

LECTURE

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The National Debate over Government-Controlled Health Care

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Abstract

Policymakers are debating whether Congress should enact a single-payer health care system or create a system based on personal choice and market competition. The fundamental question is whether government officials or individuals and families will make the key health care decisions. The adoption of a single-payer system requires major trade-offs: a loss of personal and economic freedom, the loss of existing health coverage, the imposition of unprecedented federal taxation, major payment reductions for doctors and medical professionals, long waiting lists, and care delays and denials. Public opinion on this issue is in flux and malleable, and conservatives in Congress must offer sound, concrete policy alternatives or risk forfeiting the game and handing victory to the champions of a single-payer program.

A Fundamental Conflict of Visions

ROBERT E. MOFFIT, PhD: Today, we are going to address proposals to replace America's current health care arrangements with a national "single-payer" health care system. While I will confine myself to some general remarks, I am happy to introduce two outstanding colleagues.

The first is Dr. Christopher Pope, a Senior Fellow with the Manhattan Institute, a prominent public policy institution based in New York. Chris has written extensively on Medicare, the Affordable Care Act, Medicaid, and the issue of personal freedom in health care. His work has appeared in *The Wall Street Journal*, *Health Affairs*, *U.S. News and World Report*, and *Politico*. Chris earned his bachelor's degree in government from the London School of Economics and both his master's and doctorate in political science from Washington University in St. Louis, Missouri.

This paper, in its entirety, can be found at <http://report.heritage.org/hl1305>

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KEY POINTS

- Policymakers are debating whether Congress should enact a "single-payer" health care system or create a system that is based on personal choice and market competition.
- This debate is rooted in a conflict of visions: Will government officials make the key health care decisions for us, or will individuals and families make these decisions themselves?
- The adoption of a single-payer system requires major trade-offs: a loss of personal and economic freedom, the loss of existing health coverage, the imposition of unprecedented federal taxation, major payment reductions for doctors and medical professionals, long waiting lists, and care delays and denials.
- Public opinion on this issue is in flux and malleable. Conservatives in Congress must offer sound, concrete policy alternatives or risk forfeiting the game and handing victory to the champions of a single-payer program.

Dr. Whit Ayres will follow Chris with a presentation on the changing state of public opinion on single-payer health care. Whit Ayres, well known in Washington, is a leading political consultant. With over 30 years of experience in polling and survey research, he is the founder and President of the North Star Opinion Research Corporation, a public opinion research and public affairs organization. A frequent commentator on network and cable media, Whit has appeared on NBC's *Meet the Press*, *Fox News*, CNN, NPR, and the BBC. His analysis and commentary has been published in *The Wall Street Journal*, *The New York Times*, *The Washington Post*, the *Los Angeles Times*, and *USA Today*. Before starting his career in Washington, Whit was a tenured professor in the Department of Government at the University of South Carolina. He received his doctorate in political science from the University of North Carolina at Chapel Hill.

A Conflict of Visions

A word about our topic. We are entering into another phase of America's national health care debate, regardless of whether or not Members of Congress want to engage in such a debate. The debate is unavoidable and defined by two diametrically opposed, competing visions of the future of American health care.

The first is that of a health care system powered by choice and competition. My colleagues at The Heritage Foundation, along with 90 representatives and analysts of different policy organizations, has developed the Health Care Choices Proposal as a down payment on such a system.¹ It is a major transfer of regulatory authority over the health insurance market from the federal government back to the states. It would enable state officials to tailor their statutory and regulatory initiatives and reforms to address their particular problems within the particular conditions that exist within their borders. The proposal would repurpose existing funding to better assure access to private coverage for people who have pre-existing conditions and who need financial assistance because of their relatively low level of income.

The proposal would also accomplish, if enacted into law, something that no other health care reform measure being considered in Congress would do, and that is unleash an unprecedented degree of personal choice in the health insurance markets. It would enable people who enrolled in public programs to use the money allocated to them in their public coverage, such as Medicaid or the Children's Health Insurance Program (CHIP), and transfer that funding to the private health coverage of their personal choice and it would lower premiums according to independent estimates.

The second is entirely different. It is a vision of total government control over American health care. It is what we are going to talk about today. The proponents of Medicare for All or a single-payer health care program have a very ambitious agenda. The proponents claim that they want to provide all Americans, without distinction, with health care as a legal right. They promise that their program of national health insurance will provide superior care to all Americans economically and efficiently and that care will be more affordable.

The Sanders Bill

Senator Bernie Sanders, the Independent from Vermont, has introduced a comprehensive bill (S. 1804) to establish such a system.² You all have access to it. I strongly suggest that you all read the Senator's Medicare for All bill, as well as a similar proposal in the House of Representatives backed by more than half of all House Democrats (H.R. 676).³ Senator Sanders is proposing a national health insurance program of universal coverage. This would be an entitlement for all U.S. residents, not necessarily citizens. He would establish a national health benefit program and eliminate nearly all cost sharing, making care free at the point of service.

Senator Sanders' bill would outlaw all private health insurance, including employer-based coverage, which covers roughly nine out of 10 people with private health insurance. The only exception would

1. See Edmund F. Haislmaier, Robert E. Moffit, and Nina Owcharenko Schaefer, "The Health Care Choices Proposal: Charting a New Path to a Down Payment on Patient-Centered, Consumer-Driven Health Care Reform," Heritage Foundation *Background* No., 3330, July 11, 2018, <https://www.heritage.org/health-care-reform/report/the-health-care-choices-proposal-charting-new-path-down-payment-patient>.

