

Total Control: The House Democrats' Single-Payer Health Care Prescription

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KEY TAKEAWAYS

Single-payer health care would establish government control over health care, requiring Americans to surrender key health care decisions to the federal government.

H.R. 1384 would outlaw virtually all private and employer-sponsored health insurance, as well as Medicare, Medicaid, and most other federal health programs.

H.R. 1384 would also impose major restrictions on patients' rights to secure health care outside the government program.

Representative Pramila Jayapal (D-WA) and 112 other House Members are sponsoring the Medicare for All Act of 2019 (H.R. 1384). The bill thus enjoys the support of almost half the entire Democratic membership of the U.S. House of Representatives, while similar Senate legislation is being co-sponsored by leading candidates for the Democratic presidential nomination.¹

The House bill, like its Senate companion—the Medicare for All Act of 2019 (S. 1129)—would confer enormous power on Washington officials, creating an authoritarian system of detailed federal control over virtually every aspect of American health care financing and delivery.² As Dr. Niran S. Al-Agba, an assistant professor at the University of Washington Medical School, and a practicing physician, explains, “Recent polls show a majority of Americans support ‘Medicare for All,’ but few seem to realize that no

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other system in the world operates like the current single payer proposals in Congress.”³

The legislation would create a national health insurance program, while outlawing almost all private and employer-sponsored health insurance. It would abolish virtually all of the federal government’s existing health programs, including Medicare, Medicaid, and the Federal Employees Health Benefit Program (FEHBP). It would also impose severe restrictions on the ability of doctors and patients to engage in private agreements outside the system.

According to a complete set of 2017 data, approximately 9 percent of the Americans are uninsured.⁴ To achieve “universal coverage,” the congressional sponsors of the legislation nonetheless insist on outlawing the existing coverage of almost every other American. Only the relatively small number of enrollees in the U.S. Department of Veterans Affairs’ (VA’s) health benefits and the Indian Health Service would be allowed to keep their current coverage.

The Secretary of the U.S. Department of Health and Human Services (HHS) would be the central decision maker in the system. The Secretary would exercise enormous control over the financing and delivery of health care benefits and medical services and the availability and pricing of prescription drugs, as well as the conditions of participation and practice of doctors, nurses, and other medical professionals.

Major Consequences of “Medicare for All”

If the House bill were to become law, Americans could expect major changes to their health coverage, including:

Elimination of Existing Private and Employer-Sponsored Insurance and Coverage Plans. Under Section 107 of Title I of the House bill, it would be “unlawful” for any private health plan to offer any coverage that “duplicates” the coverage of the government health insurance program. With regard to employer-sponsored insurance, Section 801 of Title VIII, declares that “no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Act of 2019.” That provision would outlaw the existing job-based health coverage of approximately 160 million Americans, regardless of whether they liked their health plans or not.⁵

Involuntary Enrollment of Medicare Beneficiaries and Other Health Program Recipients. Under Title IX of the House bill, two years after the date of enactment, all coverage ends for Medicare, Medicaid, the State Children’s Health Insurance Program (CHIP), the Tricare program

for military dependents, the FEHBP, and the health insurance plans created under the Affordable Care Act (ACA) of 2010. As noted, only the VA and Indian Health Service programs (with a combined enrollment of just 9.9 million) would remain.

New Restrictions on Independent Doctor–Patient Agreements. The House bill would restrict the rights of doctors and patients to contract privately for medical services outside the national health insurance program. For physicians who “participate” in the program, there would be a financial penalty for entering into a private contract with a patient: The doctor would have to refrain from treating any other patient enrolled in the program for one full year. A tiny number of physicians might be able to sustain a private, independent medical practice; the vast majority of doctors could not. As Dr. Adam Gaffney, president of Physicians for a National Health Insurance Program, admits: “Whether there’s someone out in Beverly Hills who sees the stars and doesn’t partake—that would be possible. The way the whole program is structured is really to make it such that that’s a very insignificant overall phenomenon.”⁶ Escaping the system would be the prerogative only of well-situated elites.

Compulsory Taxpayer Funding of Abortion. According to Section 201 of Title II, the bill provides coverage for “comprehensive, reproductive, maternity and newborn care.” As *Politico* reports, “Though the word ‘abortion’ does not appear anywhere in the text, its authors have confirmed that it’s covered.”⁷ The House bill also creates a Universal Medicare Trust Fund for the disbursement of all program funds, including provider reimbursements. Under Section 701 of Title VII, “Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health services shall not apply to monies in the Trust Fund.”⁸ In other words, the House bill would effectively nullify the Hyde Amendment and all other legislative restrictions on the use of federal funds for abortion.

Aside from reversing decades of federal policy restricting the use of taxpayer money for abortion, Section 103 of Title I specifies that no person can be “denied the benefits” of the program, and section 301 of Title III mandates that services are to be “furnished by the provider without discrimination.” In short, the bill would apparently override the ethical objections of medical professionals who do not want to participate in abortion.⁹

Mysterious Financing and the Imposition of Large and Unknown Costs. Neither the Congressional Budget Office (CBO) nor the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) have released any cost analysis or budget estimates of either the House or Senate “Medicare for All” bills.

The House bill has no financing provisions, a notable departure from the earlier version of the House bill, H.R. 676.¹⁰ Senator Bernie Sanders' (I-VT) bill also has no financing provisions. Like Senator Sanders, Representative Jayapal, however, has said that she would release a separate list of "potential taxes" to finance the program.¹¹ The congresswoman has not yet released such a list.

