

**REFORM**  
**David Blumenthal**  
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**David Blumenthal:** Good afternoon. I'm Dr. David Blumenthal, President of the Commonwealth Fund. Thank you for joining us to hear about a new study from the Commonwealth Fund and the Urban Institute entitled "Comparing Health Insurance Reform Options: From Building on the ACA to Single Payer." On the call with me today, we have Sara Collins, Vice President for the Commonwealth Fund's program on healthcare coverage and access, and the report authors at the Urban Institute, Linda Blumberg and John Holahan.

Before we begin, a reminder that the information discussed in this call is embargoed until 12:01 AM Eastern Time on Wednesday, October 16<sup>th</sup>. The study we are releasing tomorrow looks at eight different health reform options and their potential effects on critical pieces of US healthcare, health insurance coverage, national healthcare cost and spending. The analysis is part of an ongoing body of work at Commonwealth Fund where we regularly evaluate the impact of health policies on people and our healthcare system. We believe it is important to evaluate the impact of all proposals from those that build on the Affordable Care Act to wholesale healthcare or health system overhauls. That way policy makers and the public can better understand the direction any given policy or candidate is likely to take us.

This study is important because it shows that there are several health reform approaches that have the potential to increase the number of people that have insurance, make healthcare more affordable, and slow cost growth, but they achieve these results in different ways and to varying degrees, and the

details matter. Those details will be central to the national debate on healthcare and health insurance coverage as the 2020 campaign season progresses. Looking back on the past decade, the Affordable Care Act is proof that we can make progress in healthcare in America, expand coverage to millions of Americans, and make it possible for people with preexisting conditions to get covered and afford healthcare. This analysis provides exciting insights into how we can keep that momentum going.

I'll turn now to Sara Collins briefly, and then we will hear from Linda Blumberg and John Holahan and take your questions.

**Sara Collins:**

Thank you, David. As David mentioned, the Affordable Care Act has dramatically improved health insurance coverage and affordability, but significant problems remain. Twenty-seven million people are still uninsured, an estimated 44 million people are underinsured, and healthcare costs are growing faster than median income in most states. Polls indicate that healthcare is top of mind among voters and several Democratic presidential candidates and members of Congress have proposed ways to expand coverage and improve affordability, but a recent Commonwealth Fund survey suggests that people are confused about what some of these proposals might mean for them and the healthcare system and what the trade-offs are. For example, when asked whether they were in favor of a Medicare-for-all-type approach to expanding coverage, 40% of adults said they did not know enough to form an opinion about it. Given the complexity of our healthcare system, this may also be case regarding other approaches to improving coverage including those advanced by Republicans.

The Commonwealth Fund, in our support of the Urban Institute's work, believed it was important to help voters and policy makers understand the

facts about what the range of current health reform proposals might mean for Americans and for the healthcare system and what financing trade-offs might be required to implement them. The idea was not to model the exact parameters of the proposals but to select a range of policy options that are similar to the approaches under debate and therefore illustrative of what their potential effects might be. Our hope is that this extensive analysis will clarify for voters and policy makers the implications of the policy choices before us.

Thank you, and now I'll turn this over to Linda Blumberg and John Holahan.

**John Holahan:**

Hello. This is John Holahan, and I will start with an overview of what we did. I'll start with slide two which is titled "Analysis of Eight Reform Options," so we look at eight different alternatives. The first four reforms add incrementally to the ACA and build upon one another in steps. They improve premium and cost-sharing subsidies and expand eligibility for assistance particularly in states that haven't expanded Medicaid. We bring healthier people back into the insurance pool ending health plans that aren't ACA compliant, and we introduce cost containment through the introduction of a public option. The fifth and sixth reforms also build on one through four but add an auto enrollment feature which results in universal coverage for all legally present US residents, and then we further improve affordability including some provisions for workers.

Reform 7 and 8 are we call "Single Payer Lite" and "Single Payer Enhanced." They both are single payer health insurance plans that cover everyone, and there is no private coverage. The difference are in benefits and cost-sharing and whether there is coverage for undocumented

immigrants. When we look at results, the main things we focus on are the change in the uninsured brought about by the option of the reform, the change in federal spending and the effects on the federal budget, and the change in national health spending which means household spending plus employer spending, state government spending, and federal government spending.

