Health Coverage for All

What Does That Mean and What are the Implications?

July 29, 2020

#HealthCoverage4All

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Q&A
Throughout the webinar, you will be able to submit questions to the moderators for consideration. Click the icon to open the Q&A window, type and submit your questions.

Webinar controls can be found at the bottom of your Zoom window.
• Why is health insurance ‘for all’ on the minds of so many right now?

• Where will the conversation about “coverage for all” take us in the next year?

• How will we pay for rising costs of care due to COVID19?
What Does Coverage for All Mean?

And what are the implications?
“Coverage for All” - The terminology is confusing!

- Most of us support the federal government doing more to help provide health insurance. (74% 1/19 KFF Tracking Poll)

- We are confused by the terminology around a national health plan.
  - Universal health coverage
  - Medicare for all
  - National health plan
  - Single payer health insurance system
  - Public option
  - Socialized medicine
About Half Of Adults Favor Both Medicare-for-all And A Public Option

Do you favor or oppose having a national health plan, sometimes called Medicare-for-all / government-administered health plan, sometimes called a public option?

- Favor both 48%
- Favor public option, Oppose Medicare-for-all 17%
- Oppose both 22%
- DK/Ref. 7%
- Favor Medicare-for-all, Oppose public option 6%

Among the 17% who favor public option, oppose Medicare-for-all:
What is the main reason that you favor a public option but oppose a Medicare-for-all plan?

- Like that it is a an option/choice/not forced 32%
- Competition among plans/private plans 13%
- It would allow people to keep their current insurance 7%
- Concerned about the cost of Medicare-for-all/increased taxes 7%
- Concerns about government involvement 7%
- Concerned about some people taking advantage of a Medicare-for-all system 5%

How are NH residents covered?

NEW HAMPSHIRE INSURANCE COVERAGE, 2018

- **56.1%** Employer Coverage Only
- **13.9%** Medicare Coverage
- **10.5%** Medicaid Coverage Only
- **5.9%** Uninsured
- **5.3%** Individual Coverage Only
- **5.9%** Other Coverage Combinations
- **1.5%** Dual Medicare & Medicaid Coverage
- **.9%** Tricare & VA Coverage
• Premiums in NH are the highest in the region for large groups and consistently higher than the US average. (Gorman/NHID)

• Private payer prices in New Hampshire are 236% higher than prices paid by Medicare (Altarum State Health Affordability Scorecard)

• Out of pocket costs are growing faster than wages

• Between 2011 and 2016, the average deductible associated with employer coverage rose 11.8% per year in New Hampshire (Altarum State Health Affordability Scorecard)
POLL

What method do you support to achieve health insurance coverage for all?

• Medicare for all
• Expanded ACA
• Government-run public option
• Free market, competition and transparency-based methods
Panelists

Margarida Jorge
Executive Director
Health Care for America Now (HCAN)
Health Care for American Now Education Fund (HCANEF)

Chuck Blahous
J. Fish and Lillian F. Smith Chair
Senior Research Strategist
Mercatus Center
George Mason University

Patrick Ho, MD
President
New Hampshire Psychiatric Society
Chief Resident in Psychiatry
Dartmouth-Hitchcock
Clinical Instructor in Psychiatry
Geisel School of Medicine at Dartmouth
• **Charles Blahous, PhD**, The J. Fish and Lillian F. Smith Chair and Senior Research Strategist at the Mercatus Center at George Mason University. Mr. Blahous specializes in domestic economic policy and retirement security (with an emphasis on Social Security), as well as federal fiscal policy, entitlements, and health care programs.

• **Patrick Ho, MD, MPH**, is the president of the New Hampshire Psychiatric Society and has been a vocal advocate for policies increasing access to mental health care services in NH. Dr. Ho is a chief resident in psychiatry at Dartmouth-Hitchcock and is a clinical instructor in psychiatry at the Geisel School of Medicine at Dartmouth. Dr. Ho will share the provider-patient perspective with particular emphasis on individuals with mental illness.