2. H.R. 1804, Medicare for All Act of 2017, 115th Cong., 1st Sess., September 13, 2017, <https://www.congress.gov/bill/115th-congress/senate-bill/1804/text> (accessed January 28, 2019).

3. H.R. 676, Expanded and Improved Medicare for All Act, 115th Cong., 1st Sess., January 24, 2017, <https://www.congress.gov/bill/115th-congress/house-bill/676> (accessed January 28, 2019).

be small plans for certain noncovered benefits or services. Private health insurance, including employer-sponsored insurance, would otherwise disappear.

Given the fetching title of the bill, you will find this somewhat surprising: The bill actually eliminates Medicare. It also eliminates Medicaid and the CHIP program. It absorbs all of the beneficiaries of these programs into the national health insurance program.

In his bill, Senator Sanders does not specify how, exactly, he would fund his program. He does, however, provide a separate list of financing options, including new income and payroll taxes. Senator Sanders has been generous in describing the number of new taxes that will be required to pay for this program.

As a matter of governance, the Sanders bill centralizes virtually all decision-making power over Americans' health care in the office of the Secretary of Health and Human Services (HHS). The Senator specifies that Medicare rates would be the foundation for the payment of doctors, hospitals, medics, and home health agencies—virtually every medical professional throughout the entire United States. Moreover, and for many of us most important, the bill would sharply restrict the ability of doctors and patients to engage in a private contract for medical services outside the system. Under Section 303 of S. 1804, the bill would severely curtail such contracts between doctors and patients where patients spend their own money on medical services.

Broken Status Quo

Let me just make a couple of observations.

First, I think it is critical to know—very critical to grasp—that anyone's opposition to a single-payer system is not and should not be construed as a backhanded endorsement of the health care status quo. American health insurance markets are concentrated; they are distorted; and they are inefficient. Premium costs in the individual markets are very high and have been soaring over the past four years. For many individuals and families, the deductibles are outrageous.

Health care quality is uneven and falls short in many areas of this country. Far too many Americans are still uninsured. Middle-class Americans, especially those who are ineligible for Obamacare subsidies because of their income, are struggling right now to hold onto the insurance coverage they've got, and those without insurance coverage are struggling to get access to plans that can deliver quality care from a system characterized by progressively narrow provider networks.

As an economic matter, the current American health care arrangements—public and private—are not generally efficient. That is the case under Obamacare. Moreover, before Congress enacted Obamacare in 2010, that was also the case. So, except for a transfer of regulatory power from the states to the federal government, there has not been a significant structural change in the insurance markets to secure either economic efficiency or personal choice.

Second, it is important to appreciate the profound emotional appeal of the single-payer proposal. It is what mainly explains much of the positive but preliminary polling on the proposal. Consider the lofty promises: Free care for all at the point of medical service; high-quality care for everyone; universal coverage; comprehensive benefits covering everything from tonsillectomies to toupees; no deductibles; no copays; no premiums; no messy managed care networks; no high administrative costs; and, finally, really serious, no-nonsense cost control. It all really sounds great. When you think about it, who could possibly be against it?

It also has an appealing simplicity. It is logically coherent. The government gives you health care, and you pay the government taxes—very big taxes, of course, but less, so they promise, than what you would pay if you were paying all of those high premiums and deductibles to private health insurance companies. Moreover, it would impose more rational payment on the rich medical professionals. Doctors and other health care providers of all sorts would be paid less and become public servants or the equivalent of public servants, and hospitals and other medical facilities would become the equivalent of public utilities. In any case, what could be simpler than that?

Promises

Single-payer proponents make many big promises. Well, I can make some big promises too. Before I turn this discussion over to Chris, here is what I promise.

First, I promise that congressional budgetary decisions and political decisions, not medical decisions or even rational economic decisions, will drive the new single-payer program. Even so, politicians cannot repeal the laws of supply and demand. If health care is a universal free good, then it is for all practical purposes what we can expect from the provision of what economists deem a free good. Free goods have certain invariable characteristics. Consumers literally act as if they are free even if they are not; and if health care

is indeed a free good, then economic demand for that free good is unlimited. It is not subject to the price mechanism of the market, simply because there is no market.

However, unlimited demand at any given point in time must collide with limited supply. This means that government officials, not doctors, and certainly not the passive patients, are going to make the key decisions about who gets care, how they get care, when they get care, and under which circumstances they get care. The key decisions in such a system, in other words, are ultimately political decisions. You could say, of course, that these are budgetary decisions dictated by some impersonal bureaucratically designed formula, but budgetary decisions and the formulas by which funds are allocated are ultimately political decisions. Again, they are not largely medical or even conventionally economic decisions.

Second, I can promise you that cost control in the single-payer system will eventually reduce the supply of medical goods and services. Government officials cannot control demand. Control over popular economic demand is beyond their capacity. They can, however, control the supply of services. They can either control the supply through a global budget or impose a system of price controls on medical goods and services, as provided in the Sanders bill. In either case, supply is deliberately restricted in the face of rising demand, and the availability or quality of care necessarily declines.

Most of you have some familiarity with the British single-payer system, perhaps the most prominent and well-established single-payer program in the industrialized world. To their credit, the British media routinely report on periodic crises in the British National Health Service. Beyond periodic funding problems, Britain fares poorly among modern industrial nations when it comes to survival rates for patients with serious illnesses like heart disease and cancer. British patients are also routinely subject to long waiting lists, a shortage of medical specialists, and substandard quality for postoperative care. Last winter, when the flu season struck, the National Health Service canceled 50,000 “non-urgent” surgeries across the board. One can only guess what particular surgery for what particular patient was either urgent or nonurgent.

