprofitable departments or close entirely, and fewer new hospitals would be built in the future, reducing access to care.

The effects of paying all hospitals using Medicare rates under a single-payer system would vary by hospital. For example, the effects would vary according to the percentage of patients that otherwise would have been commercially insured under current law (as opposed to uninsured or covered by Medicare or Medicaid). Hospitals that derive a large percentage of their revenue from commercially insured patients would suffer the greatest loss of revenue. The effects would also vary because the extent to which commercial payment rates for hospitals exceed Medicare rates varies by geographic market and by hospital within those markets.

The Impact of a Single-Payer System on Rural Hospitals. The financial viability of rural hospitals under a single-payer system would depend on the quantity of care they delivered and on the specific payment policies established for those hospitals. If a single-payer system required little or no cost sharing, the quantity of care delivered by rural hospitals would tend to increase. Compared with urban hospitals, rural hospitals have higher costs for uncompensated care as a share of their total expenses and a lower share of patients covered by private insurance (which generally has higher payment rates than Medicare). As a result, a shift to Medicare payment rates combined with increased quantity of care would have smaller effects on rural than urban hospitals in most cases and some rural hospitals would benefit. For rural hospitals overall, the effects on total revenue and people's access to care are unclear.

Under the current system, most rural hospitals receive higher payments from Medicare than they would receive under Medicare's standard payment methods. Under the most common program, Medicare pays hospitals that are designated as critical access hospitals 101 percent of their reasonable costs for inpatient and outpatient care. If the current Medicare payment method for rural hospitals was retained under a single-payer system, the payment rates to rural hospitals for current Medicare beneficiaries would stay the same. Alternatively, payment

33. See Jared Lane Maeda and Lyle Nelson, *An Analysis of Private-Sector Prices for Hospital Admissions*, Working Paper 2017-02 (April 2017), www.cbo.gov/publication/52567.

rates for current Medicare beneficiaries would be lower if rural hospitals were paid Medicare's standard payment rates under a single-payer system.

Several states also target supplemental payments, such as disproportionate share hospital (DSH) payments, to rural hospitals.³⁴ (DSH payments under Medicaid provide financial assistance to hospitals that serve a large proportion of Medicaid enrollees and other low-income patients.) Whether rural hospitals would receive similar or lower revenues for their current Medicaid beneficiaries would depend in part on whether such supplemental payments were provided under the single-payer system.

Factors Causing Financial Distress. A recent report by GAO found that 113 hospitals closed from 2013 through 2017. During that period, a slightly greater share of rural hospitals closed than urban hospitals. GAO estimated that 64 rural hospitals and 49 urban hospitals closed between 2013 and 2017—about 3 percent of all rural hospitals in 2013 and about 2 percent of all urban hospitals in 2013, respectively.³⁵ The report found that rural hospital closures were generally caused by financial difficulties, and it listed several factors that might explain the greater financial strains faced by rural hospitals. Those factors include lower demand stemming from increased competition from other providers and a decline in the rural population, as well as lower payments from Medicare as a result of sequestration (automatic spending cuts that occur through the withdrawal of funding for certain government programs) and lower Medicare payments for bad debt as a result of a change in law.³⁶ By contrast, increased Medicaid enrollment under the Affordable Care Act appears to have improved the financial status of rural hospitals as those enrollees have been provided with greater amounts of care than they would have otherwise received and hospitals have received payments for some care that would otherwise have been uncompensated.

CBO does not have information on whether the governments of other countries have taken over ownership of hospitals under financial distress.

Dynamic Analysis of a Single-Payer Proposal. In a dynamic analysis, CBO takes into account changes that would affect total output in the economy, such as changes in labor supply, household saving, investment, and aggregate demand for goods and services. Those broad macroeconomic changes resulting from legislation can themselves have additional budgetary consequences.

If provided enough time to undertake the complex modeling required to estimate the macroeconomic effects of a single-payer system, CBO could provide an assessment of those effects. To do so, the agency would analyze the effects of the proposed changes on labor markets, household saving, investment, aggregate demand, and output.

Establishing a single-payer health care system would affect the economy and the federal budget in various ways. Effects on people's disposable income and changes in the distribution of such income among households would alter overall demand for goods and services, thereby affecting output. In addition, depending on how the government financed the system—through higher taxes or borrowing—people's incentives to work and save and businesses' incentives to invest could change.

34. See Medicaid and CHIP Payment and Access Commission, "Rural Hospitals and Medicaid Payment Policy" (August 2018), <https://go.usa.gov/xy6k5>.

35. See Government Accountability Office, *Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors*, GAO-18-634 (September 2018), www.gao.gov/products/GAO-18-634.

36. The Middle Class Tax Relief and Job Creation Act of 2012 reduced the share of Medicare beneficiaries' bad debt for which Medicare reimbursed hospitals beginning in fiscal year 2013.

When deciding how much to work, for example, people consider not only the higher earnings from working more hours but also the resulting difference in after-tax income. Among people already working, if tax rates were increased to finance a single-payer system, such increases would have two opposing effects. One is the substitution effect, in which marginal tax rates increase: People tend to work fewer hours because other uses of their time become relatively more attractive.³⁷ Another is the income effect, in which after-tax income drops from what people would have otherwise earned: People tend to work more hours because having less after-tax income requires additional work to maintain the same standard of living. On balance, the first effect appears to be greater than the second, according to CBO's assessment of relevant research. Increases in marginal tax rates, on net, decrease the supply of labor by causing people already in the labor force to work less.³⁸

Any dynamic analysis would include a quantitative assessment of the overall impact of the proposal on the economy and on employment but would not include a specific analysis of hospital closures. Other important issues of interest to policymakers—such as effects on the quality and availability of health care and the ways in which the economic circumstances and health of various groups of people would be affected differently—would be discussed qualitatively.

