Statement for the record of

Eagan Kemp

Health Care Policy Advocate, Public Citizen

for the

U.S. House of Representatives

Committee on the Budget

Hearing on Single-Payer Health Care

May 22nd, 2019

Thank you for the opportunity to submit a statement for the record on this crucial issue. And thank you for holding this important hearing on single-payer health care. Public Citizen is a national non-profit organization with more than 500,000 members and supporters. We represent the public interest through legislative and administrative advocacy, litigation, research, and public education on a broad range of issues including ensuring access to health care. Pertinent to this hearing, Public Citizen has supported the creation of a single-payer health care system since our founding in 1971. Our health care system currently fails to meet the needs of the American people, while a single-payer Medicare for All system would guarantee coverage to everyone in the United States.

The recent Congressional Budget Office (CBO) report, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System*, identified a number of key policy considerations when designing and implementing a single-payer health care system.[1] In this statement, I describe relevant findings and how Medicare for All would address the components described in the CBO report.

I. ELIGIBILITY, ENROLLMENT, AND ADMINISTRATION

Despite the successes of the Affordable Care Act (ACA) in expanding access to coverage, more than 30 million Americans remain uninsured and tens of millions more are underinsured, meaning they are unable to afford the care they need despite having health insurance.[2] Being uninsured or underinsured hinders access to health care. For example, nearly half of uninsured working-age adults lacked a regular source of care, compared with approximately 10 percent of those who were insured, whether through public or private coverage.[3] Further, nearly one in four reported postponing care due to cost and one in five reported going without needed care or prescription medication due to cost.

By improving Medicare and expanding it to everyone in the United States, Medicare for All would finally guarantee access to health care. Access to medically necessary care, including preventive services, would reduce the incidence of many preventable diseases and allow earlier treatment for a variety of maladies. This, in turn, would reduce both personal and system-wide spending by preventing illnesses or treating diseases at earlier stages when they are cheaper and easier to treat, including reducing more expensive medical interventions and related complications.

Enrollment for Medicare for All would be similar to traditional Medicare but would happen at birth, establishment of residency, or other similar circumstances. Such a system would be administered through the Department of Health and Human Services, with appropriate regional administration to ensure adequate oversight and accountability.

Our country's transition to the traditional Medicare system serves as an example of a successful transition to a single-payer system for America's seniors. After being signed into law in 1965, Medicare enrolled

[1] CONGRESSIONAL BUDGET OFFICE, KEY DESIGN COMPONENTS AND CONSIDERATIONS FOR ESTABLISHING A SINGLE-PAYER HEALTH CARE SYSTEM, at 1 (May 2019), https://bit.ly/2UPxKk8 .
[2] SARAH R. COLLINS, MUNIRA Z. GUNJA, AND MICHELLE M. DOTY, THE COMMONWEALTH FUND, HOW WELL DOES INSURANCE COVERAGE PROTECT CONSUMERS FROM HEALTH CARE COSTS? — FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY, 2016, at 1 (October 2017), https://bit.ly/2D3WbG5.
[3] KAISER FAMILY FOUNDATION, KEY FACTS ABOUT THE UNINSURED POPULATION, at 5 (September 2017), https://bit.ly/2q8AEU7.

more than 19 million people in its first year.[4] Prior to the implementation of Medicare, only around half of America's seniors had health coverage, and the coverage available to them was not very good.[5] For example, a survey in 1963 found that 80 percent of seniors paid for their own health costs out of pocket, without help from either government programs or private insurance.[6]

Medicare has grown steadily since its implementation and covered more than 58 million seniors and people with disabilities in 2017.[7] Supporting the transition to Medicare for All would be the more than 50 years of experience that the country already has with implementing and running Medicare. While the scope of the population served will expand significantly, the necessary functions and infrastructure are already in place. The Centers for Medicare and Medicaid Services already has the capacity to enroll beneficiaries and physicians, process claims, and engage stakeholders. This expertise will serve the program well both during the transition to Medicare for All and upon full implementation.