Focusing on Senator Sanders' broadly similar Senate plan, analysts from the Urban Institute and the Mercatus Center have previously estimated that the 10-year additional cost to federal taxpayers would be approximately \$32 trillion. In recent congressional testimony, Charles Blahous of the Mercatus Center and a former trustee of the Medicare program, noted that, based on his previous analysis of the Senate bill, the additional federal costs of Medicare for All could be as much as \$38.8 trillion; and the total costs of health care—including the costs currently incurred by Medicare and Medicaid and other government and private health programs—could range between \$54.6 trillion and \$60.7 trillion over the first 10 years.¹² The addition of long-term care coverage to the House bill—a cost not included in Blahous's initial estimates—would mean that total costs of the most recent versions of the House and Senate bills would be higher.¹³ As Blahous further noted: "We have no experience with enacting federal cost assumptions of this magnitude, which renders these numbers especially difficult for many to conceptualize."¹⁴

Thus far, the true cost of the legislation remains an elusive target of sophisticated guesswork. As noted, the CBO has not yet released a cost or tax estimate of the House bill, or of its Senate counterpart. Based on a variety of previous estimates of the Senate bill, however, aggregate federal spending would surely double, at the very least, along with the enormous taxes to sustain the program. Contrary to the claims of its champions, it is also unlikely that Medicare for All would yield significant overall savings.¹⁵

Displaced Workers and Families. Because the House bill would eliminate virtually all existing private health insurance, Representative Jayapal, the chief sponsor of the House bill, has conceded that the enactment of the legislation would cause an estimated 1 million health insurance workers nationwide to lose their jobs. To compensate, the bill would provide funding for a new program for displaced insurance industry workers and their families. Displaced workers would be able to receive financial assistance for up to five years following the date of the enactment of the act. The special assistance for the newly unemployed health insurance workers would compensate them for lost wages and retirement, as well as provide for job training and education benefits.¹⁶

However, the economic impact of the abolition of all private health insurance, as well as the anticipated government payment reductions to doctors, hospitals, and medical professionals, could be severe.¹⁷ Moreover, the legislation would not only affect insurance company employees negatively, but also those engaged in ancillary services.

The Creation of a National Health Insurance Program

The House bill would create a “national health insurance program to provide comprehensive protection against the costs of health care and health related services, in accordance with the standards specified in, or established under, this Act.”¹⁸ All people living in the U.S.—regardless of their legal status—would be eligible for the program.¹⁹ According to the CBO, based on 2018 data, this would include an estimated 11 million people.²⁰ To deter migration for additional enrollment, the bill provides: “In regulating such eligibility, the Secretary shall ensure that individuals are not allowed to travel to the United States for the sole purpose of obtaining health care items and services provided under the program established under this Act.”²¹

The Secretary “shall” also provide a “mechanism” for enrollment, including automatic enrollment at the time of birth and upon the establishment of residency in the United States. In all cases, the beneficiaries are to be issued a “Universal Medicare card.”²²

Universal Enrollment. Under Title I, Section 101, of the House bill, the HHS Secretary would be required to issue regulations for determining U.S. residency, and thus eligibility, for the program. The purpose of the bill is to ensure that “every person in the United States has access to health care.”²³

Under Section 103, the bill would establish “freedom of choice,” meaning that an “eligible” person would be able to secure benefits and services from any “institution, agency or individual ‘qualified’ to participate under this Act.”²⁴

Under Section 104, the bill would forbid discrimination or the denial of medical benefits, items, or services to any resident of the United States. “Discrimination” would not only encompass discrimination based on race, sex, religion, or national origin, but also, “sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including the termination of pregnancy).”²⁵

The House bill further provides that any person claiming to be a victim of discrimination would have a right to present a grievance through administrative channels, under procedures to be established by the Secretary, as well as a right of action in federal courts. The text makes clear that nothing

in the new language of the bill concerning discrimination is to be construed in such a way as to invalidate the existing rights of persons who claim grievances under Section 1557 of the ACA, the Civil Rights Act of 1964, or any state laws that provide additional protections to persons claiming to be victims of discrimination.²⁶

The Elimination of Existing Health Insurance

In creating a national health insurance program, the House bill would effectively eliminate almost all existing health insurance coverage, whether delivered by third-party payers in the public or the private sector. Such legislation would thus impact approximately 246.5 million Americans under the age of 65 with health insurance, as well as nearly 59 million Medicare beneficiaries.²⁷

According to Section 107 of Title I, it “shall be unlawful for (1) a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act; or (2) an employer to provide benefits for an employee, former employee, or the dependent of an employee of former employees that duplicate the benefits provided under this Act.”²⁸

Under Section 801, the bill prohibits employers from offering health insurance that provides benefits or services included in the government plan: “[N]o employee benefit plan may provide benefits that duplicate payment for any item or service for which payment may be made under the Medicare for All Act of 2019.”²⁹

Under Section 901, two years after the enactment of the legislation, the bill would abolish almost all major health care programs: Medicare, Medicaid, CHIP, Tricare, and the FEHBP. Under Section 701, on January 1 of the first year after the bill’s enactment, the annual aggregate funding for these major government health programs would be transferred to a new federal trust fund: the Universal Medicare Trust Fund.