• **Margarida Jorge**, Executive Director, Health Care for America Now. HCAN is the national grassroots coalition that ran a $60 million five-and-a-half-year campaign from 2008-2013 to pass, protect, and promote the Affordable Care Act (ACA) and protect Medicare and Medicaid. Ms. Jorge will discuss policy proposals and financing to address today’s gaps in health coverage.
The Costs of a National Single-Payer Healthcare System (Medicare for All)

Charles Blahous
Mercatus Center at George Mason University
Purpose and Findings

Purpose:
Provide federal budget cost estimate for “Medicare for All” bill (Sanders, 2017)

Findings:
Lower-bound estimate of $32.6 T over first ten years (2022-31)
Actual costs likely substantially greater (range: $32 T-$39 T)
Doubling federal indiv./corp. income taxes insufficient to finance

The biggest contributor to federal costs would be the federal government’s assuming responsibility for nearly all projected U.S. national health spending now done by others.

Some aspects of M4A would further increase these costs; others aim to reduce them.
Key Specifics of Medicare for All (M4A) Bill Analyzed

-- Federal universal healthcare program
-- First-dollar coverage of all health services (no deductibles or copays)
-- Not really extending Medicare; seniors also move into new program
-- Adds services (dental, hearing, vision) beyond current Medicare
-- No new long-term care benefits (unlike newer Jayapal/Sanders bills)
-- Phased in over four years; cost estimates reflect full implementation
Illustration: Construction of Lower-Bound Estimate for 2022
(More Specifics Provided on Subsequent Slides)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Cost (in Billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently projected Nat. Health Expenditures (NHE)</td>
<td>4,562</td>
</tr>
<tr>
<td>+ Added induced demand from increased coverage</td>
<td>+435</td>
</tr>
<tr>
<td>- Applying Medicare payment rates</td>
<td>-384</td>
</tr>
<tr>
<td>- Assumed drug cost savings</td>
<td>-61</td>
</tr>
<tr>
<td>- Assumed admin cost savings</td>
<td>-83</td>
</tr>
<tr>
<td>- Share of NHE not financed by fed gov’t under M4A</td>
<td>-225</td>
</tr>
<tr>
<td>- Currently projected federal health subsidies*</td>
<td>-1,709</td>
</tr>
<tr>
<td>= Total added federal cost of M4A</td>
<td>2,535</td>
</tr>
</tbody>
</table>

*Includes tax subsidies such as the tax preference for employer-sponsored insurance
Would M4A Pay Providers at Medicare Rates?
(For Hospitals, ~40% Lower than Private Insurance)
Aggressive Savings Assumptions in Lower-Bound Estimate

Cutting Provider Payments to Medicare Rates:
-- Medicare rates < providers’ reported costs (89% of costs for hospitals), putting 80% into negative margins
-- Unpredictable access disruptions if cuts imposed while demand increased
-- Cuts of this magnitude = dramatic change in federal gov’t behavior
-- Developments subsequent to study indicate such cuts are unlikely

Drug Prices:
-- Assumes immediate 12% drop in national drug costs
-- Ignores federal incentives/history, potential adverse effects on innovation, drug industry

Administrative Cost Savings:
-- M4A employs economies of scale, revenue collection advantages, avoids some private sector costs
-- On other hand, M4A can’t have cost rates as low as Medicare’s without unrealistically low per-capita costs
How Big is M4A vs. Other Federal Budget Categories?