Question. The CBO report states: “By contrast, proposals to establish single-payer systems often prohibit substitutive insurance because of concerns that it might interfere with the operation of the public plan.”

- What is substitutive insurance?
- How would substitutive insurance interfere with the public plan? What has happened in countries such as England?
- Today, how many Americans have private insurance plans? What are examples of such plans? What are Medicare Advantage plans? Are they private insurance plans? How many seniors are enrolled in Medicare Advantage plans today? Why do seniors choose these plans?

Answer. Substitutive insurance is a type of private insurance that duplicates the benefits of a single-payer health plan. It could be offered to people who are not eligible for the single-payer system, such as noncitizens who have recently entered the country or are temporary visitors. Substitutive insurance could also be an alternative source of coverage if people were allowed to opt out of the single-payer system.

Effects of Substitutive Insurance on a Single-Payer System. If substitutive insurance was allowed, some people, such as those with high income, might prefer to purchase substitutive insurance that offered more generous benefits or greater access to providers. If providers were allowed to participate in both the single-payer system and the substitutive insurance market and if providers' payment rates in the substitutive insurance plan were higher than in the single-payer system, they might prioritize the treatment of those enrollees. As a result, if many people enrolled in substitutive insurance, patients in the single-payer health care plan might experience longer wait times.

37. The marginal tax rate is the percentage of an additional dollar of income from labor or capital that is paid in taxes.

38. See Congressional Budget Office, *How the Supply of Labor Responds to Changes in Fiscal Policy* (October 2012), www.cbo.gov/publication/43674.

Allowing substitutive insurance could benefit some patients and providers. For example, some people might prefer to enroll in a substitutive insurance plan that suited their needs better than the public plan. Substitutive insurance might also improve the quality of care for people in both private and public plans. For example, private plans might introduce innovative design features to compete with the public plan, such as selectively contracting with higher-quality providers. That might encourage all providers to improve the quality of their care, which could also benefit publicly insured patients. Allowing private plans might also increase providers' income.

In the United Kingdom, for instance, about 11 percent of the population has some form of private insurance. Not all of those policies provide comprehensive major medical coverage that duplicates the benefits of the public plan. For example, few policies cover costs associated with pregnancy, childbirth, the care of newborns, or treatment for mental health, and none cover emergency care, accidents, or general practice visits. Additionally, those policies may have various restrictions, such as taking effect only if the wait times in the National Health Service (NHS) system are longer than a certain period, restricting which private hospitals patients can use without additional payment, or only covering certain conditions (for instance, cancer or cardiac care).³⁹ The private market shares the physician workforce with the NHS system. The vast majority of specialists are employed by the NHS (about 85 percent) and see private patients on their own time.⁴⁰

Private Health Insurance in the United States. Some examples of private insurance plans include employment-based insurance, Medicare Advantage (MA), Medicare Part D (the prescription drug benefit), and nongroup plans that people purchase through the health insurance marketplaces or directly from insurers or brokers. CBO estimates that, among the population under age 65, 159 million people have employment-based insurance and 14 million people have nongroup coverage in 2019.⁴¹ In addition, CBO estimates that 47 million people are enrolled in Part D for prescription drug benefits and 22 million people are enrolled in Medicare Advantage for health care benefits (about 38 percent of Medicare enrollees).⁴² All of those estimates reflect average monthly enrollment over the course of the year.

Medicare Advantage plans are private plans that deliver the benefits of the Medicare program. Beneficiaries have a choice of enrolling in traditional Medicare or MA. MA plans must offer benefits that are at least as comprehensive as traditional Medicare and cover all Part A (Hospital Insurance) and Part B (Medical Insurance) services. In addition, MA plans must include a limit on out-of-pocket expenses, which is not required in traditional Medicare. The benefit design of MA plans can vary widely in terms of the extent of extra benefits, cost sharing, premiums, and provider networks. MA plans also can offer supplemental benefits, such as dental and vision coverage or reduced premiums for prescription drug coverage.⁴³

39. See Commission on the Future of Health and Social Care in England, *The UK Private Health Care Market* (2014), <https://tinyurl.com/y37zg72s>.

40. Ibid.

41. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085.

42. See Congressional Budget Office, "Medicare—CBO's May 2019 Baseline" (May 2019), www.cbo.gov/system/files/2019-05/51302-2019-05-medicare_0.pdf (203 KB).

43. See John Bertko and others, *Medicare Advantage: Better Information Tools, Better Beneficiary Choices, Better Competition* (November 2017), <https://tinyurl.com/y5uehrrr> (PDF, 674 KB).

Some people choose to enroll in MA plans because they typically offer extra benefits—such as reduced cost sharing on Medicare benefits and, in some cases, coverage for dental, vision, or hearing services—and because of MA’s out-of-pocket limit on medical expenses. MA patients face a more restricted network of providers, and they may need to receive prior approval before seeing a specialist or before receiving certain treatments.

Question. There are several sections of the report that mention “utilization management” and choices that would need to be made about what services and treatments would be covered in a single-payer system. For example, the CBO report states: “An independent board could recommend whether or not new treatments and drugs should be covered after their clinical and cost-effectiveness had been demonstrated—a role fulfilled in England by the National Institute for Health Care and Excellence.”