Lost Liberty

Third, I can also promise that you will surrender an enormous amount of personal and economic freedom. Champions of single-payer health care always promise free care for all without exception. Your personal decisions concerning the kind of care you get or want, of course, do not count. Government officials decide what health benefits you get, when and how you get them, under what circumstances you get them, what you pay for them, and how you pay for them.

For Americans who may be subject to a single-payer regime, certain key questions are unavoidable:

- Where can I go if the government program does not provide what I want or what I need?
- Is there an exit ramp from the system?
- Can I buy an alternative health plan, a plan of my choice that will provide the coverage that I want?
- Can I privately contract outside of the government program with a medical professional or specialist of my choice to treat my medical condition?
- If I am permitted to do so, does the doctor or specialist who agrees to see me suffer a statutory, regulatory, or financial penalty?
- Do private medical consultations outside of the system incur some sort of official punishment for members of the medical profession?

All of these are critical questions, and they deserve clear and unambiguous answers. Ordinary Americans will need to know exactly how the new government-controlled system will work in practice: how, in other words, it will affect them personally.

Unprecedented Taxation and Huge Costs

Fourth, I promise unprecedented levels of federal taxation: big taxes. In his analysis of the Sanders’ proposal, Professor Kenneth Thorpe from Emory University, a former adviser to President Bill Clinton, estimates that the Senator’s plan, if fully funded, would consume about 20 percent of payroll.⁴ Understand

4. Kenneth E. Thorpe, “An Analysis of Senator Sanders Single Payer Plan,” January 27, 2016, <https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal> (accessed January 28, 2019). Punctuation as in original.

that this amount would be on top of current federal payroll taxes. Professor Thorpe concludes that 71 percent of all working families would pay more for health care under Senator Sanders' proposal than they do under the current system.

Professor Thorpe is only one independent analyst and the only one thus far who has attempted a detailed tax analysis of the Sanders bill. Over the next several months, there will be more such analyses. If Congress were to enact something like the Sanders bill, it would mean heavy federal taxation. It would mean very large taxes for middle-class persons and even low-income persons. Taxes on the perennially unpopular "rich" will not do the trick in a program of this magnitude.

Fifth, I promise that the actual cost of the single-payer system will be much larger than advertised. When Senator Sanders initially introduced his proposal, he billed the cost at \$13.8 trillion over 10 years.

Since the Senator unveiled his bill, prominent and widely respected independent analysts, liberal and conservative, have disputed the Senator's initial cost projections. The Urban Institute, a prominent liberal think tank here in Washington, estimates the 10-year cost of the Sanders proposal at \$32 trillion.⁵ Dr. Charles Blahous, a former Medicare Trustee and a prominent conservative, writing for the Mercatus Center at George Mason University, estimates the cost at \$32.6 trillion.⁶ The Center for Health and the Economy estimates the 10-year cost at \$44 trillion.⁷ Beyond massive increases in federal spending, each of these estimates projects large, additional federal deficits. I note that the single-payer proposals in California, Vermont, and Colorado have all faced similar fiscal problems.

We are now entering the next phase of America's national health care debate. It is going to be a rough debate, consuming a lot of your time and energy. It makes no difference whether Members of Congress, whether Republicans or Democrats, want to have such a debate. It is unavoidable. Too much is broken;

too much is at stake. In the meantime, every citizen should be fully informed and understand the consequences of the choices we as a nation are going to make.

It is my pleasure now to turn this discussion over to Chris Pope.

—*Robert E. Moffit, PhD, is Senior Fellow in Domestic Policy Studies, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.*

The Real Trade-Offs

CHRISTOPHER POPE, PhD: Thank you, Bob, and thank you, everybody, for coming today. Senator Sanders' bill presents us with a simple thesis: If we eliminated all the cost-control devices that private health insurers currently use, then the savings would pay for an enormous expansion of benefits. That does not make any sense. Eliminating cost controls would not reduce expenses; it would cause them to soar.

Insurance companies currently check to see whether the hospital claims are reasonable and necessary, proper or improper, legitimate or fraudulent. They do the same for doctors. They establish networks to get discounts and better control costs. They have a set of preferred providers whose integrity they trust and who they are able to reward for delivering care in a cost-effective way. In addition, most health care plans have substantial cost sharing. This obviously is a standard disincentive to the excessive utilization of services; and even though it may or may not be well designed in specific circumstances, it certainly keeps cost down.

Senator Sanders' theory is that if we got rid of all these various cost-control devices, we would actually end up saving money because, supposedly, such devices are so costly to administer. Well, that is not really the way it is likely to play out. In fact, experiences we have had in the past few years make it clear that it doesn't play out that way in practice.

5. John Holahan, Matthew Buettgens, Lisa Clemans-Cope, Melissa M. Favreault, Linda J. Blumberg, and Siyabonga Ndwandwe, "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending," Urban Institute, May 2016, https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending/view/full_report (accessed January 28, 2019).

6. Charles Blahous, "The Costs of a National Single-Payer Healthcare System," *Mercatus Working Paper*, Mercatus Center at George Mason University, July 2018, https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf (accessed January 28, 2019).

7. Center for Health and the Economy, "Medicare for All: Leaving No One Behind," May 1, 2016, <https://healthandeconomy.org/medicare-for-all-leaving-no-one-behind/> (accessed January 28, 2019).