Under Section 902, two years after the legislation’s enactment, all coverage for persons enrolled in any health plan being offered through the ACA’s health insurance exchanges would also be terminated.

The Universal Medicare Trust Fund would also absorb projected funding for the maternal and child health care program created under Title V of the Social Security Act, and the vocational, and rehabilitation and mental health services programs established under the Public Health Service Act. The new trust fund would also get funding transfers from “any other program” identified by the HHS Secretary in consultation with the Secretary of the Treasury.³⁰

These provisions are not only a radical and unprecedented restriction on the right of Americans to purchase their own health care coverage—they are also a dramatic departure from the practice of most other nations with “universal coverage.”³¹ As CBO analysts observe: “Some people might prefer to enroll in a substitutive insurance plan that suited their needs better than the public plan. Substitutive insurance might also improve the quality of care for people in both private and public plans.”³²

The Federal Standardization of Health Benefits and Services

The House bill would provide 14 categories of health care benefits and medical services, including long-term care services and supports (LTSS). Though this is a comprehensive health benefits package, the Secretary is to review and evaluate these benefits and services at least annually, and make recommendations to Congress on proposed changes to the federal government’s benefit offerings. The Secretary is to provide for medical services that are “medically necessary” and appropriate,³³ and conduct reviews and evaluations in light of emerging information related to changes in medical practice or advances in medical science and technology.

Congress, of course, would ultimately determine which medical benefits and services all Americans would receive in the government health program. The bill specifies that the House Energy and Commerce Committee and the House Ways and Means Committee would be required to receive the Secretary’s benefit recommendations and hold annual hearings on these recommendations. For both major congressional committees, these procedural requirements would be enacted as a rule of the House of Representatives, and, in the event of a conflict with other rules, this health policy rule would supersede any other rule of the House of Representatives.³⁴

In preparing benefit recommendations, the Secretary is to consult with the Director of the National Center for Complementary and Integrative Health of the CMS, the Commissioner of the Food and Drug Administration, as well as “research institutions,” “nationally recognized” specialists in complementary and integrative medicine, and other experts. State officials could also mandate the addition of medical benefits and services for their residents, but only at the expense of their own state taxpayers.³⁵

Following the practice of current Medicare law, the Secretary is required to make “national coverage determinations” for new or “experimental” medical items and services, and establish an appeals process to adjudicate the HHS coverage decisions.³⁶

TEXT BOX 1

Benefit Categories Under the Medicare for All Act of 2019

H.R. 1384, Title II, Section 201, specifies the following categories that would be covered under federal law:

- Hospital services, including inpatient and outpatient care, emergency services, and inpatient prescription drugs;
- Ambulatory patient services;
- Primary and preventive care services, including chronic disease management;
- Prescription drugs and medical devices, including outpatient prescription drugs, medical devices, and biological products;
- Mental health and substance abuse treatment, including inpatient care;
- Laboratory and diagnostic services;
- Comprehensive reproductive, maternity, and newborn care;
- Pediatrics;
- Oral health, audiology, and vision services;
- Rehabilitation and habilitation services and devices;
- Emergency services and transportation;
- Early and periodic screening, diagnostic, and treatment services;
- Necessary transportation to hospitals or clinics for persons with disabilities and low-income individuals (as determined by the HHS Secretary); and
- Long-term care services and supports.

Likewise, the bill authorizes the Secretary to establish medical practice guidelines to govern the delivery of medical services. The language of the bill specifies, however, that in the event that a doctor or medical professional determines that it would be necessary to override these guidelines, the provider may do so, provided that the practitioner’s “best judgement” is in accord with state law, is “medically necessary” and appropriate, and accords with the “best interest” of the patient or the patient’s wishes. Based on these considerations, the actions of the doctor or medical professional would be deemed to be in accordance with the federal practice guidelines authorized under the government’s national health insurance program.³⁷

No Cost Sharing. The House bill would guarantee U.S. residents that their care would be “free” at the point of service. The legislation would thus prevent any doctor or other medical professional from levying any charge over and above the government payment for a medical benefit or service. The bill would also outlaw cost sharing in the government health insurance program. Under Section 202, the Secretary “shall ensure that no cost sharing, including deductibles, coinsurance, copayments or similar charges, is imposed on an individual for any benefits provided under this Act.” This

provision is not only a major departure from current federal health policy; it is also very different from the common practice of other nations with “universal” health care systems.³⁸

Aside from private health insurance, major federal health programs, such as traditional Medicare, Medicare Advantage, the Medicare Part D prescription drug program, and the FEHBP, deploy cost-sharing strategies to constrain excessive use and contain health care costs. While zeroing out up-front patient costs would secure “free” care at the point of service, it would also guarantee that the total cost of health care would be much higher at the back end, thus sharply increasing the financial burden on patients as federal taxpayers. As CBO analysts observe, “[E]xisting evidence indicates that people use more care when the cost is lower, so little or no cost sharing in a single payer system would tend to increase the use of services and lead to additional health spending, as well as more government spending.”³⁹

Long-term Care. The House bill would provide a comprehensive set of long-term care services and supports. The Secretary would be required to issue eligibility rules for U.S. residents who suffer from medical conditions related to aging, physical or mental disabilities (“cognitive or other impairments”) that result in “functional limitations” in performing the “activities of daily living,” or need assistance in performing “instrumental activities of daily living.”⁴⁰