We include four different ways to achieve universal coverage which have trade-offs across reform options, for example, the greater the savings to household so the more affordable the reform, the greater the increase in federal government spending. Universal coverage will require some people to pay premiums or taxes that they might prefer not to have chosen to do. In other words, it can't be voluntary. The greater the savings in national health spending, the greater need for regulation and provider payment rates. The reforms we estimate and we talk about in this report are estimated as if they're fully in place in 2020. We estimate government revenues that are needed but not how to get them or who pays those new revenues.

Now, I'll turn it over to Linda to go through the results.

**Linda Blumberg:** Hi. I'll turn to slide four which is the one that says "Reforms 1 through 4" at the top. In order not to take up too much time, I'm going to talk through some topline findings on just a selection of the eight reforms we simulated, but we can answer questions about all eight if you have them. As John noted, the first four reforms and four incremental steps show how coverage and spending are affected by a set of reforms that include making marketplace premium and cost-sharing subsidies more generous for those currently eligible for them and extending them to higher income people as well, adding a permanent reinsurance program, restoring the individual

mandate penalties, and reversing the expansion of substandard or short-term plan, filling in the Medicaid coverage gap in the 17 states that have not expanded eligibility under the ACA, adding a limited auto enrollment program for most people enrolled in SNAP or TNAF, and adding a public option. The combined effect of all these reforms which is shown on this slide as Reform 4 is an increase in insurance coverage or decrease in the uninsured of almost 11 million people. Filling the Medicaid gap is critical to getting this large of an increase in coverage as is the limited auto enrollment program and enhancing the marketplace subsidy. We show that this expansion of coverage can be achieved while keeping total national health spending, spending by all private and public payers constant, but doing that requires the public option added in Reform 4. The public option lowers the marketplace premiums, lowers the federal marketplace subsidy cost, and lower subsidy costs mean lower federal spending increases. Under these set of reforms, spending by the federal government increases to pay for more people, getting coverage through Medicaid and with marketplace subsidies, but the federal cost is significantly lower than what it would be without the public option to hold down marketplace subsidy cost. We estimate that federal spending would increase by \$46.7 billion in 2020 or \$590 billion over 10 years.

If you flip to the next slide, Reform 5 adds to Reform 4 by eliminating what's often called the employer sponsored insurance firewall that prevents people with offers of health insurance from their employers that are deemed affordable to them from getting subsidies in the marketplaces. We lift that restriction, and we add what we call [CARE] which is a set of reforms that ensures that all legally present US residents have insurance coverage even those that don't voluntarily sign up for it on their own. This set of reforms reduces the uninsured by about 80% or 25.6 million people. Employer

coverage does decrease by about 10%, however, as more mostly modest income people take up subsidized coverage in the marketplaces instead of from their employers, and the additional coverage and subsidization of more people increase federal spending by \$122 billion in 2020 or about \$1.5 trillion over 10 years. National spending would fall here, however, by less than 1%. This overall but small system savings is attributable to more people obtaining lower priced insurance coverage through the marketplaces.

We'll flip to slide six. Let's talk about Reform 7 which we call our Single Payer Lite reform, and under this reform, everyone legally present in the US obtains insurance coverage that meets the ACA's benefit standards through a single government structured and administered insurance plan. There would be no private insurance, but there would be some income-related cost sharing. Standard coverage would be at the ACA's gold plan level, the 80% actuarial value level. Under this plan like under Reform 5 and under Reform 6 that I'm not talking about at the moment, 25.6 million legal residents would gain insurance coverage. However, unlike Reforms 5 and 6, an additional 4.2 million undocumented immigrants who have private insurance today, either through employers or purchased with their own money in the private non-group market, would become uninsured due to the elimination of private insurance. On that, the number of uninsured drops by 21.4 million people leaving 10.8 million people, all undocumented residents, uninsured. Federal spending under this reform increases by 1.5 trillion in 2020 and 17.6 trillion over 10 years. This is over 11 times the increase in federal spending that we showed under Reform 5 since it moved almost all the private and state spending under that reform onto the federal bill. Direct household spending on healthcare would drop dramatically though by 72% overall, and national spending would decrease by over \$210

billion in 2020 or about 6%. These savings come from moving all legal residents into government insurance plan that pays providers at lower payment rates than current commercial insurers.