A Controlled Experiment

We actually already have a good direct, controlled experiment for what a single-payer system looks like alongside a system of private, competing health insurance companies. This is the contrast between the initial Medicare program that was set up in 1965 and the Medicare Advantage Program, which has been developed over recent decades. Medicare Advantage is an option for Medicare beneficiaries who choose to receive their Medicare benefit from competing private insurance companies.

Amy Finkelstein of MIT, along with several coauthors from Stanford University, conducted an apples-to-apples controlled comparison of what it cost to deliver Medicare benefits by competing health insurance companies and having the government pay for each service directly.⁸ In short, they found that the delivery of the Medicare benefit through private insurance was 25 percent cheaper than having the government through traditional Medicare purchase medical services directly. Moreover, that is the savings from establishing networks, reviewing medical claims, and controlling access to high-cost specialists. Out-of-pocket costs under the government-administered Medicare program and the existing privately insured Medicare options are currently fixed at the same level: 24 percent of total expenditures.

The Medicare Payment Advisory Commission (MedPAC) commissioned a study of what happens to the cost to taxpayers when you eliminate cost sharing entirely in the traditional Medicare program, which Medigap's Plan F does, and found that this elimination increases Medicare spending by an extra 27 percent.⁹ If you compounded the 25 percent cost from losing the savings generated by private insurers with the 17 percent cost from eliminating cost sharing, for the sections of the population who would be effected, it would yield a 39 percent increase in total health care costs borne by Americans. That is equivalent to \$10,000 per household.

Bear in mind, all this does is get rid of health insurance claims reviews, get rid of networks, and get rid of patients' out-of-pocket medical costs. This calculation does not include the cost of extending coverage to anyone who is currently uninsured. Nor does

it include the cost of adding additional health benefits, like dental care, which are currently not covered by the traditional Medicare program. Both of those types of costs would be in addition to the extra \$10,000 a year per household that would be required to end networks, claims reviews, and cost sharing.

Additional Taxes

So the question, then, is this: Is the average American household willing to pay an extra \$10,000 over and above what their employer is paying today for their health insurance just to get rid of claims reviews, networks, and out-of-pocket costs? \$10,000 a year per household. Most Americans, when they learn the details, are likely to find that pretty hard to stomach.

The prospect of these enormous additional taxes is why states like Vermont and New York have had second thoughts about this approach. The legislatures in those states have said to their governors, "You figure out how to pay for it." Vermont's governor came back with the news that the state would have to double its tax revenue for this to be feasible. That finding killed the whole project in the bluest of blue states—and Bernie Sanders is undoubtedly aware of it.

People often ask: How are other countries able to fund everybody's care with little in out-of-pocket costs without a crippling burden for taxpayers?

The first thing to note is that the United States government currently spends more than the British government on health care. The United States government spends 8.3 percent of GDP. The British, according to World Bank data, spend about 7 percent of GDP on health care, funding its National Health Service. Therefore, if government spending is the answer, we have more than enough government spending already to purchase and deliver essentially the same health care that the British have today without touching what the private sector is doing.

A second point is that the United States has many more hospitals. The United States' Medicare program has 4,700 participating hospitals. England has 200 hospitals. Obviously, the United States is a bigger country, but that is still four times more on a per capita basis. More hospitals means higher overhead

8. Vilsa Curto, Liran Einav, Amy Finkelstein, Jonathan Levin, and Jay Bhattacharya, "Healthcare Spending and Utilization in Public and Private Medicare," National Bureau of Economic Research *Working Paper* No. 23090, January 2017, <https://www.nber.org/papers/w23090.pdf> (accessed January 28, 2019).

9. Direct Research, LLC, *Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly*, August 2014, http://medpac.gov/docs/default-source/contractor-reports/august2014_secondaryinsurance_contractor.pdf?sfvrsn=0#page=12 (accessed January 30, 2019).

costs, more costly medical equipment, and likely lower occupancy rates. If those costs are spread over fewer patients, then the costs per procedure will be higher. The United States may need more hospitals because it is a less densely populated country, but if you want to address the cost of American health care, you have to address the costs of hospitals.

Differences in Quality

Third, the quality of care really does differ from country to country. However, most people have not undergone the same major procedure in multiple countries, so they are not able to compare the patient experience of having a heart replacement in England and then having the same operation in the United States and comparing the quality of both. No one has that experience. If you look at the statistics, however, mortality is 39 percent lower after a stroke in the United States than it is in England and 72 percent lower after a heart attack in the United States than in England. The quality of care is significantly higher in the United States.

Fourth, American health care faces a tougher task in many respects because the disease burden is much greater in the United States. The United States has twice the obesity level than the European Union. That means it has much higher levels of the most expensive diseases, like diabetes, heart disease, strokes, and many types of cancer, and so America's health care system must do much more work.

Fifth, there is also the fact that high-skilled labor is also much more expensive in the United States than it is in European countries. This, in a sense, is the offshoot of a good thing: It is much easier to start a business in the United States than it is in European countries. Therefore, the health care system has to pay more to attract high-skilled people into the medical profession.

Sixth and finally, there is the issue of waiting lists. Substantial waiting lists for access to specialist physicians and surgeries are common in single-payer systems. Waiting lists actually do save money. When some people are waiting for care, some people get better. If you wait six months for treatment, some medical conditions resolve themselves.

Waiting lists also save money because patients often give up trying to get care. The process you actually have to go through in many other countries to get treatment, to get a knee replacement or a hip replacement, can be quite formidable. Patients are not going

to die from such conditions, and they just bear with the pain. That is certainly not an uncommon thing in many single-payer systems.