In administering the new federal long-term care benefit, the Secretary is authorized to establish standards for nine categories of care. This care, however, is to be “tailored to an individual’s needs.”⁴¹ The statutory language is quite specific with respect to the standards of care. The Secretary must promulgate standards that meet the patients’ “physical, mental and social needs,” provide the “maximum possible autonomy,” and secure the “maximum possible civic, social and economic participation.”⁴²

In developing long-term care regulations, the Secretary is to consult with a special advisory commission comprised of a specified set of “stakeholders,” including people with disabilities, disability organizations, groups that represent the “gender, racial and economic” diversity of the nation’s disabled population, as well as representatives of the “provider community,” organized labor, policy experts, and “relevant” academic and research institutions.⁴³

Adding the long-term care services and supports to the government’s health insurance program, along with three other benefit categories, would require a significantly larger budgetary commitment than previous iterations of “Medicare for All” legislation.⁴⁴ The CBO reports that in 2016 alone, the total spending—mostly government spending—for long-term care amounted to \$366 billion.⁴⁵ As CBO analysts further observe:

Public spending would increase substantially relative to current spending if everyone received LTSS benefits. Under the current system, many people receive Medicaid benefits for such services, but use their own funds to pay for LTSS before they qualify for Medicaid; state Medicaid programs currently pay about half the cost of such services. Private insurance accounts for a small portion of LTSS spending. Under a single payer system, government payments could replace payments by individuals and private insurance.⁴⁶

CBO analysts also note that most of the financial support for persons needing assistance with activities of daily living comes from the financial contributions and the unpaid care from family, relatives, and friends of the patients. With the creation of a universal entitlement to long-term care, there would be a major cost shift from families providing “informal care,” as well as existing private and insurance payment, to the public sector. This is particularly true if the government health insurance program covers both home-based and community-based care.⁴⁷ The House bill includes both home-based and community-based care categories.⁴⁸

RAND Corporation analysts estimate that about half of the “informal” care of family and friends would shift to “formal” care, and they project that there would be a 200 percent increase in formal-home-care cost and a 10 percent increase in nursing-home cost.⁴⁹

New Regulations for Physicians and Other Medical Professionals

Physicians and other medical professionals often complain about the imposition of administrative and paperwork burdens—the hassle factor—that accompany complex third-party payment systems in both the public and the private sector. These burdens, particularly compliance and reporting requirements, are often demoralizing and among the chief causes of widely reported American physicians’ “burn-out” and the accelerated practitioner retirements contributing to the nation’s physician shortages.⁵⁰ Based on the worsening conditions in Britain’s National Health Service (NHS), the proposition that a single-payer system would somehow remove such burdens is unsupported by the empirical evidence.⁵¹

The House bill would, in fact, create a large and formidable regulatory regime. It would not only establish rigorous conditions of provider participation and reporting requirements, but also tightly control the character and scope of medical practice.

Provider Agreements. Today, state agencies and professional organizations have the primary responsibility for establishing licensing and

standards of practice for physicians and specialists, as well as for the licensing and scope of practice rules for other medical professionals, such as nurses, nurse practitioners, dental assistants, and a wide variety of other health care workers. Under the House bill, doctors, nurses, and other medical professionals would also be required to meet new standards of qualification for practice in the government health insurance system, and accept and abide by the terms and conditions of medical practice, including federal practice guidelines such as new federal restrictions on their ability to provide medical services even outside the national program. The statutory text clarifies that medical professionals must not only meet the existing terms and conditions required under the current Medicare law, but that they would also have to sign a special “participation agreement” and file it with the HHS Secretary.

Under that legal arrangement, physicians and other medical professionals would have to agree to a number of conditions. They would have to acknowledge their responsibility to provide the medical benefits, items, and services available under the government program; agree to the full range of “non-discrimination” requirements specified in the legislation; levy no charge for any covered item or service above the amount reimbursed by the federal government; and submit any “such information” that the HHS Secretary may require in his or her efforts to secure the quality of care, as established under the federal government’s standards. Physicians and other medical professionals must also agree to submit billing or payment records, or any statistical data being gathered by the federal government, for “such other purposes” as the Secretary may require in the course of administering the program.⁵²

The bill requires doctors, hospitals, and all other medical professionals receiving government payment to submit paperwork concerning reimbursement within 30 days of providing the covered items or services.⁵³ On a quarterly basis, these “providers” must also comply with reporting requirements concerning conflicts of interest, as required by regulation. Giving proper notice, the Secretary can terminate a “provider participation agreement” if the physician or another medical professional fails to comply with the statutory or regulatory requirements of the Act, or due to a violation of the Act’s fraud and abuse provisions.

The bill includes language designed to protect “whistleblowers.” Doctors and hospital officials would be protected from unlawful terminations, such as terminations related to their cooperation with federal or state law enforcement officials, testifying before legislative committees concerning violations of the provisions of the Act, or refusing to violate the Act

or refusing to participate in efforts to violate the provisions of the Act. Beyond doctors, hospital officials, or other medical professionals, these protections would also apply to their employees. All such persons would enjoy the “anti-retaliation” protections of the Federal False Claims Act or similar protections embodied in federal or state laws. Moreover, all such persons would also have a right of action in federal courts.

