Statement for the Senate Committee on the Budget

May 12, 2022

Medicare for All: Protecting Health, Saving Lives, Saving Money

Submitted by
National Association of Health Underwriters

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I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer, and utilize health plans of all types.

The health insurance agents and brokers that NAHU represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers with choosing the health plan or plans that are best for them. Eighty-two percent of all firms use a broker or consultant to assist in choosing a health plan for their employees[1] and eighty-four percent of people shopping for individual exchange plans found brokers helpful -- the highest rating for any group assisting consumers.[2] During the 2022 open enrollment period, agents and brokers assisted 62 percent of those who enrolled through HealthCare.gov or a private direct enrollment partner's website.[3] Additionally, premiums are 13 percent lower in counties with the greatest concentration of brokers.[4] Consequently, the NAHU membership has a vested interest in ensuring that consumers enjoy affordable health coverage that is the correct fit for their clients.

Approximately 180 million Americans, nearly half of the country's total population, are enrolled in health insurance coverage from their employer. Recent surveys indicate that most adults are satisfied with their current health coverage, with those enrolled in employer plans the most satisfied.[5] For those who qualify for Medicare, 96 percent of Medicare Advantage beneficiaries are satisfied with their quality of care, as are 95 percent of those covered by traditional Medicare.[6] This means that employer-sponsored insurance and Medicare are some of the most popular forms of health coverage in the United States.

A single-payer healthcare system, like the one envisioned under many "Medicare for All" proposals, would eliminate private health insurance in the United States. These proposals would compel all Americans into a government-run plan by expanding the current Medicare program into a federal government insurance plan, gradually providing health insurance coverage to all U.S. residents. Existing individual and employer-based coverage would be replaced by the federal plan, and it would be illegal for any private insurance to compete with the government-run plan, although limited private coverage would be available for any services not covered by the plan.

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[1] Kaiser Family Foundation. Employee Health Benefits Annual Survey. October 2013.
[2] Blavin, Fredric, et al. Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources. Urban Institute. June 2014.
[3] Agents, Brokers Had a Big Role In 2022 ACA Open Enrollment. *Insurance News Net.* 2 March 2022.
[4] Karaca-Mandic, Pinar, et al. The Role of Agents and Brokers in the Market for Health Insurance. National Bureau of Economic Research. August 2013.
[5] Collins, Sara. What Do Americans Think About Their Health Coverage Ahead of the 2020 Election? Findings from the Commonwealth Fund Health Insurance in America Survey, March–June 2019. Commonwealth Fund. Sept. 2019.
[6] Jacobson, Gretchen, et al. Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ? Commonwealth Fund. 14 October 2021.

Such a system would result in untenable costs for taxpayers. Estimates show that enacting Medicare for All could result in an annual tax increase of $24,000 on the average family, as well as a total cost of at least $32 trillion over a ten-year period.[7] Additionally, according to a 2019 CBO analysis, a single-payer healthcare system could lead to longer wait times for patients, reduced access to care, and provider shortages.[8] Regarding other potential impacts on providers, passing a Medicare-for-All initiative could lead to a 5.4 percent decrease in physicians across the country, exacerbating the existing healthcare workforce shortage.[9] A single-payer system would also eliminate approximately 1.8 million health insurance jobs nationwide, including the jobs held by agents and brokers who have dedicated their professional lives to supporting consumers in the individual, Medicare, and employer-based markets.[10]

Because many people have a positive opinion of Medicare, the world "Medicare" has frequently been used by those who advocate for a greater role for the government in healthcare delivery, such as a single-payer system. Since beneficiary satisfaction rates for Medicare and Medicare Advantage are generally high, using the word "Medicare" or using Medicare as a starting off place for changes often draws the attention even of those who otherwise would say they are not interested in a single-payer healthcare system. However, public polling indicates that most Americans do not support such a shift in our system. While most Americans believe the federal government can do more to help provide health insurance and believe in the idea of universal health coverage, once they learn more about how a single-payer system would work, support for such an idea drops dramatically. For example, 60 percent of consumers oppose any major shift that would threaten the current Medicare program.[11] Because of this and the high level of satisfaction in both the current Medicare program and in employer sponsored coverage, care should be taken to ensure that any future proposals aimed at increasing Americans' access to affordable health coverage not jeopardize the employer-sponsored market or the Medicare program as they are currently structured.

Some proposals envision new government programs such as a public option competing with private coverage in order to increase market competition. Unfortunately, these proposals may do just the opposite. For market competition to work in any market, the market rules must be the same for all market participants. When the government offers a product that competes with private coverage, it plays by a different set of rules, because it can mandate the level of healthcare provider payments. This creates an unlevel playing field in the insurance market where it is offered, since private plans must negotiate the best rates they can but are unable to force providers to accept lower rates. Medicare sets reimbursement rates lower than private payers and the costs are shifted to the private market; since Medicare pays providers an average of 80 percent of the cost of care delivered,[12] and some rate differentials are even higher. Providers routinely make up for this shortfall by charging private plans more.[13] Since medical expenses are the biggest part of any

[7] Holahan, John, and Linda J. Blumberg. Estimating the Cost of a Single-Payer Plan. Urban Institute, 10 Oct. 2018
[8] Congressional Budget Office. Key Design Components and Considerations for Establishing a Single-Payer Health Care System. May 2019
[9] FTI Consulting. Medicare for All and the Future of America's Health Care Workforce. 17 January 2020.
[10] University of Massachusetts Political Economy Research Institute. Economic Analysis of Medicare for All. 30 November 2018
[11] Kaiser Family Foundation. Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage. 16 October 2020.
[12] Centers for Medicare and Medicaid Services. How to Use the Searchable Medicare Physician Fee Schedule (MPFS). March 2021.
[13] Milliman. Why hospital cost shifting is no longer a viable strategy. June 2010.

premium dollar by law, this means that the competing plan offered by the government will be priced artificially lower than private coverage. Eventually these government plans would push private coverage out of existence.