We flip to slide seven. Our last reform package is another single-payer approach, Single Payer Enhanced, that covers all US residents regardless of legal status, adds additional benefits beyond those included in the ACA's essential health benefits like adult dental, vision, hearing, and a new home and community-based, long-term services and supports benefit; eliminates all consumer out-of-pocket cost, again, eliminating all private insurance. Here, the US would have no remaining uninsured, although there's some additional uncertainty around this estimate. We can discuss later if you're interested. All household healthcare spending and state healthcare spending is eliminated except for a small share associated with institutional long-term care. Federal spending would increase, however, by \$2.8 trillion in 2020 and 34 trillion over 10 years, about 87% more than Single Payer Lite. In addition, national health spending would increase by 720 billion, about 20%, in 2020 compared to a decrease under our other universal coverage approaches. National spending increases here because of the broader benefits provided, the higher use of care resulting from eliminating of all cost-sharing expenses to consumers, and the additional coverage for about 11 million undocumented residents.

Now, if you can flip to the last slide, I just want to note a handful of issues that ideally we'd spend a whole separate conversation on but are very important when thinking about the implications of different reforms, so I'm going to just touch on each here briefly. First, reforms including a public option are Reforms 4 through 6 and single-payer reforms like our Reform 7 and 8 all rely on a price-regulated insurance market. In the case of the public

option reforms, price regulation in the individual insurance markets is how that works. In the case of single-payer reform, price regulation is applied to everyone. However, the optimal level which the payment rates for hospitals and doctors and other providers should be paid are really unknown at this time if that issue has very large implications for government cost.

Second, phase-in periods for reforms get much more important the larger the changes being made to the healthcare system, and these have large implications for cost in the 10-year budget window. We did not develop phase-in periods for the reforms here for ease of comparison of the packages to each other. Third, as employer health spending decreases, it doesn't necessarily mean that employer spending as a whole goes down. Since health insurance spending will get passed back to workers over time as higher wages. Fourth, we haven't simulated specific tax policies to fund these reforms, and how that is done is likely to vary a lot by income and that's the overall financial effect of these reforms once funded, and how those are going to impact different households differently is a big issue to be looked at more seriously once folks settle down on how they might want to fund these different kinds of reforms.

Finally, we're hoping to have highlighted the critical trade-offs and designing reforms intended to expand coverage and improve affordability. In order to reduce household cost, government cost must increase. Voluntary reforms will never get you the universal coverage, but reforms that guarantee universal coverage will require some people to do things they would otherwise choose not to do, and the more national cost savings that are achieved through lower prices paid to providers, the greater the potential disruption to the provider system.

With that I will pause, and we're happy to take any questions that you might have.

**Operator:** At this time, if you'd like to ask a question, please press star (\*) and one (1) on your touchtone phone. Star (\*) and one (1) on your touchtone phone. We'll take our first question from Jack O'Brien with HealthLeaders Magazine. Please go ahead. Your line is open.

**Jack O'Brien:** Thank you for hosting this again. This [really] will be a two-part question. I'm curious, for our audience which is primarily hospital and health system executives, what can they expect in terms of a public option or a single-payer system being implemented affecting their bottom line and any [Unintelligible] insights on how that would affect their operations would be helpful.

**David Blumenthal:** This is David Blumenthal. If I understand your question, you're asking about the likelihood that a public option will be implemented and what would happen after that?

**Jack O'Brien:** Yes.

**David Blumenthal:** Is that the correct interpretation?

**Jack O'Brien:** Yes.

**David Blumenthal:** It's hard not to model these technically without modeling the politics as well, so I think that we're not here to speculate about the way the election will turn out or who will advocate what. I think there are others who are better equipped to speculate about that than we are.

**Jack O'Brien:** If I could follow up on the second part of the conversation though, what would the impact be of a single-payer or even a public option in terms of how their operations go? I think that would be something they would be interested in.

**David Blumenthal:** I think that depends entirely on what our public leaders, as a result of political process, decide to do with respect to payment rates, and that again, is something that's very hard to predict or speculate about. There is a vast range of generous or less generous rates of payment that could be decided upon, and those would be critical. Obviously, there would be a very, very active discussion of that item should a public option actually be included in legislation that passes and is signed by the President.