Federal Quality Standards. A “qualified” provider, according to the bill, is a doctor, nurse, specialist, or other medical professional who is qualified to deliver “items and services” provided under the act if the provider is licensed or certified in the state in which he or she practices, and fulfills the requirements of federal and state law in providing these items and services.

The House bill provides that the Secretary “shall establish and update ‘minimum’ standards for all providers”—doctors and other medical professionals, as well as hospitals and other “institutional” providers—to “ensure the quality of items and services” delivered under the government health insurance program. Within their jurisdiction, however, states can impose additional quality standards.⁵⁴

The basic quality standards for the government program would be the standards of quality already required in current Medicare law. This would include standards governing the adequacy of institutions to deliver care, staffing requirements, standards governing the training and competence of health care staff, the comprehensiveness and continuity of medical services, patient waiting times, and access to services, as well as medical outcomes.⁵⁵

The Center for Clinical Standards and Quality, an office of the CMS, would be required to develop quality measures and standards in “coordination” with the Agency for Healthcare Research and Quality, an HHS office. The Center would be the central agency to “review and evaluate” medical practice guidelines and performance measures for physicians and other medical professionals. The center staff would undertake methodological analyses and develop criteria that regional directors of the program could employ for their own internal regional reviews of quality performance. On an annual basis, the Center would also submit reports to the Secretary on medical outcomes and practice guidelines.⁵⁶

The Center for Clinical Standards and Quality would also be required to address the problem of health care disparities, and, in pursuit of this effort, collect relevant data on race, ethnicity, and gender, as well as geographic and socioeconomic data. The center would be required to prepare a report and make policy recommendations to address these disparities within 18 months of the enactment of the act. Thereafter, the center would be required to submit a report to Congress on these issues every four years.⁵⁷

Restrictions on Private Payment. The House bill would severely restrict Americans' ability to spend their own money to pay a doctor for medical services outside the government program. A personal right to contract with a doctor would depend on whether a doctor is participating or nonparticipating, whether the medical service is covered or non-covered, and whether the patient is eligible to receive reimbursed services under the government program.

According to Section 303 of Title III: "An institutional or individual provider with an agreement in effect under Section 301 may *not* bill or enter into any private contract with *any* individual eligible for benefits under the Act for *any* item or service that is a benefit under this Act."⁵⁸ (Emphasis added.)

For that small number of "non-covered" benefits and services, the House bill specifies that a "participating" doctor would be able to enter into a private contract with a patient "eligible" for government benefits.

But there are crucial limiting conditions: The doctor could not get *any* payment (either "directly or indirectly") from *any* organization that also gets government payment for the government's benefits and services. Moreover, *any* doctor contracting privately with a patient for "non-covered" services must sign an affidavit to that effect and file it with the Secretary of HHS within 10 days of the contract.⁵⁹

The House bill, however, would permit "non-participating" providers—that is, doctors and other practitioners who have *not* signed an agreement to participate in the program—to contract privately for "non-covered" services with any individual. If, however, a "non-participating" provider were to contract privately with patients enrolled in the government's "covered" medical services, the House bill prescribes detailed terms and conditions of the contract: The private contract must be in writing, signed by the parties, entered into outside an "emergency situation"; and the patient must acknowledge that the government program will not pay or cap the costs of these privately delivered services. The "non-participating" doctors must also file an affidavit that they entered into such a private contract with their patients and file it with the HHS Secretary within 10 days of the contractual agreement. Concerning this required affidavit, the text states that "the provider will not submit *any* claim for *any* covered item or service provided to *any* individual enrolled under this Act during the 2-year period beginning on the date the affidavit is signed."⁶⁰ (Emphases added.) In short, the bill contains a "lock-out" clause.

These proposed congressional restrictions—not only on the right to purchase private health insurance, but also to secure private medical care—are far more severe than those imposed by the British socialists who created the

British National Health Service in 1948. Today, not only are British citizens free to enroll in private health plans, they are also free to engage privately the services of British doctors, even though these doctors also practice in the NHS.⁶¹ Because of significantly longer NHS waiting times, according to the *British Medical Journal*, British patients are increasingly relying on private medical services.⁶²

Central Planning: How Washington Would Run the Program

The Secretary is required to develop policies, procedures, guidelines, and regulatory requirements to implement the national health law. The scope of the Secretary's administrative authority would be very broad. The Secretary's regulatory penetration into the details of care delivery would be very deep.⁶³

Scope of Control. The Secretary's broad range of authority would cover the program's eligibility and enrollment; adding or modifying health benefits and services; developing or implementing standards for provider participation and standards for the quality of care; preparing the national health care budget; developing and implementing new payment methodologies; establishing processes and procedures for addressing grievances and appeals; planning for capital expenditures and professional education funding; working in coordination with state officials concerning regional planning; and issuing "any other regulation necessary to carry out the purposes of the Act."⁶⁴

In carrying out this vast range of administrative responsibilities, the Secretary would be required to consult with a wide variety of entities and organizations, including federal officials in other agencies that have health policy responsibilities, Indian tribes, professional organizations, representatives of organized labor, and academic experts or specialists in health care policy.

National Database. As noted, the purpose of the bill is to ensure that "every person" residing in the United States has access to health care. The bill thus reads: "The Secretary shall have the obligation to ensure the timely and accessible provision of items and services that all eligible individuals are entitled to under this Act."⁶⁵

Such a task would require comprehensive data collection. Therefore, the Secretary would establish "uniform" reporting requirements for a national database. The database would contain information on the provision of medical items and services, information on the costs and quality of these services, and the "equity of health" among various population groups.⁶⁶ In

the process of gathering this large body of data, the Secretary would also be responsible for protecting the privacy of patients and collecting information without imposing an undue burden on medical professionals.