- What does CBO mean by “utilization management”?
- What trade-offs and risks would occur if there is no control compared to too much control?
- How do we make these decisions now for federal programs such as Medicare or the ACA?
- What is the United States Preventive Services Task Force? What are some examples of recommendations that have been made from them?
- Under a single-payer system what types of decisions would be made regarding covered treatments and drugs? What are some examples?

Answer. Utilization management refers to methods used by or on behalf of payers to manage health care costs by influencing decisions about patient care.⁴⁴ Utilization management includes review of care prior to its provision and more intensive management of high-cost patients. Prior review involves the payers’ assessment of the appropriateness of proposed procedures or services. High-cost case management focuses on patients with past or expected large medical expenditures. Through an assessment of individual needs, alternative treatment options with lower costs might be identified. Retrospective review (that is, review of claims after the provision of care) is not typically considered utilization management. Payers could use the information from retrospective review for provider education programs and to select providers for their networks.

Trade-offs and Risks of Utilization Management. On the one hand, the use of cost-containment techniques through utilization management could reduce waste in the system and lower the growth of total health care spending. In a system in which the provision of care was limited by its supply, the reduction or elimination of unnecessary care would free up providers’ time, thus improving access to care for those who need it compared with allocation of care in some other way, such as by using a waiting list. On the other hand, a payer’s assessment of the appropriateness of care might differ from that of the patient or the provider. Greater control by a payer over a patient’s choices of services could also adversely affect access to and quality of care for that patient. Less spending on medical services could also alter manufacturers’ incentive to develop new technologies or providers’ incentive to invest in capital, which could affect patients’ choices over the longer term.

44. See Institute of Medicine (U.S.) and Committee on Utilization Management by Third Parties, Marilyn Jane Field and Bradford H. Gray, eds., *Controlling Costs and Changing Patient Care? The Role of Utilization Management* (National Academies Press, 1989), <https://tinyurl.com/yxmk12lf>.

How Federal Programs Make These Decisions Now. In the United States, public programs have implemented few utilization management programs directly. Private insurers participating in public programs—such as Medicare Advantage, Medicare Part D prescription drug insurance, and subsidized insurance purchased through the ACA’s marketplaces—have increasingly used them to lower costs. For example, some private insurers require prior authorization for patients seeking certain care, such as expensive therapies.

The U.S. Preventive Services Task Force (USPSTF). The USPSTF was formed in 1984 to make independent, evidence-based recommendations about preventive health care services, including medications and screening. The USPSTF is made up of 16 volunteer members who are nationally recognized experts in prevention, evidence-based medicine, and primary care. Their fields of practice and expertise include behavioral health, family medicine, geriatrics, internal medicine, pediatrics, obstetrics and gynecology, and nursing. Task force members are appointed by the Director of the Agency for Healthcare Research and Quality (AHRQ) to serve four-year terms. Members are screened to ensure that they have no substantial conflicts of interest that could impair the scientific integrity of the task force’s work. AHRQ has been authorized by the Congress to convene the task force and to provide ongoing scientific, administrative, and dissemination support to the task force.

The USPSTF’s recommendations are based on a systematic review and synthesis of peer-reviewed literature. The services graded are those that would be provided in a primary care setting or that would be received following referral from a primary care provider. The recommendations apply to asymptomatic patients.

The USPSTF assigns grades of “A,” “B,” “C,” “D,” and “I” to health care services and procedures. The task force recommends that clinicians offer or provide services with a grade of “A” or “B.” Services with a grade of “C” can be recommended to select patients on the basis of the provider’s judgment and the patient’s preferences. The task force discourages the use of services with a grade of “D.” When there is insufficient evidence about a given set of services, those services receive a grade of “I.” The task force does not take costs into account when deciding the grade given to a preventive health care service.

In many cases, the USPSTF’s recommendations are tailored to specific populations. For example, the grade for abdominal aortic aneurysm screening depends on patients’ sex, age, and smoking history. The task force’s recommendations are made available on its website (www.uspreventiveservicestaskforce.org/BrowseRec/Index) and in peer-reviewed publications.

Some examples of recommendations from the USPSTF include:

- Screening for colorectal cancer starting at age 50 and continuing until age 75 (grade A).
- Screening for depression in the general adult population, including pregnant and postpartum women (grade B).
- Recommending that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 milligrams of folic acid (grade A).
- Referring adults who are overweight or obese and have additional risk factors for cardiovascular disease (CVD) to intensive behavioral counseling—or offering such services—to promote a healthful diet and physical activity for CVD prevention (grade B).
- Screening for osteoporosis with bone-measurement testing to prevent osteoporotic fractures in women age 65 or older (grade B).

Decisions About Coverage Under a Single-Payer System. To specify the benefit package for a single-payer system, policymakers would first need to decide the set of services to include,

which might encompass the essential health benefits provided by the Affordable Care Act, the benefits covered by Medicare or Medicaid, or some other set, perhaps based on a cost-effectiveness criterion or the federal government's willingness to pay to cover certain services. Decisions would also need to be made about which new treatments and technologies would be covered. One approach would be to limit coverage to items or services that are judged to be reasonable and necessary for the diagnosis or treatment of illness and injury, similar to Medicare's existing national coverage determination process.