**Linda Blumberg:** We did make some assumptions what the provider payment rates would be or how the premiums would change under a public option in the reforms that we modeled. What we did was we had a proxy for what those rates would be in the public option, what the premiums would be if it was a market that was very highly competitive because that's something that we can measure so competitive having at least five or more competing insurers in the individual market and having reasonably competitive hospital markets, and that was our proxy both for roughly Medicare rates and rates that we thought would be potentially attainable in the non-group market. I think one of the things that is important to remember is that when you're looking at the public option versus the single-payer reforms that you're talking about rates being regulated in a smaller percentage of the insured population under the public option, so the impacts on providers, even if the rates have come down, are going to be smaller than under a single-payer option where the regulated rates affect all patients that would be seen by the

providers. On the side of additional revenues, if you're enhancing subsidies at the same time, you're also increasing the number of people accessing services, and so additional revenues may be coming in from greater insurance coverage enrollment. All of those things need to be balanced in terms of thinking about the impact on providers, but we have not taken these particular reforms and estimated impacts on different kinds of providers at this point in terms of total revenues.

**John Holahan:** [Unintelligible] would do, they flag provider payment rates that are approximately Medicare levels and that's not – as David Blumenthal said, [if] that isn't the way it works out, then the cost would be somewhat higher than we're estimating there.

**Jack O'Brien:** Thank you.

**Operator:** We'll take our next question from Ronald Brownstein with The Atlantic. Please go ahead. Your line is open.

**Ronald Brownstein:** Hey. Good afternoon, everybody. I had a two-part question as well, part of the course here. First part is is option 8 that you have here essentially the single-payer plan that has been introduced in Congress, and secondly, when you look at the difference in total cost to the federal government between 7 and 8, how much of that difference is attributable to 8 covering undocumented immigrants?

**Linda Blumberg:** In...

**David Blumenthal:** [Crosstalk] Yes, go ahead.

**Linda Blumberg:** We did not specifically simulate any of the bills in Congress. We were trying to include a lot of the components of those bills, but those bills were not actually written in a way where the specifics were so clear that we could actually simulate them. What we have assumed here is that the providers would be paid roughly Medicare rates. We have increased that above current Medicare rates on the hospital side by 15% since current Medicare rates are estimated to be somewhat below hospital cost, and we assumed that if you were going to do this for the population at large, you would have to at least cover those costs. We have a home and community-based long-term services and support estimate in here that is, I think, of a flavor of that in one of the bills, but again, we had to make some assumptions and put some limits on in order to make it [estimatable].

In terms of how much of the difference is associated with the undocumented population being covered – let's see. I think this is right, the 218. The \$218 billion of the difference between Reform 7 and 8 is attributable to the larger enrollment of people under 8.

**Ronald Brownstein:** That's year one, Linda. That's just in year one?

**Linda Blumberg:** Yes. That's the year one, and that is if that population was just excluded and everything else stayed the same.

**Ronald Brownstein:** Yes. Just a follow-up on my first question, the basic positions that you're examining in 8, no copay, no private insurance, expanded benefits, is that the one that is most similar to the single-payer proposals that are in Congress of the eight?

**Linda Blumberg:** It is the most similar, but it is not precisely those.

**David Blumenthal:** This is David Blumenthal. It's important to know that these models do not precisely replicate any particular plan, but they do represent the major options that are available to people who are planning healthcare reforms.

**Ronald Brownstein:** Right.

**Operator:** We'll take our next question from Rick Newman with Yahoo Finance. Please go ahead.

**Rick Newman:** Hey, everybody. Does anybody know which of these options [Audio Gap] Joe Biden's plan which is obviously not Medicare pro but a new public option, an enhanced ACA? Also, just looking at the economics of them, is there any way to identify any one of these options that seems to be the optimal approach?

**John Holahan:** We think the Biden plan, as we understand it, is a mix of Reform 4 and 5, and I don't think we have ourselves formulated a view as to what we think is best, and that really depends on your goals, I think.

**Linda Blumberg:** Yes, what we're trying to highlight here are the trade-offs and costs for various different payers and coverage and allow people to identify their own strengths of what is optimal based on their values and objective.

**Rick Newman:** Thanks.

**Operator:** Our next question comes from Lilo Stainton with New Jersey Spotlight. Please go ahead. Your line is open.

**Lilo Stainton:** Hi. Thank you. I'm curious. I'm very struck by how the different options appear to reflect or echo what some of the states have done on their own. Obviously, I come from New Jersey. They now have an individual mandate. They have reinsurance. They expanded Medicaid. I'm curious. It seems that these reforms all would build out some of those kinds of reforms into a national plan. First of all, is that a first assessment as you move through the different reforms? Secondly, if anyone of these are to be done on a national level, it appears that you're going to have states that are going to be winners and losers because some states have already taken some of these steps themselves. Does anyone want to talk about how that would have to be figured in or is that sort of that political calculation that you didn't do because some of these are already in place in some parts of America obviously?