Within two years of the date of enactment, the Secretary must report to Congress on the implementation of the national health insurance program, including progress on enrollment; the provision of benefits; health costs, including per capita costs; and the financing of the program. The report must also address the issues of cost containment, quality assurance, health status of Americans, and any problem that the Secretary encountered in implementing the law, as well as recommendations for program improvement. The Comptroller General of the United States would also be required to conduct an audit of the program and submit a report to Congress every five years.⁶⁷

Regional Administrators. The House bill would create a pyramidal system of program management. The Secretary “shall” establish regional program offices to administer the program, incorporating wherever “feasible” the existing system of regional organization established under the current Medicare program and managed by the CMS. The Secretary would appoint the regional directors, and they, in turn, would appoint deputy regional directors to represent Native American tribes, as appropriate, in any given region of the country.

The regional directors would present the Secretary with an annual report on the health needs of the region, make recommendations for the regional reimbursement of doctors and other practitioners, and establish a quality assurance program to oversee care delivery for residents of the region. The regional directors would also monitor providers to “minimize both underutilization and overutilization” of medical items and services.⁶⁸

The Secretary would also appoint a Beneficiary Ombudsman to help enrollees who have complaints or grievances resolve them. The ombudsman would report to Congress annually and would identify for Congress any systemic problems with the program that should be resolved, including any problems with coverage of benefits or services or payment issues.

Establishing a Global Health Care Budget

Under the House bill, the HHS Secretary would establish a “national health budget” by September 1 of each year. This is commonly referred to as a “global budget,” which is an arrangement whereby medical institutions, such as hospitals or clinics, and medical professionals, such as doctors, nurses, and other medical professionals, get a fixed payment, usually on an annual basis.⁶⁹

Under the House bill, the budget would contain the Secretary's estimate of what level of federal spending would be necessary to administer the national health insurance program, including the program's operating expenses, capital expenditures, and funding for the program's "special projects." The budget would also outline the necessary expenditures for other categories, including quality assessment, professional education, administrative costs, prevention initiatives, and a "reserve fund," which would anticipate the need for public spending to cope with epidemics, pandemics, or other unforeseen national emergencies.⁷⁰

Regional Budget Allocations. The Secretary would allocate the budget for program administration in each of the program's regional offices. These regional budget allotments would be used to cover the regular operational expenses of the program, such as payment to doctors and hospitals. The regional budgets would also cover capital expenditures for the construction and renovation of hospitals and other medical facilities, and, of course, special projects, such as the funding needed to staff medically underserved areas with the appropriate kind and level of medical personnel.

Annual payment to "institutional providers"—such as hospitals, skilled nursing facilities, and medical clinics—would be in the form of lump-sum payments for providing the program's approved medical items and services. Regional directors, however, would be responsible for reviewing the performance of these providers and determining whether their payments should be adjusted, particularly in the case of unforeseen costs or the emergence of unforeseen or complex medical challenges. Group medical practices would be paid under the regional budget directly, or through the global budget allocated to "institutional" providers, such as hospitals or other medical institutions.

Negotiated Rates. The regional directors would "negotiate" payment amounts with providers annually. The providers' negotiated rates would factor in the historical volume of services, the actual spending from the most recent costs, the levels of comparative spending and payment rates of other providers, volume projections, and wage levels. Negotiated rates would also reflect the spending on education and prevention programs. Payments to institutional providers, such as hospitals, could not factor in capital expenditures or be used or diverted for capital expenditures.

Resurgent Fee-for-Service (FFS). For individual providers, such as physicians and medical specialists, who are not paid a salary, or are paid through a government negotiated group practice payment rate, the Secretary would be required to pay them on an FFS basis. Under the terms of the program, these payments would be payments in full; and no physician,

specialist or other “individual provider” would be able to charge any amount above the government’s FFS payment.

The House bill would require the Secretary to establish this new FFS system within one year of the enactment of the program. The system would be updated annually and would be operationalized with a system of electronic billing. In developing the new FFS system, the Secretary would be required to “take into account” the existing Medicare payment rates for medical items and services, the medical practitioners’ “expertise” in providing the services, and the “value” of these medical items and services.⁷¹

In determining the “value” of services for patients, the House bill imposes certain limitations. Payments could not be made to reflect any provider’s marketing expenses (such as advertising her medical services) or a provider’s profits or bonuses based on “patient utilization” of medical items and services. The bill also includes a clear prohibition: “The use of Quality Adjusted Life Years, Disability Adjusted Life years, or other similar mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments.”⁷²

Government officials would determine “value” for all provider payments in the program. Under Section 613 of the House bill, the Secretary is to establish a process to review the “relative values of physicians’ services,” and provide a written description of the review process that would be used to determine the “value” of physicians’ services. The House bill specifies that this review would take place annually, in consultation with the existing Medicare Payment Advisory Commission (MedPAC), the panel that advises Congress on reimbursement for Medicare physicians and participating hospitals. The Comptroller General of the United States would also be required to conduct a “periodic” audit of this exercise.