However, for many conditions, people actually do die while they are waiting for care—which will also “save” money. In that case, you are one less person taking up space in the hospital. You are one less person who is not going to be using expensive drugs. You are one less person who is going to be requiring skilled medical labor. There are real savings in that, but that is *not* a good thing.

A key issue is our attitude toward health care spending. Health care is a good thing, and it is good that we are able to purchase a lot of it. We have a lot of sick people, and treating more of them means spending more. If we provide higher-quality treatment, then we will also spend more. However, there is also the question of value: We are clearly doing many things in a very inefficient way, and our hospital industry is clearly bloated and inefficient.

Misleading Comparisons

People like to compare different countries' health care systems, but countries' health systems and populations vary in so many different ways that it is easy to produce misleading comparisons. A much clearer way to understand the issue is just to look at directly comparable situations within our country: traditional Medicare run by the government versus Medicare Advantage, a system of competing private health plans driven by patient choice. Here we have the same kind of patients, who have the same choice, covering the same conditions in the same locations throughout the United States. Both programs, at a minimum, deliver the same benefits, and the same people are entitled to the same things. The result: We have savings in Medicare Advantage, the quality of care for the same people is much better, and medical outcomes are also better.

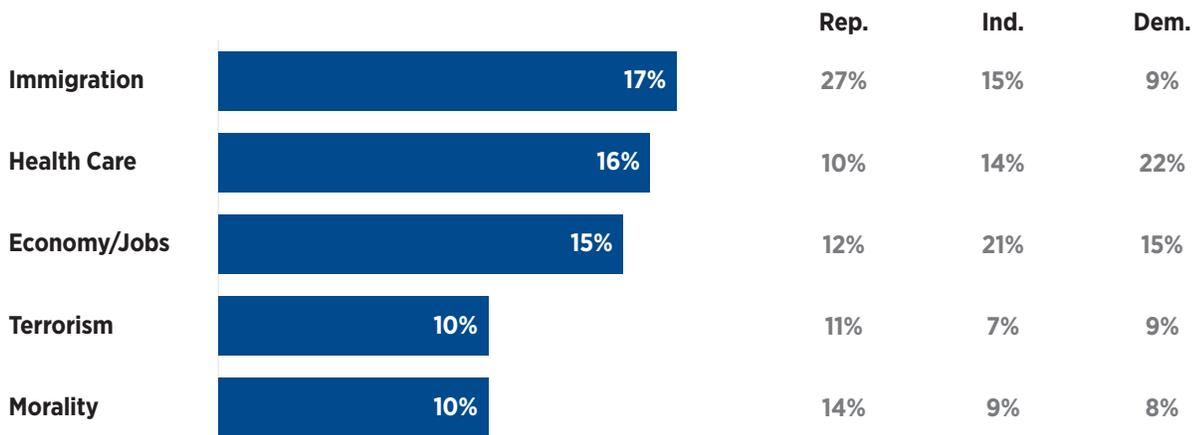
We have this direct comparison of privately competing insurance companies to the government micromanaging payments and benefits. At the end of the day, when the government micromanages everything, you have people show up here on Capitol Hill and say to you, “I want you to cover my expensive procedure” or “I want you to increase the payment for my billing code” or “I want you to prevent my facility from closing down with subsidies in this way.”

When the federal government starts micromanaging these things on a much larger scale than Medicare, you will not have costs going down over time;

CHART 1

Health Care Remains One of Top Issues Facing Country

Q: In your opinion, what is the most important problem facing the U.S. today?



SOURCE: Ipsos/Reuters poll, July 13–17, 2018.

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you will have costs going up and up and up over time. The medical professionals and the administrators of hospitals and medical institutions do not want to be put out of business, and so they will come to Washington to demand higher payment and higher spending. Politicians will become responsible for the solvency of every hospital and medical practice, and so they will have no choice but to provide whatever money is needed to keep them in business.

Those are a few of the reasons why the single-payer approach is so problematic and a good reason to go exactly in the opposite direction: the path of choice and competition.

A Malleable Public Opinion

WHIT AYRES, PhD: Good afternoon, and thank you for taking time out of your day to talk about one of the more challenging and complex policy issues facing America. During the 21st century, health care is going to be a major challenge, especially as the baby boomers retire and age. Our health care costs are inevitably going to increase substantially no matter how many days a week we work out. My goal is to give you a brief overview of American public opinion—and it *will* be brief—to allow plenty of time for questions.

A Persistent Priority

First, it is clear that as an issue, health care is not going away. It ranks as one the most important issues

facing America today. Because Donald Trump has focused so heavily on the problem of illegal immigrants, Republicans think illegal immigration is the top issue. Relatively, they split it equally between health care, followed by the economy, terrorism, and morality. Independents pick the economy first, and then there is a tie for second place between immigration and health care. Democrats say health care by far is the most important issue facing the country, followed by the economy.