Alternatively, an independent board could recommend whether or not new treatments and drugs should be covered after their clinical efficacy and cost-effectiveness had been demonstrated. For example, policymakers would need to decide whether a single-payer system would cover gene therapy treatments that might be very costly, such as those that treat spinal muscular dystrophy. Another example is whether the single-payer system would cover specialty drugs that treat rare conditions but might be costly to develop, or whether experimental treatments would be covered. If experimental treatments were covered, policymakers would need to decide how much evidence would be required before coverage of a new treatment was authorized. Policymakers would also need to decide how much to pay for DNA tests and new diagnostic tests, and the ways in which medical care could be individualized for patients.

Question. The CBO report helpfully provides examples of other countries which have some elements of single-payer systems.

- What are examples of countries that have a more market-based system?
- What are examples of countries that have hybrid systems, some public and some private, and some which are shared?
- What are examples of controls used in other countries to contain the budgetary impacts of their single-payer systems? Can the government decide which treatments to offer? Can they approve use of certain medications? What factors do these governments/systems use to determine which treatments to allow and which not to allow? Does cost play a role in their decision making? What is the process they use for rare but groundbreaking treatments? Could a potential treatment, that doctors might say is reasonable, be denied due to decisions that were made by the government or a board? In other countries can the government overrule what a patient or guardian would request?
- Which other countries use global budgets in their single-payer systems? Is it common or rare? What would happen to patients in facilities that run out of money before the next budget cycle?

Answer. Germany and Switzerland are examples of countries that have achieved universal coverage through a more market-based health care system rather than a single-payer system. Those two countries have a multipayer system, in which people can choose from a number of competing private, nonprofit insurance plans.⁴⁵ In Germany, about 90 percent of the population chooses from the more than 100 private, nonprofit "sickness funds" that participate in the statutory health insurance system. The rest of the population chooses from private insurance plans operating under a separate system. In both Germany and Switzerland, all citizens and legal residents are required to have health insurance.

45. Unless noted otherwise, all of the information on the health care systems of other countries included in this response comes from Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.4 MB).

Hybrid Health Care Systems. Germany and Switzerland could also be regarded as having hybrid systems because each country relies primarily on public financing for health care, and government bodies in each country regulate the benefit packages that private insurers offer. In Germany, a federal government agency specifies broad requirements concerning the benefit package, and a committee consisting largely of representatives of providers and the sickness funds has the authority to decide whether specific services and drugs are included in the benefit package. To the extent possible, the committee takes into account studies of the comparative effectiveness of different treatments. In Switzerland, a federal agency specifies the services that must be included in the benefit package by evaluating whether services are effective, appropriate, and cost-effective. CBO did not find any specific information on the process for approving coverage for new treatments for rare conditions in those countries.

Cost-Containment Methods in Countries With Single-Payer Systems. Global budgets, which are discussed in greater detail below, are commonly used in countries with single-payer systems to contain costs. Such countries also contain costs through the prices they pay for medical care. Countries with single-payer systems also use various forms of utilization management to contain health care spending. In Canada's single-payer system, some provinces make lower payments to specialists when a patient has not been referred by a primary care physician. In England, access to specialists generally requires a referral from a primary care physician. Taiwan monitors the use of services and costs in near real-time through its information technology system to identify wasteful spending and inappropriate care.

In countries with a single-payer system, the government determines which health care services and drugs are covered. The benefit package typically provides comprehensive major medical coverage, including hospital and physician care, mental health services, and diagnostic tests. Prescription drugs are covered by most single-payer systems, but not by the Canadian system. For new treatments and technologies, a group of experts generally provides evidence on their cost-effectiveness to agencies that make decisions about their coverage or payments. Examples include the National Institute for Health Care and Excellence (NICE) in England, the Health Technology Assessment division of the Center for Drug Evaluation in Taiwan, and the Canadian Agency for Drugs and Technologies in Health in Canada.⁴⁶ For treatments of rare conditions, other countries with single-payer systems generally have a separate process for their appraisals, such as the Highly Specialised Technology evaluations by NICE in England.⁴⁷ Canada is establishing a new federal agency, the Canadian Drug Agency, to assess the cost-effectiveness of drugs and negotiate prices, and the new agency is tasked with developing a national strategy for drugs that treat rare diseases.⁴⁸ Currently in Canada, the cost-effectiveness of cancer drugs is assessed through the pan-Canadian Oncology Drug Review, which is a separate review process from other drugs (or the Common Drug Review).⁴⁹

A potential treatment that a doctor deems reasonable might not be covered by a single-payer system. CBO determined that information on whether and under what circumstances

46. See Center for Drug Evaluation, Taiwan, "Health Technology Assessment" (accessed on October 24, 2019), <http://www.cde.org.tw/eng/HTA/>; and Canadian Agency for Drugs and Technologies in Health (accessed on October 24, 2019), <https://cadth.ca/about-cadth>.

47. See National Institute for Health Care and Excellence, "NICE Highly Specialised Technologies Guidance" (accessed on October 24, 2019), <https://tinyurl.com/yybengso>.

48. See Government of Canada, "Moving Forward on Implementing National Pharmacare" (accessed on October 24, 2019), <https://tinyurl.com/y2gl6o5b>.

49. See Maureen E. Trudeau and others, "Pan-Canadian Oncology Drug Review (pCODR): A Unique Model to Support Harmonization of Cancer Drug Funding Decisions in Canada," *Journal of Clinical Oncology*, vol. 36, supplement 30 (October 2018), pp. 41–41.

physicians or patients can appeal coverage decisions in countries with single-payer systems was not readily available. Some patients in such situations obtain care in other countries.

