Congressional Budget Office
Nonpartisan Analysis for the U.S. Congress

ANSWERS TO QUESTIONS FOR THE RECORD

Following a Hearing on a

Single-Payer Health Care System That Is Based on Medicare's Fee-for-Service Program

Conducted by the
Committee on the Budget
United States Senate

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On May 12, 2022, the Senate Committee on the Budget convened a hearing at which Phillip L. Swagel, the Congressional Budget Office's Director, testified about the agency's analyses of illustrative single-payer health care systems.[1] *After the hearing, Senator Van Hollen submitted questions for the record. This document provides CBO's answers. It is available at www.cbo.gov/publication/58132.*

Question. Dr. Swagel, in your analysis of single-payer models and specifically the model that most reflects this Medicare for All bill [S. 1129], would our medical providers still receive the same levels of compensation they receive now or similar?

Answer. Under the Congressional Budget Office's illustrative options for a single-payer system, the compensation that health care professionals receive could be more or less than under current law depending on the policy specifications and the type of provider. In its analysis, CBO considered a higher payment-rate scenario and a lower payment-rate scenario:

- In the higher scenario, the average payment rates for hospitals and physicians would be similar to the average of the rates that CBO projects for all payers (including government programs and private insurers) under current law.
- In the lower scenario, hospitals and physicians would be paid lower rates, on average, than CBO projects for all payers under current law (in 2030, 13 percent lower for hospitals and 7 percent lower for physicians).

The rates in both scenarios would be higher than what Medicare or Medicaid pays but considerably lower than what private insurers pay under current law. In both scenarios, providers would be paid using a system that closely resembles Medicare's fee-for-service system. Variation in payment rates among different types of providers would more closely resemble the variation in Medicare than in private insurance or other public plans.

S. 1129, as introduced in the 116th Congress, does not specify the rates that would be paid, so it is unclear whether those rates would be closer to the higher payment-rate scenario, the lower payment-rate scenario, or outside that range. In general, lower payment rates for providers would push down costs to the federal government and the health care system but would also reduce the average compensation of health care professionals.

Besides the policy specified for payment rates, a provider's characteristics and its compensation under current law could determine whether the payments it receives would increase or decrease. For instance, under the higher payment-rate scenario CBO examined, hospitals that serve relatively more people with private insurance would see their payment rates fall, on average, whereas those that serve relatively more people with Medicare or Medicaid coverage would see their average payment rates rise. That outcome would occur because rates paid by private insurers are generally higher than the rates paid by Medicare and Medicaid. Additionally, a single-payer system that established a more uniform payment rate would cause some providers (such as certain high-cost specialists) to receive smaller payments than they would receive under current law, whereas other providers (such as certain low-cost general practitioners) would see larger payments.

The compensation of health care professionals accounts for a large share of the costs of producing health care services and would tend to rise or fall with the rates paid by the single-payer system.

Question. Dr. Swagel, do you have any estimates on the savings [prescription drug] price negotiation generates under the Medicare for All system?

Answer. In its analysis of illustrative options for a single-payer system, CBO projected that spending on retail prescription drugs (prescription medicines that people purchase at pharmacies or by mail order) under current law would be $574 billion in 2030. In the higher payment-rate scenario, prices for prescription drugs would be 6 percent lower than under current law—which equates to a reduction of $34 billion in total spending on retail prescription drugs for the quantity purchased under current law; in the lower payment-rate scenario, prices would be 28 percent lower than under

1. See the testimony of Phillip L. Swagel, Director, Congressional Budget Office, before the Senate Committee on the Budget, *A Single-Payer Health Care System That Is Based on Medicare's Fee-for-Service Program* (May 12, 2022), www.cbo.gov/publication/57973.

current law—for a reduction in spending of $161 billion.[2] CBO did not quantify reductions in spending on prescription drugs administered in a facility, such as a hospital outpatient department.

CBO assumed that the single-payer system would begin providing health insurance coverage in 2025. For brand-name retail prescription drugs already on the market in 2025, under the higher payment-rate scenario, CBO assumed that prices would be set equal to the average of the prices projected for all payers under current law in 2025 and that they would increase at the rate of the consumer price index for all urban consumers (CPI-U) plus 4 percentage points. Under the lower payment-rate scenario, CBO assumed that prices for retail prescription drugs in 2025 would be set at the average of net prices paid by Medicare Part D and Medicaid and that those prices would grow at the rate of increase in the CPI-U.

CBO anticipates that, under the illustrative options for a single-payer system, the federal government could restrain the average launch prices of brand-name drugs introduced after 2025 by using various tools. Those tools could include price-setting based on comparative-effectiveness analyses (which identify which treatment works best for improving health) or cost-effectiveness analyses (which compare the cost of a treatment with the number of additional quality-adjusted years of life it provides).

CBO did not specify the process that would yield the prices assumed under the higher and lower payment-rate scenarios. Exclusion from the single-payer system's formulary (its list of covered drugs) is one possible tool to restrain drug prices. The authority to impose a tax if a manufacturer did not agree to the single-payer system's price would have the same effect if the tax was high enough to cause the manufacturer to lose money on sales of the drug in the United States.

S. 1129, as introduced in the 116th Congress, specifies that the Secretary of Health and Human Services would negotiate the prices paid for prescription drugs, establish a formulary, and "promulgate rules regarding the use of off-formulary medications." It is unclear whether the prices resulting from that process would fall closer to the higher payment-rate scenario, the lower payment-rate scenario, or outside that range. In general, the prices paid for prescription drugs under a single-payer system would depend crucially on how the Secretary determined whether a negotiation was successful and what the consequences of an unsuccessful negotiation would be.

2. See CBO's Single-Payer Health Care Systems Team, *How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program*, Working Paper 2020-08 (Congressional Budget Office, December 2020), www.cbo.gov/publication/56811.