The Medicare for All Act of 2019 (H.R. 1384) includes details for a two-year transition to a single-payer Medicare for All system. In the first year after enactment anyone under 19 and anyone 55 or older would be transitioned to Medicare for All coverage. All other populations should be transitioned to Medicare for All within 2 years of enactment. A Medicare transition buy-in would be established that would allow anyone to purchase into the Medicare for All system prior to full implementation. For-profit private insurance would still be available to cover things not covered by Medicare for All, such as non-therapeutic cosmetic surgery or lifestyle treatments or medications.

Certain populations, including patients with complex long-term care needs, would need particular attention in the transition to Medicare for All, as any disruption in their care could lead to serious health consequences. Beneficiaries with complex medical needs would need to have consistent access to necessary services throughout the transition, which H.R. 1384 provides for.

Once everyone is enrolled in Medicare for All, there would be no further need for additional coverage transitions. Everyone in the U.S. would finally be covered when they were born, became residents, or under other similar circumstances and would remain covered throughout their lives. Compared with the constant disruptions and transitions in insurance plans that Americans currently face every time they change jobs or their employer changes their insurance plan, the one-time transition to Medicare for All would be much less disruptive to Americans

II. COST CONTAINMENT, FINANCING, AND PAYMENT RATES

In the United States, we spend $3.5 trillion, or more than $10,000 per person, on health care annually—a staggering sum—a great deal of which is wasted or unnecessary.[8] As a country, we spend far more on health care than other comparably wealthy nations. Our public spending on health care, per capita, alone is higher than what nearly all other wealthy countries pay, per capita, for their *entire* health care systems. This is all the more remarkable because all of these countries, unlike the United States, provide universal

[4]Steve Anderson, *A Brief History of Medicare in America*, MEDICARE RESOURCES (February 27, 2018), https://bit.ly/298fU4W.
[5]Louis Jacobson, *Were the Early 1960s a Golden Age for Health Care?,* POLITIFACT (April 12, 2012), https://bit.ly/2UpFvxs.
[6]*Id.*
[7]Steve Anderson, *A Brief History of Medicare in America*, MEDICARE RESOURCES (February 27, 2018), https://bit.ly/298fU4W.
[8]CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURES 2016 HIGHLIGHTS, at 1 (January 2018), https://go.cms.gov/1V5YDcI.

coverage to their residents. Despite this excessive spending, the United States has the worst health outcomes compared to similar countries. [9]

Numerous studies have analyzed the prospective effectiveness of single-payer plans nationally and at the state level, as well as other universal coverage approaches.[10] Most of these studies found savings, to varying degrees. These findings are supported by the experiences of countries that already have universal health care and provide care more efficiently than the United States.[11] A recent study found that Medicare for All could save nearly 20 percent versus our current system, with the largest sources of savings being increased administrative efficiency and significantly lower pharmaceutical prices.[12] Another recent estimate found that simplified administration under Medicare for All would save the U.S. more than $500 billion a year.[13]

Medicare for All would create enough savings that even a significant increase in the amount of care rendered would be more than offset.[14] This would be achieved by reducing administrative waste, harnessing the federal government's negotiating power to bring down the price of care, and setting global budgets for institutions that would reduce the incentive for providers to administer unnecessary, expensive treatments.