Global Budgets. Global budgets (which establish a prospective budget for health care spending during a specified period) are commonly used in other countries with single-payer systems. England and Taiwan both set national global budgets for their single-payer systems. In Canada, most hospitals operate under annual global budgets. In Australia, Denmark, and Sweden, hospitals receive part of their funding through global budgets and part through other methods, such as predetermined payments per admission based on the patient's diagnosis.

One limitation of a global budget is that health care providers might reduce the number of services they deliver if it appears their total costs will exceed their budget. The likelihood of this occurring depends partly on how the global budget is determined and updated over time. In England, the global budget is allocated to approximately 200 local organizations that are responsible for paying for health care. Since 2010, the global budget in England has grown by about 1 percent annually in real (inflation-adjusted) terms, compared with average real growth of about 4 percent previously. The relatively slow growth in the global budget since 2010 has created severe financial strains in the health care system. Providers' payment rates have been reduced, many providers have incurred financial deficits, and wait times for receiving care have increased.

Congressman Roy

Question. CBO estimated in the report that an average of 29 million people per month—11 percent of the U.S. residents under the age of 65—were uninsured in 2018.

- Of the 29 million people who are under the age of 65 and uninsured, how many are eligible for health benefits but not enrolled?
- How many have access to insurance but choose not to purchase it?
- Who pays for their health care right now, the uninsured population under the age of 65, under the current system? For example, if someone receives medical care without coverage, who pays for their services? What is the net cost of this coverage?

Answer. CBO estimates that 30 million people who are under the age of 65 are uninsured in 2019. Of those people, CBO estimates that 23 percent are eligible for subsidized coverage through a marketplace; 20 percent are noncitizens who are not lawfully present in this country; 15 percent are eligible for Medicaid or CHIP but are not enrolled; 12 percent have income that is less than 100 percent of the federal poverty level and live in a state that did not expand Medicaid; and 30 percent have access to coverage through an employer or directly from an insurer but have chosen not to purchase it.⁵⁰

The uninsured seek care in various settings, including physicians' offices, community health centers, and hospitals. Some uninsured patients pay for their care out of pocket. In some cases, they pay a provider's full charges, which are typically higher than the payments providers receive from insured patients. In other cases, low-income uninsured patients receive

50. The responses to this question are based on CBO's estimates for 2019. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085. That report was published shortly after the release of *Key Design Components and Considerations for Establishing a Single-Payer Health Care System*.

charity care—that is, services are furnished by the provider at no cost or at a reduced price. Providers can also incur bad debt as a result of treating uninsured patients—that is, the provider bills the patient but receives no payment or only a partial payment.

People who are eligible for Medicaid or CHIP but not enrolled are identified in most states when they go to a hospital. Those people are regarded as presumptively eligible for a limited period. In such cases, Medicaid pays the hospital for the person's care. The person must file a complete Medicaid application after leaving the hospital in order to obtain Medicaid eligibility for a longer period. In addition, in most states, when people apply for Medicaid they can receive retroactive coverage for up to three months before the date of application. If, during that period, applicants met Medicaid eligibility criteria and incurred medical expenses, Medicaid pays providers for any covered health care services they used. Data are not available on the amount that Medicaid spends on hospital care for people determined to be presumptively eligible or the amount that Medicaid pays providers under the retroactive coverage option.

CBO is not aware of any recent studies focusing on the amount of health care used by the uninsured or the sources of payment for that care. The most recent such study is of limited relevance because it relied on data for 2013 and thus does not capture the effects of the insurance coverage expansions under the Affordable Care Act.⁵¹

The federal, state, and local governments provide financial support to providers to help offset the costs of caring for the uninsured. Examples of such support include Medicare and Medicaid disproportionate share hospital payments and funding for the Veterans Health Administration, community health centers, state and local health departments, and the Indian Health Service.

Question. Would individuals who currently have coverage, roughly 300 million Americans, be affected if we moved to a single-payer system? How many individuals who currently have coverage would have their coverage disrupted by the potential effects of such an overhaul?

Answer. If private insurance was eliminated under a single-payer system, people who currently have it would enroll in the public plan. Among people under age 65, CBO estimates that 159 million have employment-based insurance in 2019, 14 million have private nongroup coverage, and 1 million have coverage through the Basic Health Program.⁵² Those estimates cannot be added to yield an estimate of the total number of people with private insurance because some people report more than one type of coverage. People who currently have private insurance would probably need to switch their coverage. The role of private insurance under a single-payer system would depend on its design. For instance, the system might eliminate private insurance, or it could retain a role for private insurance, such as by offering benefits that supplement the public plan.

If current public programs were eliminated, people who currently have public coverage would enroll in a new public plan under a single-payer system. Their covered benefits and cost sharing might change, depending on the system's design. Taking into account people of

51. See Teresa A. Coughlin and others, *Uncompensated Care for the Uninsured in 2013: A Detailed Examination* (Kaiser Commission on Medicaid and the Uninsured, May 2014), <https://tinyurl.com/y45a95aq>.

52. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085.

all ages, CBO estimates that there are 75 million enrolled in Medicaid in 2019, 61 million enrolled in Medicare, and 7 million enrolled in CHIP.⁵³

Question. What percentage of total health expenditures is NOT paid for by the federal government, which would likely be shifted to the federal government under a single-payer system?

Answer. Currently, national health care spending—which totaled \$3.5 trillion in 2017—is financed through a mix of public and private sources. Private sources paid more than half of that amount, and state or local governments paid about one-tenth. The federal government paid 37 percent of the total, or \$1.3 trillion.⁵⁴ The amount of total health care spending that would be shifted to the federal government under a single-payer system would depend on the design of the system. Two key design features are the services that would be covered by the single-payer system and the amount of cost sharing that would be required. In a system covering a comprehensive set of benefits with little cost sharing, the shift of national health care spending from other payers to the federal government would be substantial.