As a % of GDP, 2027

*Includes tax subsidies such as the tax preference for employer-sponsored insurance*
Experts from Range of Affiliations Produce Similar Numbers
(Assume M4A Implemented 2017-26, to Match Other Studies)

<table>
<thead>
<tr>
<th>Estimate</th>
<th>2017-26 Net New Federal Cost ($T)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHE Alternate Estimate</td>
<td>$40.2 T</td>
</tr>
<tr>
<td>Blahous (w/o provider cuts or drug cost savings)</td>
<td>$29.5 T</td>
</tr>
<tr>
<td>Urban Institute (w/o long-term care provision)</td>
<td>$29.1 T</td>
</tr>
<tr>
<td>Blahous (w/drug cost savings, w/o provider cuts)</td>
<td>$28.9 T</td>
</tr>
<tr>
<td>CHE Primary Estimate</td>
<td>$27.3 T</td>
</tr>
<tr>
<td>Blahous (w/provider cuts and drug cost savings)</td>
<td>$25.2 T</td>
</tr>
<tr>
<td>Thorpe</td>
<td>$24.7 T</td>
</tr>
</tbody>
</table>
Common Questions

Q: If the U.S. is already paying for most of these health costs, what difference does it make whether M4A creates large new costs for the federal government?

A: The federal government must determine how to finance M4A, in the same way it would need to figure out how to assume its citizens’ costs for housing, food, or all current state/local government functions. All financing methods discussed for M4A would substantially reduce the size of the U.S. economy relative to current methods of paying for health care.

Q: Would M4A lower national health care costs or further increase them?

A: Most neutral studies find it would increase national costs. Most of the range of my projections shows a net cost increase. The lower-bound estimate showing a slight reduction assumes very unlikely outcomes, and would still require the federal government to grow by more than the amount of all current federal income taxes.
Health Coverage for All

*What Does That Mean and What are the Implications?*

Patrick Ho, MD

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COVID Changing Health Care Debate

Public Health vs. Health Care Costs
COVID & Health Care

- Huge new burdens on health systems.
- Researchers estimate that 27 million people have lost job based insurance.
- People who lose employer-sponsored insurance (ESI) often can elect to continue it for a period by paying the full premium (called COBRA) employer premiums average $7,188 for a single person and $20,576 for a family of four – plus an additional 2%.
- Some become eligible for Medicaid or subsidized coverage through the Affordable Care Act (ACA) marketplaces. Among people who become uninsured after job loss, nearly half (12.7 million) are eligible for Medicaid, and an additional 8.4 million are eligible for marketplace subsidies, as of May 2020 (Figure 2).
- Medicaid caseloads increasing by double digits; state cuts because of budget shortfalls.
- Over time, as unemployment benefits end, some may fall into the “coverage gap” that exists in states that have not expanded Medicaid under the ACA.
- COVID Medicines and Vaccines covered under no cost preventive care (ACA) but corporations will continue to set prices.
Supreme Court Challenge on ACA puts coverage and protections at risk for millions. [October-November docket].

- 11.4 million coverage through marketplaces (9.2 subsidies)
- 12 million Medicaid expansion
- 133 million pre-existing conditions (The Kaiser Family Foundation estimated that 52 million people have conditions serious enough that insurers would outright deny them coverage if the A.C.A. were not in effect)
- 171 million protected from caps on coverage
- 60 million Medicare beneficiaries would face changes to medical care and possibly higher premiums.
- 2 million young adults lose coverage.

Trump Administration supports the lawsuit along with Republicans AGs.
Repeal is a huge tax windfall for the wealthy and industry corporations.
What Does The Future Hold?

CONGRESS, KEY FACTORS:
• Party Control of Congress
• COVID Conditions
• Revenue (Big Shortfalls, Repealing TJCA)
• Mid-Term Elections
• Increasing Costs/Sustainability
• Future of ACA

PRESCRIPTION DRUG REFORM?
• Cross Party Consensus on the Problem
• Pressure for a solution.
• Addressing Cost v. Regulating Price
• COVID Creates More Opportunity.
POLL

• Has the COVID-19 pandemic made you more likely to support government intervention to achieve health insurance coverage for all?

• Should cost to taxpayers and economic impact be significant considerations in achieving health insurance coverage for all?
Questions
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