The House bill would “terminate” certain physician payment programs created under the Medicare Access and CHIP Reauthorization Act of 2015: the Merit-Based Incentive System, the alternative payment models, and the incentive program for “meaningful use” of electronic health records. It would also eliminate key payment and delivery-reform programs created under the 2010 ACA: the “value-based” purchasing provisions for hospitals, nursing homes, and home health agencies, as well as the accountable care organizations, the hospital readmission reduction program, and the “value-based” purchasing program for ambulatory surgical centers.⁷³

Capital Expenditures. The Secretary is to pay providers such “sums deemed appropriate” for the funding of capital projects. The bill would require the Secretary to give priority to capital projects in “medically

underserved” areas, or to address health disparities among racial, ethnic, or socioeconomic classes that suffer from such disparities. Also, under the terms of the bill, if a “non-governmental” agent funds a capital project, and that funding would lead to a reduction in patient care, health care staffing, or the availability of primary care, there would be a consequence: Federal funds would be disallowed for that capital project.⁷⁴

The House bill would also prohibit the use of federal funds for capital projects financed by charitable donations in any region without the specific approval of the regional director.⁷⁵ In no case would “providers” be permitted to co-mingle capital and operating funds.

Prescription Drug Payment. On a yearly basis, the Secretary must “negotiate” the prices for drugs, medical supplies, technologies, and devices. In negotiating these prices, the Secretary is to “take into account” several factors: the comparative clinical and cost effectiveness of these items, the impact of government payment on the program’s budget, the treatment alternatives available, and, in the case of drugs, the manufacturers’ total revenues, sales, and investment data.⁷⁶

If the Secretary is unsuccessful in negotiating a price for a particular drug, notwithstanding all other federal laws, the Secretary must cancel the manufacturer’s patent exclusivity, and “shall authorize the use of any patent, clinical trial data or other exclusivity granted by the Federal Government with respect to such drug as the Secretary determines appropriate for purposes of manufacturing such drug for sale under the Medicare for All Program.”⁷⁷

If the Secretary were to take such a strong action against a drug manufacturer, the manufacturer would be entitled to “reasonable compensation” for these losses based on the “risk-adjusted” value of any federal subsidies and the manufacturer’s investment in the development of the drug. The compensation would also reflect the impact of the drug on prices and health benefits, and “other relevant factors determined as appropriate by the Secretary to provide reasonable compensation.”⁷⁸ The bill would also allow the drug manufacturer to “seek recovery” of such losses by filing suit against the United States in the United States Court of Federal Claims.

Before negotiation and until one year after drug approval by the U.S. Food and Drug Administration, the federal government would pay the average price of the drug in the 10 countries of the Organization for Economic Co-operation and Development with the largest gross domestic product and a per capita income of “not less than half the per capita income” of the United States. The bill would also authorize the Secretary to procure a drug directly from the manufacturer.⁷⁹

Many champions of “single-payer” proposals believe that such one-sided government “negotiations” would secure significantly lower drug costs and overall health care savings without adverse consequences. As Blahous warns, however:

There are hard limits on the potential savings that can arise from such a provision because prescription drugs account for just 10 percent of total national health expenditures, and generics already make up 85 percent of all prescription drugs sold. Nevertheless, the lower bound estimates employ aggressive assumptions for prescription drug cost savings, specifically an immediate 12 percent reduction in prescription drug expenditures, without attempting to model potential adverse effects of this reduction on the pharmaceutical industry or the pace of innovation.⁸⁰

Commanding a Fast-Track Transition

The House bill provides for the creation of a transitional government health program, and the universal availability of health benefits and services, no more than two years after the date of enactment.⁸¹ The Secretary must establish a Medicare Transition Buy-In program, run by the CMS Administrator. The plan would function as an alternative health plan in the ACA’s health insurance exchanges nationwide. While the initial enrollments would be among those ages 55 and older, or ages 18 and younger, anyone living in the United States would be entitled to the benefits of the transitional program, assuming the person meets the Secretary’s eligibility determinations.⁸² During this two-year transition, the Secretary would also be required to consult with “interested parties,” including groups representing “providers,” beneficiaries, employers, and insurers.

The transitional program would comply with all of the ACA’s existing insurance requirements, including benefit requirements. The program’s benefit offerings must also have an actuarial value of 90 percent, meaning that the plan would pay 90 percent of the total average costs for the covered benefits.⁸³ The actuarial value of 90 percent is the highest level of health plan coverage (“platinum” level) in the ACA’s health insurance exchanges. It would be significantly “richer” than the actuarial value of the rest of the ACA plans, such as the “bronze”-level plans (60 percent), “silver”-level plans (70 percent), and “gold”-level plans (80 percent).

The transitional program would reimburse doctors, hospitals, and other medical professionals and facilities on a FFS basis, while the Secretary would negotiate the drug prices with the drug manufacturers. The bill also

imposes a mandate on providers: Participating “providers” in the Medicare program must be participating providers in the Medicare Transition Buy-In program.⁸⁴ The Secretary would establish a “process” to allow other providers to participate.

The CMS Administrator would set the temporary program’s beneficiary premiums, and these premiums could vary by single or family coverage and tobacco use, but not on the basis of geography. Beneficiaries in the program would also be eligible for more generous federal premium and cost-sharing subsidies.