Question. The report stated that roughly 29 million people do not have coverage, and 11 million of those individuals are not legally present in the United States. Has CBO done analyses on the federal spending impact of those 11 million people, including the net impact on healthcare spending? If so, please include the relevant responses.

Answer. An average of 11 million people per month in 2018 were estimated to be noncitizens who were not lawfully present, and about half of the 11 million people had health insurance that year (mainly through private insurers).⁵⁵ Noncitizens who are not lawfully present are ineligible for most federal programs, including Medicare, Social Security, Supplemental Security Income, the Supplemental Nutrition Assistance Program, subsidies for nongroup health insurance, Pell grants and federal student loans, and unemployment insurance.⁵⁶ Noncitizens who are not lawfully present are not eligible to enroll in Medicaid. However, Medicaid pays hospitals for emergency services provided to noncitizens who are not lawfully present if they would have qualified for Medicaid if not for their immigration

53. See Congressional Budget Office, “Medicaid—CBO’s May 2019 Baseline” (May 2019), www.cbo.gov/system/files/2019-05/51301-2019-05-medicaid.pdf (139 KB); “Medicare—CBO’s May 2019 Baseline” (May 2019), www.cbo.gov/system/files/2019-05/51302-2019-05-medicare_0.pdf (203 KB); and “Children’s Health Insurance Program—CBO’s May 2019 Baseline” (May 2019), www.cbo.gov/system/files/2019-05/51296-2019-05-chip.pdf (171 KB).

54. The estimates of national health care spending by source of payment are from Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, “National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960–2018” (accessed February 15, 2019), <https://go.usa.gov/xEUS6>. The estimates of national and federal spending on health care include spending on investment in the medical sector, which accounts for 5 percent of national spending on health care and 3 percent of federal spending on health care. The estimates of federal spending for Medicare exclude the effects of premiums and other offsetting receipts. The estimates do not account for tax subsidies, such as the federal tax exclusion for employment-based health insurance.

55. See Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System* (May 2019), www.cbo.gov/publication/55150.

56. See Congressional Budget Office, *How Changes in Immigration Policy Might Affect the Federal Budget* (January 2015), www.cbo.gov/publication/49868.

status.⁵⁷ In fiscal year 2018, federal Medicaid spending on emergency services provided to such people was \$1.6 billion, or 0.4 percent of total federal spending on Medicaid.⁵⁸

Noncitizens who are not lawfully present are generally not eligible to enroll in CHIP. However, since 2002, states have had the option to cover prenatal care to women regardless of their immigration status by extending CHIP eligibility to the unborn child. As of January 2019, 16 states had exercised that option.⁵⁹ No data are available on the number of noncitizens who are not lawfully present who have received such services under CHIP.

Question. The report states, “participants would not have a choice of insurer or health benefits... the benefits provided by the public plan might not address the needs of some people.”

- Can you elaborate on what that means? The plan might not address the needs of some people?
- How many people in the US are covered by private insurance? How many are covered by a public program?

Answer. Under a single-payer system that eliminated private insurance entirely, there would be only one insurer with a standardized set of benefits. Thus, patients would not have a choice of insurer or benefits, and those standardized benefits might not meet the needs of some people. For example, certain specialty drugs or expensive new treatments, such as gene therapy, might not be covered under a single-payer system.

CBO estimates that, among the population under age 65 in 2019, average monthly enrollment for people with employment-based insurance is 159 million, and the number of people with nongroup coverage is 14 million.⁶⁰

Among the entire population, the agency estimates, an average of 61 million people are enrolled in Medicare on a monthly basis in 2019: 47 million are enrolled through a private insurer in Medicare Part D (for prescription drug benefits) and 22 million are enrolled through a private insurer in Medicare Advantage (for health care benefits).⁶¹ Average monthly enrollment in Medicaid and CHIP is 75 million and 7 million, respectively, in 2019. (Those numbers count people with two sources of coverage, such as Medicare and Medicaid, in both categories.) Most Medicaid beneficiaries are enrolled in one or more private managed care plans.⁶²

57. See Samantha Artiga and Maria Diaz, *Health Coverage and Care of Undocumented Immigrants*, Issue Brief (Kaiser Family Foundation, July 2019), pp. 3–4, <https://tinyurl.com/y48owh5b> (PDF, 270 KB).

58. Those estimates are from the Medicaid Financial Management Report for Fiscal Year 2018 produced by the Centers for Medicare & Medicaid Services. That report is not yet publicly available.

59. See Tricia Brooks, Lauren Roygardner, and Samantha Artiga, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings From a 50-State Survey* (Kaiser Family Foundation, March 2019), pp. 10–11, <https://tinyurl.com/y4c8n7ye> (PDF, 2 MB).

60. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085.

61. See Congressional Budget Office, “Medicare—CBO’s May 2019 Baseline” (May 2019), www.cbo.gov/system/files/2019-05/51302-2019-05-medicare_0.pdf (203 KB).

62. See Congressional Budget Office, *Exploring the Growth of Medicaid Managed Care* (August 2018), www.cbo.gov/publication/54235.

Question. A recent Association of American Medical Colleges study found the U.S. will see a shortage of up to nearly 122,000 physicians by 2032—this is under current law. Would a single payer system in the United States lead to an even greater shortage of physicians in the U.S.?