1. Reducing Administrative Waste

In the 1980s our spending was much more in line with similar countries, before rapidly rising over the last few decades.[15] Increased administrative costs are one of the key reasons that overall health care costs have risen sharply over the past 40 years. The United States has the highest rate of administrative health care costs among wealthy countries.[16] Excessive administrative spending is wasteful because it contributes nothing to treating patients or improving health outcomes. Under our fragmented system, around one-third of U.S. health care dollars are spent on administrative functions, including insurance company overhead; administrative costs of hospitals, practitioners, nursing homes and other providers; and costs incurred by employers in managing their workers' benefits.[17]

---

[9]Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1024 (2018).
[10]See *e.g.*, *Listing of Single Payer Studies*, HEALTHCARE-NOW, https://bit.ly/2ypJxwr (viewed May 20, 2019).
[11]Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1024 (2018).
[12]ROBERT POLLIN, ET AL, POLITICAL ECONOMY RESEARCH INSTITUTE, ECONOMIC ANALYSIS OF MEDICARE FOR ALL, at 66 (November 2018), https://bit.ly/2E6AhCw.
[13]Steffie Woolhandler and David U. Himmelstein, *Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs*, 166 ANNALS OF INTERNAL MEDICINE 587-588, 588 (2017).
[14]ROBERT POLLIN, ET AL, POLITICAL ECONOMY RESEARCH INSTITUTE, ECONOMIC ANALYSIS OF MEDICARE FOR ALL, at 2 (November 2018), https://bit.ly/2E6AhCw.
[15]*OECD.Stat – Health Expenditure and Financing*, ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, https://bit.ly/2sNaLux (viewed on January 27, 2019).
[16]ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (OECD), TACKLING WASTEFUL SPENDING ON HEALTH, at 232 (January 2017), https://bit.ly/2yVVrhT.
[17]Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENGLAND JOURNAL OF MEDICINE 768-775, 772 (2003).
Alexis Pozen and David M. Cutler, *Medical Spending Differences in the United States and Canada: The Role of Prices, Procedures, and Administrative Expenses*, 47 INQUIRY 124-134, (2010).

Costs relating to managing health insurance are a major component of these rising administrative costs. Private insurers spend around 12 percent of their annual budgets on administration.[18] Traditional Medicare is much more efficient, spending only around two percent on administrative costs.[19] Higher costs for hospitals also contribute to our excessive spending. If our hospital administrative spending were brought in line with more efficient countries, the U.S. could save more than $150 billion each year on hospital spending alone.[20]

2. Lowering Health Care Costs Through Negotiation

One reason our health care is so expensive is that prices for common procedures, such as appendectomies, hip replacements, and angioplasties, are often significantly higher in the United States than in other comparably wealthy countries.[21] In addition, basic health care prices for the same procedure vary wildly between health care providers, which reveals inefficiencies and overpriced services.[22] Providers and insurers generally negotiate prices behind closed doors and refuse to disclose their negotiated prices, citing trade secrets.

Allowing the federal government to use its full negotiating power would make health care pricing more rational and wring out the massive amount of abusive overcharging. Under Medicare for All, the U.S. government would be able to negotiate reasonable prices for services and would prevent providers from charging vastly different prices for the same services.

The prices Americans pay for prescription drugs are also unreasonably high. One recent study compared our health care spending with 10 other wealthy nations and found that the United States spent around $1,450 per capita on prescription drugs, the most of any wealthy country and more than double the roughly $750 per capita average of all 11 countries.[23] Further, an analysis by *The Wall Street Journal* compared U.S. prices across a number of drugs to prices in England, Norway, and Ontario, Canada. It found that U.S. drug prices were almost always higher, often significantly higher.[24]

Spending on prescription drugs in the United States totaled more than $480 billion in 2016, almost 15 percent of the $3.3 trillion total spent on health care that year.[25] Instituting a Medicare for All system would finally allow the government to negotiate the price of prescription drugs on behalf of all Americans.