**Linda Blumberg:** Sure. Some components are, so as you said, some states have an individual mandate. Some have reinsurance. We took that into account in our estimates, and so when we move from having no individual mandate penalties back to having mandate penalties without revenue is coming off of the state side and going on to the federal side to the extent that revenue is collected on the individual mandate penalty. The states who have reinsurance programs in place and are contributing towards the cost of those, they're getting savings, and those costs are now absorbed within the federal system. In the enhanced subsidies that star in our first step, our Reform 1, and carry through Reform 5 and are built on from there, there really isn't a state that has enhanced subsidies as generous as those. You have a couple of states, Vermont and Massachusetts, that have been adding additional subsidies. California is going to, but they didn't have a schedule yet specified, but none of those states, even the two states that have already

put enhanced subsidies in place, have done anything that was this comprehensive.

On the Medicaid side, what we did in terms of filling in the Medicaid gap specifically and not in the non-expansion states was we lowered eligibility for the subsidies in the marketplaces, but these are enhanced subsidies under our approach to just above Medicaid eligibility in all of those non-expansion states to allow those folks who are currently cut out from any assistance to get them generous subsidized coverage through the marketplaces in those 17 states. Because, as you said, many states have already expanded Medicaid and it seemed unfair to just buy out the states that hadn't done that while the other states were paying 10% of their expansion population cost, we included in our cost the federal government picking up that 10% from the expansion states on the expansion populations in order to make it more even, so that was how we dealt with that.

**Lilo Stainton:** Essentially they wouldn't pay for having already gone through the work themselves. They wouldn't have to pay for others to do that same expansion?

**Linda Blumberg:** It will all be federalized so that 10% that the expansion states are paying would be part of the federal bill as would the eligibility for subsidies for that Medicaid gap population that we're taking in.

**Lilo Stainton:** Thank you.

**Operator:** We'll take our next question from Ricardo Alonso-Zaldivar with the Associated Press. Please go ahead.

**Ricardo Alonso-Zaldivar:** Hi. Thank you for taking my question. I was wondering. On Reform #8, that large increase in federal revenue needed of almost 2.7 trillion annually, is there any way to do that without a broad-based tax?

**David Blumenthal:** As Linda and John specified, and this is David Blumenthal, we have not modeled the tax implications of this...

**Ricardo Alonso-Zaldivar:** Is this David talking now?

**David Blumenthal:** Yes, it is.

**Ricardo Alonso-Zaldivar:** Thank you. Yes, please go ahead.

**David Blumenthal:** We've not modeled the tax revenue implications or options, so I don't think we can comment on the question you just asked.

**Ricardo Alonso-Zaldivar:** Just based on your general familiarity with the tax system and the ability of the federal government to raise that kind of money, do you see any way to do it without a broad-based tax?

**David Blumenthal:** Ricardo, you're forcing me to reach back to my public finance course in graduate school which was 1975.

**Ricardo Alonso-Zaldivar:** Which you aced, right? You aced that one. [Laughter]

**David Blumenthal:** Absolutely. It's a little foggy right now, so I don't want my professor to get irritated with me. [Laughter] I think I'll pass on that question.

**Ricardo Alonso-Zaldivar:** Okay.

**Operator:** Thank you. We'll go next to Peter Sullivan with The Hill. Please go ahead.

**Peter Sullivan:** Hi. I have a two-part question. The first is technical. I'm just wondering on Reform 8 in Table 16 you list two different numbers for the 10-year cost. One of them is 33.988 and then one of them is 32.15. My understanding is one of them takes into account the income tax feedback, I guess, basically. We're just looking for a headline 10-year cost of Reform 8. Which of those numbers do you think is more the cost? It sounds like maybe it's the 32 trillion because that's after the income taxes are taken into account?

**John Holahan:** Yes, I think it's probably clear to most people. They go with the one that's closer to 34, but as employers pass these savings back on in terms of higher wages, federal revenues will go up as a result, so the amount that needs to be financed is the lower number, 32. You could really use either one, but I think most people probably would find it easier to get their hands around the 34, but the 32 is...