Answer. CBO has not reviewed the methods and assumptions used in the study by the Association of American Medical Colleges. That study concluded that the United States will face a shortage of physicians, but experts disagree about that. A report by the Institute of Medicine reviewed the available studies and concluded that the evidence does not indicate that the United States faces such a shortage.⁶³

If a single-payer system had little or no cost sharing, the demand for physicians' services would tend to rise. If payment rates were reduced, on average, the supply of care from physicians would tend to fall. Both of those factors would contribute to a shortage of physicians in the United States. By contrast, the time that was previously spent on administrative tasks associated with multiple insurers and utilization management could be used instead to increase the supply of care. On net, whether a single-payer system would lead to a shortage of physicians would depend on the system's design. The government could also implement some policies that would increase the supply of physicians, such as increasing subsidies for medical education. Lower payments to providers would cause changes in the nature of the health care system in the long term, such as leading different people to become physicians, and could result in greater use of nurse practitioners and physician assistants. Some of the decisions involved, such as the scope of practice for health professionals, would be made at the state level.

Question. Has CBO done a report on average wait times for care in the United States under current policy? If so, what do average wait times look like? What would average wait times look like for a patient under a single-payer system?

Answer. CBO has not conducted an analysis of average wait times for care under the current system or under a single-payer system. Average wait times under a single-payer system would depend on the system's design features, such as the covered services, cost-sharing requirements, and providers' payment rates. For example, if there was little or no cost sharing and payment rates were substantially lower than what providers would receive under current law, CBO expects that average wait times would increase.

Question. With respect to Obamacare's Medicaid expansion, has CBO done any analysis of crowd out—both the numbers of people dropping private coverage to enroll in expansion, and the Medicaid spending for those individuals? I've seen some reports suggesting significant numbers of people may be dropping private coverage to enroll in Medicaid, Louisiana specifically. Can CBO elaborate on this?

Answer. CBO has not conducted its own analysis of the extent to which people drop private coverage to enroll in Medicaid as a result of the ACA. However, recent peer-reviewed studies found mixed results, with some showing little or no evidence of crowding out from Medicaid

63. See Institute of Medicine, "Chapter 2: Background on the Pipeline to the Physician Workforce," in Jill Eden, Donald Berwick, and Gail Wilensky, eds., *Graduate Medical Education That Meets the Nation's Health Needs* (National Academies Press, 2014), www.nap.edu/read/18754/chapter/4.

and others showing some evidence of that phenomenon in certain populations.⁶⁴ Decker, Lipton, and Sommers (2017), Freaan, Gruber, and Sommers (2017), and Courtemanche and others (2017) found little or no evidence of such crowding out.⁶⁵ Wehby and Lyu (2018) found some evidence of crowding out of private coverage, including both individually purchased and employment-based coverage, among certain groups of people, particularly among adults ages 19 to 26 and women.⁶⁶ Sommers, Kenney, and Epstein (2014) examined the phenomenon in Connecticut and the District of Columbia, which implemented the ACA Medicaid expansion before 2014. They found evidence of some crowding out of private coverage in Connecticut (accounting for 30 percent to 40 percent of the increase in Medicaid coverage), particularly for healthier and younger adults ages 19 to 25, but found no evidence of crowding out in the District of Columbia.⁶⁷

The data from Louisiana contribute to the literature that shows some evidence of crowding out. Louisiana expanded Medicaid to nonelderly adults with income up to 138 percent of the federal poverty level on July 1, 2016. The data about that experience have not been analyzed using methods as rigorous as those applied in many of the peer-reviewed studies, which used statistical methods to control for other factors that could cause insurance coverage rates to change. One study used two types of analysis and concluded that the Medicaid expansion in Louisiana resulted in a substantial crowding out of private coverage.⁶⁸

The first analysis relied on estimates from a survey of Louisiana residents that found that, among other things, the number of nonelderly adults with income up to 138 percent of the FPL who had private insurance coverage declined from 2015 to 2017.⁶⁹ The biggest decline among people in that segment of the population was for employment-based insurance; the number of people with such coverage fell from about 181,000 in 2015 to about 140,000 in 2017. The crowding-out study characterized the difference between those two numbers (about 40,000) as the number of nonelderly adults with income up to 138 percent of the FPL who dropped employment-based insurance to enroll in Medicaid. However, the decline of 40,000 nonelderly adults with employment-based insurance and income up to 138 percent of the FPL was mostly due to the fact that the survey estimated a substantial decline in the total number of nonelderly adults in that income range in Louisiana (from

64. See Kaiser Family Foundation, *The Effects of Medicaid Expansion Under the ACA: Updated Findings From a Literature Review* (August 2019), p. 4, <https://tinyurl.com/yxp66v2v> (PDF, 1.5 MB).

65. See Sandra L. Decker, Brandy J. Lipton, and Benjamin D. Sommers, “Medicaid Expansion Coverage Effects Grew in 2015 With Continued Improvements in Coverage Quality,” *Health Affairs*, vol. 36, no. 5 (May 2017), pp. 819–825, <https://doi.org/10.1377/hlthaff.2016.1462>; Molly Freaan, Jonathan Gruber, and Benjamin D. Sommers, “Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act,” *Journal of Health Economics*, vol. 53 (May 2017), pp. 72–86, <https://doi.org/10.1016/j.jhealeco.2017.02.004>; and Charles Courtemanche and others, “Early Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States” *Journal of Policy Analysis and Management*, vol. 36, no. 1 (Winter 2017), pp. 178–210, <https://doi.org/10.1002/pam.21961>.