---

[18] CONGRESSIONAL BUDGET OFFICE, PRIVATE HEALTH INSURANCE PREMIUMS AND FEDERAL POLICY, at 27 (February 2016) https://bit.ly/1Qw9D0s.
[19] Nick Buffie, *Overhead Costs for Private Health Insurance Keep Rising, Even as Costs Fall for Other Types of Insurance*, CENTER FOR ECONOMIC AND POLICY RESEARCH (CEPR) BLOG (February 6, 2017), https://bit.ly/2l6XVB0.
[20] David U. Himmelstein, et al., *A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far*, 33 HEALTH AFFAIRS 1586-1594, 1589 (2014).
[21] INTERNATIONAL FEDERATION OF HEALTH PLANS, 2015 COMPARATIVE PRICE REPORT: VARIATION IN MEDICAL AND HOSPITAL PRICES BY COUNTRY, at 17, 22, & 24 (September 2016), https://bit.ly/2RS7R6K.
[22] Elisabeth Rosenthal, *The $2.7 Trillion Medical Bill*, THE NEW YORK TIMES (June 1, 2013), https://nyti.ms/2yW7Gef.
[23] Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1035 (2018).
[24] Jeanne Whalen, *Why the U.S. Pays More Than Other Countries for Drugs*, THE WALL STREET JOURNAL (December 1, 2015), https://on.wsj.com/2pe6SiS.
[25] Nancy L. Yu, Preston Atteberry, and Peter B. Bach, *Spending on Prescription Drugs in The US: Where Does All the Money Go?*, HEALTH AFFAIRS BLOG, (July 31, 2018) https://bit.ly/2LJPRbm.

Under its prescription drug benefit, known as Medicare Part D, Medicare is currently prohibited from negotiating drug prices.[26] In contrast, the Veterans Health Administration (VHA) negotiates the price of drugs for the veterans it serves. As a result, the VHA pays much lower drug prices than the general public. A 2015 study that Medicare Part D would save around $16 billion a year if the agency were able to negotiate similar prices to those negotiated by the VHA on the same brand-name drugs.[27]

Given that Medicare for All would mean the government would have negotiating power on behalf of a much larger population—all Americans—drug prices would be even lower under Medicare for All than they are for the VHA. A recent estimate found that Medicare for All could save over $100 billion a year on drug costs.[28]

3. Using Global Budgets to Improve Efficient Spending

Finally, by using global budgets—comprehensive budgets negotiated between the government and health care institutions (such as hospitals and nursing homes)—Medicare for All would control spending while ensuring access to medically necessary services.[29] Under global budgets, institutions have the incentive to control costs as they provide care. In contrast, our current system creates incentives for institutions to maximize revenue, for example by building expensive new hospital wings and then pressuring providers to refer patients for care, instead of furnishing the most sensible and medically necessary care.[30] Global budgets would have the potential to align providers' incentives with their missions to provide medically necessary care to those who need it.

A key part of reducing the incentive for institutions to maximize revenue is to ensure rational spending on expensive renovations and on purchasing brand-new health care technology that can cost millions of dollars for a single machine. This would be done by creating a separate budget for capital expenditures, such as on medical equipment and expansions of facilities, from operating expenditures under global budgets. Capital purchases impose upfront costs on providers. Once purchased, they create incentives to provide unnecessary care to recoup their investments.[31] By requiring separate budgets for the purchases of expensive medical equipment and building expansions, Medicare for All could ensure that such purchases are warranted by a community's needs and would thus reduce unnecessary spending, both on the capital expenses themselves as well as on spending for related services. Instead of having every hospital compete by purchasing complex

---

[26] JULIETTE CUBANSKI AND TRICIA NEUMAN, KAISER FAMILY FOUNDATION, SEARCHING FOR SAVINGS IN MEDICARE DRUG PRICE NEGOTIATIONS, at 1 (April 2018), https://bit.ly/2i1ffYJ.

[27] MARC-ANDRÉ GAGNON AND SIDNEY WOLFE, MIRROR, MIRROR ON THE WALL: MEDICARE PART D PAYS NEEDLESSLY HIGH BRAND-NAME DRUG PRICES COMPARED WITH OTHER OECD COUNTRIES AND WITH U.S. GOVERNMENT PROGRAMS, at 11 (July 2015), https://bit.ly/2p8FRJi.