**Linda Blumberg:** Meaningful.

**John Holahan:** ...is very meaningful as well.

**Peter Sullivan:** Thanks. Thank you. That's good.

**Operator:** We'll take our next question from Amy Lotven with Inside Health Policy. Please go ahead.

**Amy Lotven:** Yes, hi. Thanks for taking the question. Going to go back to what somebody else had mentioned before about the Medicare rates, I was wondering. You

have Washington State that tried to do 100% Medicare levels for their public option but ended up at 160, and then you have in Colorado, I think, they ended up at 175. I guess I wanted to ask, first of all, are you planning on watching to see what's going to happen with those public options over the next year and perhaps make changes to your model, and second of all, what does the situation in those states make you think about the possibility of actually getting to a flat Medicare reimbursement level?

**John Holahan:** Many of these proposals have talked about using Medicare rates or something close to it, and so that informed our thinking about what we wanted to do. The numbers you mentioned, those two states, really refer to hospitals, I'm pretty sure. We're going to be increasing rates for current Medicare and Medicaid bringing down the higher commercial rates, but it is a big change. We discussed that at some length in this paper that even though this is the way we modeled it to get there, [it would] take a long time and be very difficult to do, but we had to hang this on something, so that's what we did.

**Linda Blumberg:** I think that the phase-in conversation which we just touched on briefly at the beginning and the end of our presentation really speaks to this, and I think it does related to where we are with some of these other states which is where you start is potentially merely the start. Part of it is getting some experience with seeing how providers are able to cut cost and become more efficient. I think any of us would say it would be unwise to go from where we are now down to Medicare rates in one step, in one moment, and that thinking about that path from where we are now to potentially where we might want to be in the future is a really important conversation to have. That path would require, from my perspective, a lot of monitoring and evaluation to assess that as rates were being brought down over time that it

was the right balance between cost savings and access and quality of care, and that's why we think phasing in lowered rates somewhat slowly and over time would be a very important thing here. We didn't do that in this analysis because we wanted to be able to have more straightforward comparisons across different types of reforms, but we do think that's very important consideration.

**Amy Lotven:** Thank you.

**Sara Collins:** This is Sara too. The states that are already moving forward on the public option provide a unique opportunity to get to learn more about how this would work. In fact, it also suggests that are different approaches to doing a lot of the reforms that are done in this report and are being talked about on the campaign trail, and one of those is to experiment with the public plan over time and fold it in state by state in states that have less competitive markets, for example, and just have a better sense of how that might work and where the pressure points are for providers.

**David Blumenthal:** Yes. This is David Blumenthal. I just want to point out one perspective on the reductions in payments that are hypothesized to occur under a public option is that they are potentially dangerous in compromising the quality of care and access to care to those institutions that are experiencing reduced revenues. Another point of view is to look internationally which we do a lot at the Commonwealth Fund and recognize that, in the United States, we use about the same amount service that the rest of the developed world does. The reason we cost twice as much as the nearest competitor is because our prices are so high compared to what is paid in the rest of the world where outcomes of care as good or better. I think, as you take a long view of the price controversy, you have to look at both sides of that controversy and

recognize that we also have lots of markets, at least the great majority of markets, where there is no competition because there's such consolidation within those markets. We don't have a way of setting prices that is reflective of the underlying cost of providing the services.

**Amy Lotven:** Thank you.

**Operator:** As a reminder, star (\*) and one (1) for any further questions today. Star (\*) and one (1). We'll go next to Harris Meyer with Modern Healthcare. Please go ahead.

**Harris Meyer:** Hi. There's a Woolhandler study coming out tomorrow that basically finds that the ACA and Medicare did not increase doctor visits or procedures, and of course, Dr. Woolhandler says the cost of Medicare for all is being overestimated. I was just wondering how your analysis looks at utilization impacts. I know you talked about the lack of cost sharing in Reform Option 8. I'm wondering throughout all the options whether you're envisioning or building in an increase in utilization and how that compares to what Dr. Woolhandler and her colleagues found.

**Linda Blumberg:** We definitely, within the model that we used, rely on the best economic research and analysis of how utilization spending on medical care increases with lower prices facing the consumer, and those elasticities which have been demonstrated over time and the best research out there are built into these models. Yes, as prices, out-of-pocket cost to consumers go down, utilization goes up according to those elasticities. For example, the elasticities are larger for people who spend little compared to people who are quite ill and using a lot of medical care today which makes sense. If you are very seriously ill, you're already over your deductible and have reached

your out-of-pocket maximum. A lower price is not going to really change your use very much at all, but the elasticities or responses to those lower prices are great for people who are at the lower end of the medical consumption distribution, but yes, we do rely on economic research in that respect.