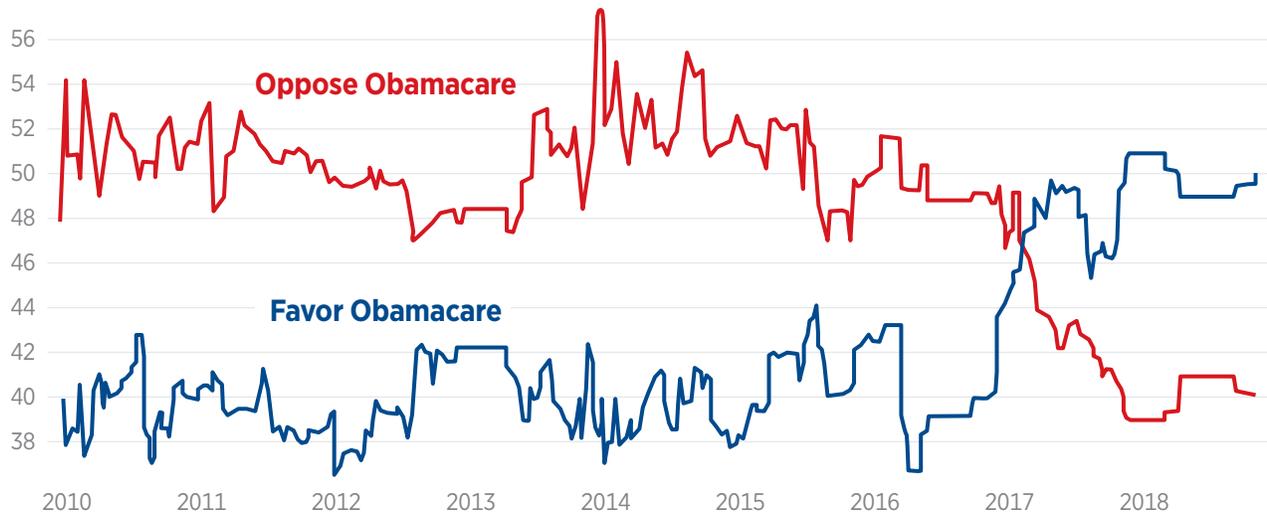
Therefore, it is safe to say this is one of the top issues facing the country. It is not going away, regardless of what happens in the midterms.

There is an interesting phenomenon with public opinion and the Affordable Care Act. We—I mean we on the Republican side—cleaned up in 2010 because the numbers in opposition to the Affordable Care Act were substantially greater than the numbers in support for the Affordable Care Act. Opposition to the Affordable Care Act continued right up until the end of 2016.

What happened at the end of 2016? Well, there was a prospect of repealing the Affordable Care Act. In addition, look what happened to public opinion: Boom! All of a sudden, the majority of Americans think the Affordable Care Act is not such a bad idea after all. Moreover, it has maintained that popular support as the Republicans have talked more and more about alternatives and repealing various provisions of the Affordable Care Act.

CHART 2

Obamacare Support Surged with Prospect of Repeal



SOURCE: Real Clear Politics, “Public Approval of Health Care Law,” https://www.realclearpolitics.com/polls/other/obama_and_democrats_health_care_plan-1130.html (accessed December 17, 2018).

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Now we start asking questions about something like a Sanders plan. Do you favor or oppose a national health plan? Do you favor or oppose what some call single-payer, or the “Medicare for All” plan, where all Americans get their insurance from a single government plan? Look at this poll taken last year.

Initial Polling

The numbers are very similar in other polls taken more recently. I am using this one because I followed it up with a number of other questions I want to share with you. However, 55 percent favor, and 40 percent oppose. *The Washington Post* teamed up with the Kaiser Family Foundation and conducted another poll this year that showed 51 percent favor. This number, expressing approval, has languished in the 40s for many years. Therefore, this is something new. You now have the majority of Americans, somewhere in the low 50s or low to mid 50s, supporting a single-payer health plan.

Think about it. Let us remember that 40 percent oppose, and 55 percent favor. Let us say we ask people who favor the single-payer proposal at 55 percent, “What if you heard that opponents say the guaranteed universal health care plan would give the government too much control over health care?” Bingo! Only 33 percent favor; the 55 percent in favor goes down to

33 percent. In addition, the 40 percent opposed goes up to 62 percent. All you have to do is tell people one thing—this proposal is going to turn health care over to the government—and you end up with a two-to-one opposition to a single-payer health plan.

What if they hear that will require many Americans to pay much more in taxes? You just heard about *how* much more in taxes. You have almost a two-to-one opposition to the proposal if the respondents hear just that one thing. Therefore, you go from 40 percent opposition to 60 percent opposition when the American people find out they might have to pay more taxes.

How does the public feel about eliminating or replacing the Affordable Care Act? Well, you have a majority opposing this single-payer health plan. That is a lot of change in public opinion when just a couple of points are made that will inevitably be made in the course of the national debate.

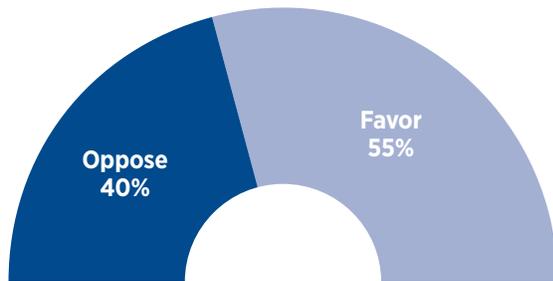
Let us look at this the other way, though. Let us ask that 40 percent who *oppose* the plan: “What if you heard supporters say with guaranteed universal coverage, under such a plan, we’d reduce health insurance administrative costs?” Wow! The 55 percent in favor goes up to 72 percent in favor, and the 40 percent of folks who oppose goes down to 23 percent.

Let’s ask this question: “How would you feel about the plan if you knew that it would ensure that all

CHART 3

Polls Show Majority Support Single-Payer Health Plan

Q: Do you favor or oppose having a national health care plan, or single-payer/Medicare-for-all plan, in which all Americans would get their insurance from a single government plan?