[28] Steffie Woolhandler and David U. Himmelstein, *Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs*, 166 ANNALS OF INTERNAL MEDICINE 587-588, 588 (2017).

[29] STEPHEN H. LONG AND M. SUSAN MARQUIS, RAND CORPORATION, TOWARD A GLOBAL BUDGET FOR THE U.S. HEALTH SYSTEM: IMPLEMENTATION ISSUES AND INFORMATION NEEDS, at 1 (July 1994), https://bit.ly/2O3v3YS.

[30] ROBERT A. BERENSON, ET AL., URBAN INSTITUTE, GLOBAL BUDGETS FOR HOSPITALS, at 2 (April 2016), https://urbn.is/2O2ExmU. JOSHUA M. SHARFSTEIN, ET AL., THE COMMONWEALTH FUND, AN EMERGING APPROACH TO PAYMENT REFORM: ALL-PAYER GLOBAL BUDGETS FOR LARGE SAFETY-NET HOSPITAL SYSTEMS, at 3 (August 2016), https://bit.ly/2Ra6awE.

[31] U.S. GOVERNMENT ACCOUNTABILITY OFFICE, MEDICARE: HIGHER USE OF ADVANCED IMAGING SERVICES BY PROVIDERS WHO SELF-REFER COSTING MEDICARE MILLIONS, at 16 (September 2012), https://bit.ly/2CDgusT.
Dan Munro, *Why Physician Self-Referrals Have to Stop Now*, FORBES (January 26, 2015), https://bit.ly/2ArvYPd.

new technology or building fancy new hospital wings, city and regional capacity would be considered to ensure access to needed care across the country.

Health care providers in private practice or in other care settings without global budgets would be paid through fee-for-service, the rates for which would be negotiated through mechanisms similar to traditional Medicare. However, because Medicare rates would now serve as the primary rates for the health care system, there is likely to be variation from current Medicare payment rates. Similar to current rates, provider payments will likely vary by a number of factors, including region, specialty, and care setting. However, given that Medicare for All will have a more holistic view toward ensuring adequate access to necessary care, underpaid providers in primary care, mental health, and other settings may actually see their rates go up. In addition, providers will have more time to see patients as they will no longer need to spend as much time dealing with billing multiple different insurance companies and related administrative issues.

III. COVERED SERVICES AND COST SHARING

Poor quality coverage and the presence of excessive cost sharing are key reasons that Americans have the worst health outcomes of peer nations and report the highest rates of unmet health care needs of comparable countries.[32] Nearly one in four Americans reported skipping a health care appointment due to the cost, a number more than double the average across comparable countries.[33] For lower-income Americans, than number was even higher, with more than 40 percent reporting having unmet health care needs due to cost—meaning not going to the doctor; skipping a test, treatment or follow up; or not filling a prescription or skipping doses.[34] Another study found that the U.S. ranked worst out of 16 industrialized countries for deaths that could be prevented with proper medical care.[35]

And when Americans seek care, many face medical debt or bankruptcy. A survey by the Consumer Financial Protection Bureau found that medical debt was the most common reason for debt collection calls in the United States.[36] Nearly 60 percent of consumers who were contacted about debt collection were contacted due to outstanding medical debt.

Even Americans with insurance may have difficulty paying their medical bills. The percentage of working-age adults with insurance through their job who were underinsured—meaning they face such excessive out-of-pocket costs that they cannot afford to use their coverage—rose from 10 percent in 2003 to 25 percent in 2016.[37]

---

[32] Eric C. Schneider, et al., The Commonwealth Fund, Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care, at 5 (July 2017), https://bit.ly/2PTfYe2.

[33] Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1037 (2018).

[34] *Id.*

[35] Ellen Nolte and Martin McKee, *Variations in amenable mortality—Trends in 16 high-income nations*, 103 HEALTH POLICY 47-52, 49 (2011).