**John Holahan:** One thing I could add to that is that sometimes people make estimates of the impact of a change in price in a world in which the supply of care doesn't have a chance to respond. As we said early on in this, we assume a fully phased-in system so the supply system has had a chance to respond to say non-physician personnel, telemedicine, and other ways that the system could become more efficient. We assume that the supply system has reached new equilibrium, and that being said, the supply constraints you'd have in the short run that could be part of somebody else's estimates are not really in these estimates because we let the system respond to meet the increased demand of coming from the coverage reform.

**Linda Blumberg:** That means if there are supply constraints in the short run, the cost may be lower than what we estimate, but then also the increase in access is not fully met either.

**Sara Collins:** This is Sara too. Just to put this in more simple terms, we know from years of research that people who are not uninsured or underinsured use significantly less needed care than they should, and so part of the motivation for universal coverage and reducing financial barriers is to enable people to get the healthcare that they need. It's the point of this. Some of these proposals have greater cost sharing than others, but it is what you would expect, and it is certainly what we saw after the reforms of the Affordable Care Act.

**Operator:** Thank you. Just as a reminder, it's star (\*) and one (1) for any further questions today. We'll pause to allow questions to queue. [Pause] We do have a follow-up from Ronald Brownstein with The Atlantic. Go ahead. Your line is open.

**Ronald Brownstein:** Thank you. I did have one more question, and I know you said you can't model how you would meet the revenue that would be required here, but the magnitude of the revenue that would be required is something that – I'm not aware the federal government has ever raised in one fell swoop before. If you're just talking about 2.7 trillion in one year, that is the 10-year estimate for the Elizabeth Warren wealth tax. I'm just wondering. Can you even identify what might be a plausible way of raising that much money that would have any political prospects? Do you think this requires, for example, a value-added tax? I think this is more than double the amount the payroll tax anticipated to raise over the period. What are some of the ideas that could even approach this level of cost in example 8?

**Linda Blumberg:** We have an estimated specific revenue but my guess is – setting aside the political viability.

**Ronald Brownstein:** Yes.

**Linda Blumberg:** ...because I won't comment on that. I would presume you would use a mix of broad-based taxes, things like additional payroll taxes, possibly a VAT. You could increase income taxes on various groups, but oftentimes when you think about [Unintelligible] the cost associated with government programs, mixes of different revenue sources are often considered. That

would be my guess as to where you would want to start thinking about things.

**John Holahan:** Your assumptions is correct. It is a big lift to get this kind of money, for sure.

**Sara Collins:** This is Sara. I do want to point out though that the single-payer options do decrease household spending substantially, so that is a political discussion to have with people in terms of [the shifting] sources of how we finance our healthcare system, but it's not as if increased taxes will be added on top of what people are already paying. They would actually be substituted, and so some people at the lower end of the income distribution, it would probably be a net savings for them. At the upper end of the income distribution, it might be [a wash] or might be an overall net increase, but it really does have to be considered within and discussed within the context of the substantial decrease and spending that households and employers would actually experience under this.

**Ronald Brownstein:** Sara, as I looked at the numbers, I think the decrease in household spending was in the range of 600 billion a year, and the cost is in the range of 2.7 trillion a year. Unless that's being made up entirely by way – I mean the cost is greater than the household savings, is it not? It's five times as big.

**John Holahan:** There are also reductions in corporate spending and state and local spending too. That's why, in Reform 8, we have a net increase in national spending because the new federal spending is going to offset savings to households, employers, and state and local governments.

**Linda Blumberg:** There would be potentially tax saving from state spending going down and some wage increases as we noted from employer spending going down, but we still have an increase in national health spending.

**David Blumenthal:** This is David Blumenthal. I would just like to also point out that I don't think there's any – except for the United Kingdom which I don't think covers all of the things that Reform 8 proposed, but almost every developed country with universal coverage has cost-sharing requirements of various kinds, limitations on coverage. The result is more similar to Single Payer Lite and shows a decrease in total national health spending under the Urban model. Reform 8 is atypical in its comprehensiveness and extensiveness of what internationally is prevalent for the developed world.

**Ronald Brownstein:** Thank you.

**Operator:** We'll take our next question from Shannon Firth with MedPage Today. Please go ahead.

**Shannon Firth:** Hi. This is Shannon. Thank you for taking my question. I just wanted to talk about one of your key takeaways that reform ideas 5, 6, and 7 don't increase national health spending while still achieving universal coverage. Can you flesh out a little bit how they achieve that, and what are the caveats there, their limitations that, for example, if you weren't using Medicare payment rate or if you weren't doing X, you might not see that balance? Thank you.