66. See George L. Wehby and Wei Lyu, “The Impact of the ACA Medicaid Expansions on Health Insurance Coverage Through 2015 and Coverage Disparities by Age, Race/Ethnicity, and Gender,” *Health Services Research*, vol. 53, no. 2 (April 2018), pp. 1248–1271, <https://doi.org/10.1111/1475-6773.12711>.

67. See Benjamin D. Sommers, Genevieve M. Kenney, and Arnold M. Epstein, “New Evidence on the Affordable Care Act: Coverage Impacts of Early Medicaid Expansions,” *Health Affairs*, vol. 33, no. 1 (January 2014), pp. 78–87, <https://doi.org/10.1377/hlthaff.2013.1087>.

68. See Chris Jacobs, *What You Need to Know About Medicaid Crowd Out* (Pelican Institute for Public Policy, 2019), <https://tinyurl.com/vero52f> (PDF, 434 KB).

69. See Stephen R. Barnes and others, “Louisiana Health Insurance Survey, 2017” (sponsored by the Louisiana Department of Health), Table 2.5, <https://tinyurl.com/y58neud8> (PDF, 1.2 MB).

about 900,000 in 2015 to about 715,000 in 2017). When measured on a percentage basis, the decline in employment-based coverage among that segment of the population was much smaller (from 20.1 percent in 2015 to 19.6 percent in 2017). Moreover, that percentage change in employment-based coverage might have been due to changing economic conditions or other factors and cannot be attributed entirely to people choosing to drop their coverage.

In the second analysis, the study focused on people who enrolled in Medicaid in Louisiana under the expanded eligibility criteria in August 2017. The study reported that 36 percent of those people had dropped private coverage within 30 days of enrolling in Medicaid. The 36 percent figure appears not to be limited to people who voluntarily dropped their coverage before enrolling in Medicaid but also includes people who lost their coverage (for example, because of the loss of employment or a change from full- to part-time employment). A challenge is to distinguish between people who lost their insurance coverage because of the Medicaid expansion (for example, if employers of low-wage workers stopped offering health insurance as a result of the Medicaid expansion) and people who lost private coverage for other reasons (such as losing their jobs). The former represent crowding out and the latter do not.

Question. Finally, and with respect to the budgetary treatment of cost-sharing reductions, did CBO tell Budget Committee staff that CBO now assumes that all states will incorporate CSRs into their premium estimates over time? On June 8 last year, CBO wrote that it “generally expects the costs associated with CSRs to be covered by increases in premiums.”⁷⁰ Is CBO required to assume payments will be made in all cases—not some cases, or generally, or over time, but in all cases, and in all states?

Some states, including North Dakota, Vermont, and South Dakota did not allow insurers to raise premiums for 2018 after CSR payments stopped. Yet CBO assumed that each of these states would do the exact opposite. Did CBO contact these states regarding their insurance markets when adjusting the treatment of CSRs in 2018, and when were they contacted? Director Hall had previously admitted that he provided incomplete and inaccurate information to the Budget Committee Members when asked about this issue at a January 2018 hearing. I am greatly concerned about this issue and would appreciate it if CBO could provide clarity on this subject in response to the above QFRs.

Answer. Starting in the spring of 2018, CBO anticipated in its baseline projections that the expenses associated with cost-sharing reductions (CSRs) would be covered in all states by the government’s premium tax credits. In most cases, insurers promptly increased premiums to accomplish that result.⁷¹ However, in the few cases in which states barred such increases in 2018, the agency projected that premiums were sufficient to cover the cost of CSRs without increases for that purpose. In 2019, insurance regulators in all states (but not the District of Columbia) have allowed insurers to explicitly increase premiums for silver plans in the marketplaces to account for CSRs.

In preparing its projections, CBO discussed this matter with some insurers and state regulators. For many states—including North Dakota, Vermont, and South Dakota—CBO relied

70. See Congressional Budget Office, letter to the Honorable Mark Meadows providing information about the budgetary treatment of cost-sharing reductions (June 8, 2018), www.cbo.gov/publication/53961.

71. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029* (May 2019), www.cbo.gov/publication/55085, and *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), www.cbo.gov/publication/53826.

on information provided by the National Association of Insurance Commissioners and the Commonwealth Fund and on information in insurers' public rate filings for the 2018 plan year.⁷²

Regarding the budgetary treatment of CSRs, if legislation was enacted that appropriated funds for direct payments for CSRs, CBO would update its baseline projections to incorporate those appropriations and to reflect lower premium tax credits and other effects because insurers would no longer increase gross premiums for silver plans offered through the marketplaces to cover the costs of providing CSRs. For such legislation—which would change the means of funding the CSR entitlement—CBO would estimate that enactment would not affect the federal deficit because the obligations stemming from the entitlement to CSRs could be fully satisfied through either a direct payment or higher premiums and larger premium tax credits. Those procedures reflect consultation with the budget committees about the baseline and about cost estimates relative to that baseline.

72. See National Association of Insurance Commissioners, "System for Electronic Rates & Forms Filing" (accessed most recently on February 25, 2019), www.serff.com; Sabrina Corlette, Kevin Lucia, and Maanasa Kona, "States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments," *To the Point* (blog entry, October 27, 2017), <http://tinyurl.com/y728ro2y>; and Centers for Medicare & Medicaid Services, "Rate Review" (accessed most recently on February 25, 2019), <https://ratereview.healthcare.gov>.