[36] CONSUMER FINANCIAL PROTECTION BUREAU (CFPB), CONSUMER EXPERIENCES WITH DEBT COLLECTION: FINDINGS FROM THE CFPB'S SURVEY OF CONSUMER VIEWS ON DEBT, at 21 (January 2017), https://bit.ly/2ODJkk5.

[37] A person in the study was considered underinsured if they had out-of-pocket cost, excluding premiums, over the prior 12 months were 10 percent or more of household income (or 5 percent of household income for households making less than 200 percent of the federal poverty level) or if their deductibles was 5 percent or more of their household income.

Rising out-of-pocket costs, such as co-pays and deductibles, are a key reason many Americans face challenges affording the care they need. Studies have found that out-of-pocket costs cause consumers to decrease their use of needed health care.[38] Further, a recent survey found that middle-income Americans with private insurance were the most likely to report increases in their out-of-pocket costs.[39] By eliminating out-of-pocket costs, Medicare for All would ensure access to needed care for everyone in the United States and would reduce the administrative burden of collecting and processing those payments.

Medicare for All would also guarantee access to vision and dental services, which many Americans, including seniors, struggle to afford. Lack of access to dental services can put Americans at risk for infection, decreased quality of life, and difficulty eating. Low-income seniors were particularly likely to not have had a dental visit, with only around one in four having done so in the past year, compared to nearly 75 percent of beneficiaries with higher incomes.[40] By including vision and dental services in Medicare for All, everyone in the U.S. would finally be able be guaranteed access to the services they need to live a full life.

Medicare for All would also ensure access to long-term care, improving patients' quality of life while also bringing down the cost of care, as more people would be able to receive care in their homes instead of in expensive institutions, like nursing homes. The long-term care benefits available under Medicare for All would provide more comprehensive and sensible benefits than Medicaid, including ensuring that beneficiaries could be served in the setting of their choice with the services they need. And by providing more care through long-term home and community-based services (HCBS), Medicare for All could save money compared to institutional care, given that a year of care in a nursing home costs more than twice as much as having a home health aide for a year and five times as much as a year of care through adult health day care.[41]

Improving the efficiency of our long-term care is crucial because around 70 percent of people over 65 will require at least some long-term care in their lifetimes.[42] Given our changing demographics—by 2030 all baby boomers will be 65 or older and by 2035 Americans age 65 and older will outnumber the number of children under 18 for the first time in U.S. history—we must ensure that we are providing access to

---

SARAH R. COLLINS, MUNIRA Z. GUNJA, AND MICHELLE M. DOTY, THE COMMONWEALTH FUND, HOW WELL DOES INSURANCE COVERAGE PROTECT CONSUMERS FROM HEALTH CARE COSTS? — FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY, 2016, at 1 (October 2017), https://bit.ly/2D3WbG5.
Rich Daly, *Narrow Networks Spread From ACA Plans to Employers*, HMFA (December 5, 2017), https://bit.ly/2O6GLSo.
Stephen Miller, *Employers May Adopt 'Narrow Networks' of Health Care Providers*, SHRM (January 10, 2017), https://bit.ly/2ikrVLj.

[38]Zarek C. Brot-Goldberg, et al,, *What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 THE QUARTERLY JOURNAL OF ECONOMICS 1261-1318, 1261 (2017).

[39]Nearly sixty percent of respondents with private insurance responded that their out-of-pocket health care spending had increased, compared with 51 percent of the uninsured, 46 percent for Medicare, 43 percent for Medicaid and 39 percent for VA & TRICARE.
IPSOS, HEALTH CARE EXPERIENCE STUDY, at 3 (April 2018), https://bit.ly/2TjJRpr.

[40]*Id.*

[41]ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), https://bit.ly/2CAzEPY.

[42]Emily Gurnon, *The Staggering Prices of Long-Term Care 2017*, FORBES (September 26, 2017), https://bit.ly/2W5hFZp.

needed long-term care in the most humane and efficient way possible.[43] Medicare for All would meet both of these goals and begin the crucial transition from the institutional bias of our current long-term care system to a system that serves patients in the setting and community of their choice.