**Linda Blumberg:** Sure. Number one, you're absolutely right. If the payment rates for the reforms in the marketplaces in 5 and 6 or for the single-payer system in 7 were higher, you may not see – and we haven't done sensitivities on those with the payment rates, but you might not see those are small decreases in

national health spending. You might not achieve those if you had higher payment rates. One of the ways in with the federal government costs are kept down in 5 and 6 specifically is that there are a lot of people still remaining in the employer-sponsored insurance system. They receive the tax subsidy that we have in current law for employer-based insurance contributions by employers, but they're not being additionally subsidized here in the marketplaces. We retain premium contributions that are income related for households to be spending and out-of-pocket costs that are income related, so all of those keep dollars in the private sector.

In addition, state governments are continuing to help finance the Medicaid program in those reforms, and all of those help to reduce cost. They also are leaving the undocumented population outside of these reforms. In 5 and 6, the undocumented population can still buy private insurance with their own funds or through their employer, but they are not being subsidized through the marketplace subsidies. Under 7, more dollars are being shifted onto the federal side and away from the private than in 5 and 6, but you've got the lower provider payment rate. You still have some income-related cost sharing, and the benefits are more limited than what you see in Reform 8. They're consistent with the Affordable Care Act benefits just like Reforms 5 and 6 are, so those are really the big pieces that I've raised in there.

**John Holahan:** Just 5, 6, and 7 don't cover undocumented immigrants and 8 does so...

**Linda Blumberg:** That's certainly part of it, but yes. If you ended up, for example, [Unintelligible] the provider payment rates are quite a bit higher. National health spending might well be increasing instead of decreasing a little bit here.

**Shannon Firth:** Thank you.

**Operator:** We'll take our next question from Merrill Goozner with Modern Healthcare. Please go ahead.

**Merrill Goozner:** Yes, going back to something said earlier that none of these plans are based on anything that is specific to a piece of legislation. Was there nothing on the conservative side that you found worthy of analysis in thinking about how to bring down the uninsured rate from where we are today? I could outline some ideas, but I'm just curious if you took a look at some things and just simply rejected them or that you never really considered some alternative approaches that at least some think tanks I know talk about.

**Linda Blumberg:** We did. One of the things that we've done this year is we have modeled the implications of full repeal of the ACA that is supported by current administration, and we do have estimates out on that, and those are state by state estimates if you're interested in it. During 2017, we estimated a whole array of repeal and replace proposals that were being supported by the Republican Congress, so we have done a wide array of those kinds of reforms as well. This was a specific look at this set of proposals, but we expect to do more as more reform proposals are developed on all sides.

**David Blumenthal:** We would be delighted to model proposals introduced by the administration, by the Republican Study Committee which is rumored to be developing a plan, but they are not as well formulated as the plans that are available from the other side of the aisle.

**Merrill Goozner:** Can I do a follow-up on that?

**David Blumenthal:** Sure.

**Merrill Goozner:** On the other side, looking at the single-payer plans, at least one of the democratic candidates has talked about single payer but doing it with essentially Medicare Advantage and competing it rather than no private insurance option as you've outlined in the two single-payer plans here. There's the idea of having the private insurance companies compete by selling different versions of a Medicare for All plan like Medicare [Unintelligible]. Did you not consider that or is there nothing concrete enough to take a look at?

**Linda Blumberg:** I think that kind of approach would likely have very similar results to Reform 8, but we had to limit just how many we could do in one paper because already eight and three sensitivities on two of those are a huge amount of information. There's actually a lot more data in the full report, even then in the brief, that I think you've all had access to. It is something that we've talked about possibly doing, but for the purposes of this which we really wanted to give some benchmarks on the broad spectrum of options being discussed that that would give results that were so substantially different than Reform 8 that it made sense to add it as another one. We were just trying to limit how much we're throwing at everybody at one time.

**John Holahan:** It was also introduced fairly when most of this work was already well along too.

**Linda Blumberg:** Yes. It is something that we'll think about, whether it makes sense for us to look at that in the future.

**Operator:** Thank you. It does appear we have no further questions. I'll return the floor to our presenters for any closing remarks.

**David Blumenthal:** Thank you very much for your attention and for your questions. Thanks, Linda and John and the Urban Institute. If you need additional information, we will be available this afternoon, and I just want to remind you that the embargo for this report lifts at 12:01 AM tomorrow.

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