SOURCE: Kaiser Family Foundation Health Tracking Poll, June 14-19, 2017.

HL1305 heritage.org

Americans have health insurance as a basic right?” Then the favorable to unfavorable numbers are 71 to 24 percent. Further, “How would you feel if the proposal would reduce the role of all private health insurance companies in health care?” You end up with a two-to-one margin favoring the single-payer plan.

Unstable Numbers

What do these two slides tell you? These two slides tell you that whether it is 51 or 55 percent who say they favor a single-payer plan, that number is very malleable. It is very unstable. It is open to substantial movement depending on how the debate unfolds and which side is able to make the key points that can win that debate.

The key message I want you to take away from this short briefing is that the numbers that you are going to see in numerous polls are not in any way cut in stone. They are just a starting point for talking about health care, and they will move all over the place depending on which side is more persuasive in getting its points across. Just to drive that point home, it is interesting to see the numbers go positive or negative in reaction to each of the following terms.

CHART 4

Arguments Against Single-Payer Health Plan Increase Opposition

Q: What if you heard guaranteed universal coverage through a single-payer plan would ...

... give the government too much control over health care.



... require many Americans to pay more in taxes.



... eliminate or replace the Affordable Care Act.



SOURCE: Kaiser Family Foundation Health Tracking Poll, June 14-19, 2017.

HL1305 heritage.org

- “Medicare for All.” Wow! That is a two-to-one positive reaction, as is “Universal Health Coverage.” Who could be opposed to that, letting everyone have health coverage?
- “National Health Plan.” That is a 57 percent positive to 34 percent negative.
- “Single-Payer Health Care.” That starts to get under 50 percent positive.
- And “Socialized Medicine” is all of a sudden an even-up positive or negative.

Is it any wonder that Democrats have been talking recently about “Medicare for All” while Republicans like to talk about “Socialized Medicine”? This is not an accident. It is perfectly logical and perfectly consistent with this chart.

CHART 5

Arguments in Favor of Single-Payer Health Plan Decrease Opposition

Q: What if you heard guaranteed universal coverage through a single-payer plan would...

... reduce health insurance administrative costs.



... ensure that all Americans have health insurance as a basic right.



... reduce the role of all private health insurance companies in health care.



SOURCE: Kaiser Family Foundation Health Tracking Poll, June 14-19, 2017.

HL1305 heritage.org

This yet again shows that public opinion is malleable and dependent upon which phrases you use to describe the proposal you are talking about.

So let me conclude. Health care will remain an important issue regardless of who wins the midterm elections. It is not going away. It is not going away as a political issue, especially for you folks who work up here on Capitol Hill. The attempted dismantling of Obamacare, coupled with the absence of a viable Republican alternative replacing it, will increase pressure for a new government initiative of some sort.

Senator Lamar Alexander, the Tennessee Republican, desperately tried to build some sort of bridge with Senator Patty Murray, the Washington State Democrat, enabling the country to pass from what we have now to something better in the future. It was a good-faith effort; it was a bipartisan effort. For some reason, Senator Murray blew it up. Nonetheless, something

CHART 6

Support for Single-Payer Plan Varies Dramatically Depending on How It Is Phrased

Q: Do you have a positive or negative reaction to the following terms?

Medicare-for-all



Universal health coverage



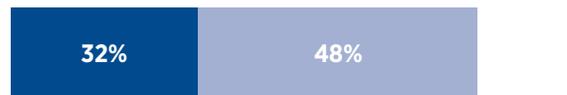
National health plan



Single-payer health insurance



Socialized medicine



SOURCE: Kaiser Family Foundation Health Tracking Poll, November 8-13, 2017.

HL1305 heritage.org

like that will at least help us to bridge from the current problems to better solutions. Trust me. There will be pressure on those of you who work on Capitol Hill to produce something as Obamacare continues to decline without any other alternative in place.

Finally, if conservatives in Congress leave the field without concrete health policy alternatives, forfeiting that game only hands victory to those who are campaigning for a single-payer plan. I am convinced of that. If folks on my side of the aisle just throw up their

hands and say, “We’re not into health care. We do not know anything about it,” the pressure will build for some form of a single-payer plan not unlike the proposals we’ve been talking about here today.

Questions & Answers

DR. MOFFIT: Thank you. Ladies and gentlemen, please ask questions of any one of us.

QUESTION: Looking at the Affordable Care Act, it appears that it was designed to create increased frustration. Doesn’t that contribute to the sense of desperation on the part of the American people that they needed to cheat us so badly that we need the government to figure this all out? Did you look at that or have any thoughts?

DR. AYRES: We have not asked any question exactly that way. There is no question that the increasing frustration with the health care system increases the demand for something different. I do not know if it is a single-payer plan, but for something different. Keep in mind, most Americans, even those covered by employers, are very satisfied with their health care coverage. However, if you ask people systematically, “Do you think the American health care system is working well? Are you satisfied with the overall health care system?” they are not as satisfied.

QUESTION: One of the ironies of single-payer or government-dominated health care systems overseas that I’ve observed, whether it’s the U.K. or other systems, is how quick people are to sign up and pay for private insurance on top of the taxes that they’re already paying. As soon as people have the means, they tend to sign up for the private insurance that the single-payer was supposed to replace. There is some work to be done to highlight that point.

DR. POPE: I think that is a very good point. What does it mean to have health insurance? In countries like Britain, obviously, only 20 percent actually have health insurance that delivers a quality of care that is comparable to the United States. You can go privately and see a specialist and have a surgery done in a timely manner. Therefore, insurance is not a generic product; insurance is coverage of a spectrum. The question is: How much are you covered and at what cost?