IV. ROLE OF CURRENT PROGRAMS

Medicare for All would build on Medicare's current success at providing timely access to care. Medicare patients reported having consistent access to care, with more than 95 percent reporting having a usual source of care, such as a doctor's office or primary care clinic.[44] Around 90 percent of Medicare beneficiaries reported that they were able to schedule timely appointments for primary and specialty care.[45] Seniors with Medicare were more likely than adults age 50-64 with private insurance to report that they had never had to wait longer than they wanted for a routine care appointment.[46]

In addition, Medicare for All would build on the success of the expansion of access to HCBS, something many states have been improving in recent years. Under our current system, the availability of HCBS varies widely by state, because states must request waivers of certain federal Medicaid requirements in order to do so.[47] However, even states with waiver programs often have waiting lists for their programs and face challenges ensuring access to services for all who need them.[48] And regardless of waivers, before someone can receive Medicaid long-term care, they must prove they are already in poverty or spend down their assets.[49] These requirements can create significant hardship for many families, especially those who may face significant or unexpected expenses not covered by Medicaid after having spent down their assets.

Advocates have successfully pushed to improve access to home and community-based services in recent decades. As a result, HCBS recently overtook institutional coverage, in terms of overall Medicaid long-term care spending.[50] The states with the highest percentage of HCBS spending—Minnesota, New Mexico, and Oregon—devote more than 75 percent of their Medicaid long-term care spending to HCBS, while the states with the lowest spending—Mississippi, Florida and Indiana—all devoted only around a third of their spending toward home and community-based services.[51] Medicare for All would build on the successful expansion that many states have undertaken by ensuring that more Americans would be able to access HCBS, regardless of what state they live in.

---

[43] Press Release, U.S. Census Bureau, *Older People Projected to Outnumber Children for First Time in U.S. History* (Sep. 6, 2018), https://bit.ly/2p8zoQY.
[44] CRISTINA BOCCUTI, CHRISTINA SWOOPE, ANTHONY DAMICO AND PATRICIA NEUMAN, KAISER FAMILY FOUNDATION, MEDICARE PATIENTS' ACCESS TO PHYSICIANS: A SYNTHESIS OF THE EVIDENCE, at 2 (December 2013), https://bit.ly/2D6KFtl.
[45] *Id.* at 3.
[46] *Id.*
[47] ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), https://bit.ly/2CAzEPY.
[48] MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, DATA DO NOT SUPPORT RELATIONSHIP BETWEEN MEDICAID EXPANSION AND HOME AND COMMUNITY-BASED SERVICES WAIVER WAITING LISTS, at 1 (March 2018), https://bit.ly/2O25tTZ.
[49] ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), https://bit.ly/2CAzEPY.
Harold Pollack, *Health-Care Reform's Disability Blind Spot*, THE AMERICAN PROSPECT (January 9, 2018), https://bit.ly/2yxmi4l.
[50] STEVE EIKEN, ET AL, TRUVEN HEALTH ANALYTICS, MEDICAID EXPENDITURES FOR LONG-TERM SERVICES AND SUPPORTS (LTSS) IN FY 2015, at 10 (April 2017), https://bit.ly/2PUZmm3.
[51] *Id.* at 11.

While enrollees in most health care programs would be enrolled in Medicare for All, some health programs would remain independent, including the Veterans Health Administration and the Indian Health Service, because they provide specialized care to populations with unique medical needs. However, beneficiaries of such programs could be able to supplement their coverage with services through Medicare for All, when appropriate.