The payment structure under a single-payer or public option system would have an adverse impact on many providers, including those that operate in major urban areas. For example, hospitals in large population centers in states like Illinois and New York could be disproportionately affected. Fifty percent of hospitals in Kings County, New York, within the borough of Brooklyn – which counts fewer hospital beds than necessary to serve the population – would be at higher risk under such a payment structure. Similarly, community advocates in the south side of Chicago have cautioned that a hospital closure could further strain the community's already overloaded health system. Despite this fact, nearly one-third of hospitals in their county could be at risk under a public option.[14]

Rural providers would be at an even greater risk of negative workforce impacts and closure. Compared with urban areas, rural populations have lower median household incomes, a higher percentage of children living in poverty, fewer adults with postsecondary educations, more uninsured residents under age 65, and higher rates of mortality.[15] On top of this, 180 rural hospitals have already closed since 2005.[16] The patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas,[17] so those who live on farms, ranches, reservations and frontiers often travel long distances to reach a provider. For specialists, the data is only starker; for example, as of 2014, 54 percent of rural counties did not have a hospital with obstetrics services.[18] Additionally, greater distances between hospitals result in longer wait times for rural emergency medical services.

Some provisions to extend federal healthcare programing, including lowering the eligibility age for Medicare, would create a comparable imbalance in the current individual market because of this unequal pricing ability. It creates a similar problem in the employer market because, under current proposals, employees in employer-sponsored plans would be able to opt out of employer coverage in favor of buying into Medicare. Additionally, in the employer market, this opt-out ability would create adverse selection in the employer market as those opting out of employer coverage in favor of Medicare would likely be most attractive to employees who were younger and healthier since Medicare benefits are less generous than those found in most employer sponsored plans. This would leave those remaining in the employer coverage likely to be older and sicker, potentially damaging the viability of the pool of covered individuals in the employer plan.

[14] FTI Consulting. Ripple Effects: Potential Impacts of a National Public Option on Provider Viability and Disparities in Access to Care. July 2021.
[15] The Cecil G. Sheps Center for Health Services Research. Rural Health Snapshot (2017). NC Rural Health Research Program. May 2017.
[16] The Cecil G. Sheps Center for Health Services Research. Rural Hospital Closures.
[17] Hing, E, Hsiao, C. U.S. Department of Health and Human Services. State Variability in Supply of Office-based Primary Care Providers: United States 2012. NCHS Data Brief, No. 151, May 2014.
[18] Hung, Peiyin et al. Access to Obstetric Services in Rural Counties Still Declining, With Nine Percent Losing Services, 2004–14. *Health Affairs*. September 2017.

On top of the unlevel playing field it would create, lowering Medicare's eligibility age would not significantly increase the number of people with insurance. Almost two-thirds of the more than 20 million people between the ages of 60 and 64 already have private health coverage, with 25 percent obtaining public coverage through Medicaid or other government programs. And 11 percent purchase plans on the individual market, including through the ACA's exchanges. Less than 10 percent of people in this age group are uninsured. In other words, expanding Medicare would simply replace the soon-to-be seniors' existing coverage, which is typically private, with publicly funded coverage.

Additionally, Medicare scarcely has enough money to cover the costs of its current beneficiaries. According to the latest report from its trustees, Medicare's hospital insurance trust fund will be exhausted by 2026.[19] At that point, the program will not be taking in enough in tax revenue to pay claims. The federal government may have to unilaterally cut rates to providers, which would undermine patients' ability to access care. With insolvency looming for Medicare, expanding the program is not prudent nor fiscally appropriate.

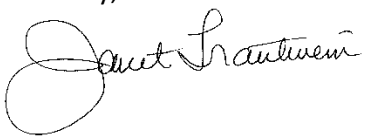
While lowering Medicare eligibility and creating a single-payer system or public option would undoubtedly threaten the Medicare program and private markets, there are other proposals that also threaten the system. One of the most important structures in the health insurance market is the barrier between employer-sponsored health coverage and the individual market, commonly referred to as "the firewall." The firewall prevents employees who have an offer of affordable minimum value job-based coverage from receiving premium tax credits in the marketplace; this is one ACA provision that has been most useful in limiting disruption to individuals already enrolled in employer-sponsored coverage. Any proposal that seeks to eliminate or significantly weaken this firewall threatens the viability of the employer-sponsored market and could result in crowding out. High levels of crowd-out could encourage employers to drop coverage, causing many of those who previously had access to employer plans to search for a new plan or go uninsured.

ACA premium tax credits are helpful for consumers who receive individual market coverage from the ACA Marketplace. Due to the passage of the American Rescue Plan Act in 2021, premium tax credits were extended to those with incomes above 400 percent of the federal poverty level, reducing premium contributions significantly for those who purchase coverage on the individual market. This change to premium tax credit policy resulted in a record-breaking 14.5 million Americans receiving health coverage through one of the ACA marketplaces during the 2022 open enrollment period. NAHU supports expanding and building upon the ACA, as opposed to any sweeping changes to the Medicare program that could jeopardize the entire system. However, these expanded subsidies are only effective when there is a clear line between the individual market and employer-sponsored market. For these reasons, any future proposals impacting health insurance must maintain the ACA's firewall.

[19] Stewart, Jackie. Medicare Part A Funds to Run Out in 2026. *Kiplinger*. 31 August 2021.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,



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