I frequently encounter the question: Is health care a right? Well, in a sense, it does not really matter whether it is or not. The question is: *Who* pays for it, and how much will they pay? If it is a right, then you still have to pay for it. If it is a right and you pay nothing, someone else is paying for it. Whether or not

it is a right, the answer to that question does not practically resolve anything important. These necessary trade-offs are the essence of the single-payer issue.

QUESTION: Chris, a question for you. You said that Medicare Advantage today saves 25 percent over Medicare. Does that include the costs of the government or the costs of the individual? That is part one. Part two: When you make the comparison, does it encompass the Medicare supplement or Medicaid?

DR. POPE: That comparison is really just the cost of the Medicare package: the physician services and the hospital benefits. Many Medicare Advantage plans have dental and drug coverage, vision coverage; the traditional Medicare benefit package does not. The traditional Medicare benefits package actually does not have an out-of-pocket cap. Therefore, you will have to buy a Medicare supplemental plan on the side. Medicare Advantage has a requirement to protect enrollees from catastrophic costs.

QUESTION: So, then, for the senior citizen the savings are greater because they would have to buy the Medicare supplemental plan on top of the traditional Medicare plan? The Medicare Advantage plan often has no additional premiums, includes all A and B benefits and often drug coverage plus an out-of-pocket cap.

DR. POPE: Yes, the savings could be substantial.

QUESTION: I think I heard one of you jump in and mention that, given the absence of a Republican replacement for Obamacare, you believe that there will be a continued outcry for single-payer. What about what is happening right now with the alternatives that have been offered like association health plans and short-term plans? They exist; they are options for people.

I tend to agree with you: Without a legislation at the federal level, there will continue to be pressure for single-payer. I think part of it, however, is that people do not know these options exist. So are we going to have to pass something on the Republican side? Alternatively, can we do better just by messaging that there are options?

DR. MOFFIT: I think you have no choice. The American people need legislation that is competently crafted and consequential, meaning a bill that will lower their health insurance costs and increase affordable health plan choices for millions of Americans. We cannot think small on such a big subject.

The Secretary of HHS and the Secretary of Labor are to be commended; they have given people,

primarily middle-class people, options to get affordable health insurance with the association health plans and the short-term plans. They are what they are: stopgap measures. They do not and cannot change the fundamental structure of the health insurance markets nor remove the provisions of the Affordable Care Act that are damaging these markets, killing choice and competition, and contributing to the dramatic cost increases in the individual and small-group markets.

You can only go so far using administrative authority under current law to create these kinds of patchwork options. What can be done by administration can be undone by administration. Ultimately, Congress is going to have to deal with the problems directly and reform the health insurance markets. That is why I mentioned the Health Care Choices Proposal, which is at this point the most comprehensive way to stabilize the health insurance markets and give people options that they need.

We have to reduce the high premium costs for middle-income Americans right now. They are actually paying the equivalent of a second mortgage in the premiums they are forking over for health insurance.

DR. POPE: I actually think that the Trump Administration's initiatives would be significant. The reason: It really does make available health plans that are more like the plans that individuals had before the enactment of the Affordable Care Act. If you think about the most unpopular thing about the ACA, it was the broken promise that if you liked your health care plan, you could keep it. These affordable plans would be only a third or half the price of plans on the ACA's health insurance exchanges.

The short-term plans are really going to make affordable coverage a viable alternative. With regard to the new regulations, you would have to sign up for them, and you would have a renewal for up to three years. That is substantial coverage. Then, after three years, you can sign up afresh with the guarantee that you can have coverage for another three years. That can go a long way to restoring the kind of full life coverage for people in the individual market. The short-term plans can help people between jobs who would otherwise be covered in the employer market. The individual market has always mostly been a matter of filling in the gaps.

DR. MOFFIT: Let me also comment on that. When the Trump Administration unveiled this option, it did not present it as a long-term solution to the problems in the individual market. They offered these plans as a stopgap measure, primarily to help people who found the health plans in the ACA exchanges so expensive that they could not afford them. These short-term plans were also offered for people between jobs who lost their job-based coverage or people who felt the Affordable Care Act plans did not meet their specific health care needs. They are what they are.

Remember, too, another key legal point: Congress authorized the short-term health plans under the Health Insurance Portability and Accountability Act of 1996. Under that law, Congress gave the states the authority to regulate these plans, and thus, the states will have an awful lot of say about whether or not these plans prosper. I can assure you that many states, particularly liberal or "blue" states, will hinder or close off these coverage options.

In principle, progressive or liberal legislators are often opposed to these plans, and they can be expected to block an individual's access to them because they do not have the full range of benefits or regulatory restrictions required of ACA-compliant plans. This may not be what individuals may want; it is what state *legislators* want that counts. They describe the Trump Administration's efforts to expand personal options as a form of "sabotage" rather than a rescue plan for workers between jobs or middle-class Americans who find their current health insurance too expensive.

QUESTION: Just a follow-up on alternative plans. As you know, plans like Liberty Healthcare and other Christian organizations offer options where premiums or payments are sometimes half those of regular health insurance plans that are "qualified" under Obamacare. Have there been any studies of the financial stability of those organizations?

DR. MOFFIT: I am not aware of any. Thus far, however, they seem to be doing all right.

This this will conclude our session. Do not hesitate to contact any one of us if you have further questions. You can reach us at The Heritage Foundation: that is, *heritage.org*. Again, ladies and gentlemen, thank you very much.