V. PROVIDER ROLES AND RULES

Under Medicare for All, most doctors' offices and institutions would remain in private hands, as they do now. However, Medicare for All would limit the ability of providers to use public funds for profit, marketing, and other expenses that drive up the cost of health care without improving health outcomes. In addition, Medicare for All would also end the scourge of unexpected bills that can devastate families' finances and even send them into medical debt or bankruptcy. This happens because some providers located in facilities that are otherwise in-network for someone's insurance may not actually be included in their insurer's network. For example, during an emergency, a patient doesn't have time or the ability to check whether each provider that is treating them is considered in-network by their plan. And during surgery, there could be multiple doctors and nurses, some of whom may not be in-network.[52] Referred to as "surprise billing" or "balance billing," this practice leaves patients on the hook for the difference between the amount the insurance company is willing to pay and a provider's total fee.[53]

Even a patient who is vigilant and tries to ensure they are being treated by in-network providers may have trouble avoiding surprise bills. Nearly 70 percent of respondents who experienced surprise bills that they were unable to pay did not know that the health care provider was considered out-of-network when they received care.[54] In addition, more than half of Americans received a medical bill for something they thought their health insurance covered.[55] Medicare for All providers would be prohibited from submitting any such bills to patients as their compensation would be handled through the Medicare for All system.

VI. CONCLUSION

It is inhumane to have 30 million Americans lack any form of health care coverage, placing them at risk of personal and financial ruin if they get sick. Further, having so many Americans uninsured leads to tens of thousands of needless deaths each year.[56] The United States has for too long debated creating a single-payer universal health care system without delivering. Despite this failure, Medicare has successfully achieved universal coverage for Americans 65 and older since its passage more than 50 years ago. The

---

[52] GARY CLAXTON, ET AL., KAISER FAMILY FOUNDATION, AN ANALYSIS OF OUT-OF-NETWORK CLAIMS IN LARGE EMPLOYER HEALTH PLANS, at 3 (August 2018), https://bit.ly/2OOHNaN.

[53] ADAM CROWTHER, PUBLIC CITIZEN, OUT OF CONTROL: PATIENTS ARE UNWITTINGLY SUBJECTED TO ENORMOUS, UNFAIR, OUT-OF-NETWORK 'BALANCE BILLS', at 4 (April 2014), https://bit.ly/2yyzrdA.

[54] KAREN POLLITZ, KAISER FAMILY FOUNDATION, SURPRISE MEDICAL BILLS, at 1 (March 2016), https://bit.ly/2ObKpe0.

[55] NORC AT THE UNIVERSITY OF CHICAGO, AMERICANS' VIEWS ON HEALTHCARE COSTS, COVERAGE AND POLICY, at 7 (March 2018), https://bit.ly/CuBUXo.

[56] Steffie Woolhandler and David U. Himmelstein, The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?, 167 Annals of Internal Medicine 424-431, 429 (2017).

success of Medicare highlights the importance of building on that program's accomplishments and finally extending guaranteed access to health care to everyone in America.

Everyone depends on the health care system at some time in their lives. From the moment you are born (likely at a hospital) to the day you die, you are part of the health care system whether you are healthy or sick. Even when we feel perfectly fine and haven't had a checkup, the health care system serves and protects us through the development of vaccines, control of infectious disease, and research on ailments likely to befall us, our family, or our community.

And because we rarely know when we might experience our next brush with illness or injury, we need the health care system ready and waiting, just in case.

Thankfully, momentum for a better system is growing. The public outcry for a fairer system that allows everyone access to the care they need will only get stronger as costs of the status quo continue to rise. For example, a recent poll found that 70 percent of Americans, including a majority of Republicans, support providing Medicare to every American.[57]

A single-payer Medicare for All system would improve the current Medicare program and expand it to everyone in the United States. Such a system would provide better access to care and would be far more efficient than our current fragmented health care system. The successful experience of other nations implementing similar programs for their citizens shows what great potential such a system has for improving the lives of everyone in the United States.

For questions, please contact me at ekemp@citizen.org.

[57] Julia Manchester, *70 percent of Americans support 'Medicare for all' proposal*, THE HILL (October 22, 2018), https://bit.ly/2FZoy9N.