The premium tax credits for the temporary program would be available for persons with annual incomes in excess of the ACA’s cap of 400 percent of the federal poverty level, or \$103,000 for a family of four.⁸⁵ For persons in states that have *not* expanded Medicaid, under the terms of the ACA, these federal subsidies would also be available to persons below 100 percent of the federal poverty level.⁸⁶

In the meantime, the House bill would eliminate the 24-month waiting period for Medicare enrollment for persons with disabilities and ensure the continuity of coverage and care for persons with health insurance, including persons with group health insurance coverage.

A Tight Timetable. The CBO warns: “The transition toward a single-payer system could be complicated, challenging and potentially disruptive.”⁸⁷ In this connection, RAND Corporation analysts note that the House bill would engineer “a massive reorientation” of American health care in an uncomfortably short period of time: “The Jayapal bill includes a two-year transition period; however a longer time may be required to enable consumers, providers and regulators to fully adjust to this substantial change.”⁸⁸

Historically, major health reform measures—highly consequential but far less ambitious—have usually provided far more generous time frames for transitions, giving employers, employees, doctors and patients, medical institutions, and professionals ample time to adjust. The Affordable Care Act of 2010 (ACA), which effected a major shift in regulatory authority over health insurance from the states to the federal government, provides a graphic example. In 2014—the first year of full implementation—the ACA got off to a rocky start, even with almost four years of federal and state preparation. Nonetheless, the Obama Administration had to grapple with an initial failure of its enrollment website, unanticipated disruptions and losses of coverage in the insurance markets, explosive premium and deductible increases, and much narrower than anticipated provider networks in the ACA plans. Even targeting a much smaller population for health insurance coverage, the

federal administrative task proved to be large and complex and was routinely plagued by serious glitches.

Conclusion

The congressional sponsors of H.R. 1384 would create a single, national health insurance program and provide “universal” coverage for every “resident” of the United States—regardless of whether that resident is in the U.S. legally or illegally.

Universal government coverage means universal government control. Two years after enactment, the legislation would virtually eliminate all existing public and private coverage alternatives, including all private health plans, employer-sponsored health insurance, health insurance exchange plans, Medicare, Medicaid, CHIP, Tricare, and the FEHBP. It would also severely restrict the ability of doctors and patients to enter into any independent relationship outside the government program, and government officials would closely monitor those external arrangements that are permissible. If enacted, the House bill would amount to another quantum leap forward in the power of the modern administrative state.

Under the House bill, any remaining independent, private transactions in American health care would largely disappear; private market profit and loss would be replaced by public program spending and program funding shortfalls.⁸⁹ The legislation would thus complete the politically driven concentration of federal power over American health care, a process of market consolidation accelerated in 2010 by Obamacare’s rapid multiplication of federal government mandates.⁹⁰ The legislation would also hasten the already rapid erosion of independent medical practice and physician autonomy.

While Congress would exercise the final authority over program financing and the content of the benefits package, the key, day-to-day decision making over most aspects of American health care would be vested in the HHS Secretary and the Secretary’s many subordinates. Among numerous administrative and regulatory duties, the Secretary would be required to create a national health database and national health budget and oversee regional offices and the transition program. Though the House legislation contains no financing provisions, the sheer size of this vast enterprise, and the federal spending and taxation to sustain it, would be enormous and unprecedented.⁹¹

Congressional sponsors of the legislation often claim that a single government system would be more equitable and economically efficient, while

generating significant cost savings and superior medical outcomes. They thus propose the adoption of a global budget to reduce health care costs. It could be done, of course, but not without shifting costs, in the form of pain and suffering, to patients. The “single-payer” experience of other countries demonstrates a clear pattern of waiting lists, delays, and denials of access to care.⁹²

As of yet, there is no CBO cost analysis of the bill to justify a belief in either imagined savings or greater economic efficiency. In fact, as noted, a broad range of diverse and respected independent analysts—ranging from the liberal Urban Institute to the conservative Mercatus Center—warn that overall costs could be considerably greater than the leading congressional proponents of these House and Senate proposals have claimed.⁹³

The first set of congressional hearings on the House bill in 2019 marks a turning point in the national health care debate. The proponents of the proposal promise a bright health care future. Opponents rightly point to dismal performance of countries with similar systems in place, particularly long wait times and reduced access to quality care.

Opposition to this concentrated federal power and control over American health care is not, in any sense, an endorsement of the status quo. Members of Congress have a grave responsibility to address the central problems of American health care, including distorted and uncompetitive markets, constraints on the choice of health plans and providers, artificially high health insurance costs, uneven quality, and the gaps in care and coverage. The Health Care Choices Proposal, developed by conservative health policy analysts, would directly address these problems and thus reduce costs, expand personal choice, reignite competition, and stabilize coverage in the nation’s health care markets.⁹⁴

Sound reform can address America’s worst problems without destroying what is best: America’s capacity for medical innovation and rapid responsiveness in the treatment and cure of deadly disease. Most important, comprehensive reform can expand Americans’ personal freedom while solving these problems, instead of eliminating it.

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Endnotes

1. In celebrating the emergence of the single-payer bills, a champion in the media observes: "There is one thing we can be thankful for: Medicare for All is now a mainstream position in the Democratic Party, to the point where most of the leading Democratic candidates say they support it." Libby Watson, "A Public Option Isn't Good Enough," *Splinter*, February 1, 2019, <https://splinternews.com/a-public-option-isn-t-good-enough-1832011806> (accessed July 8, 2019).
2. "The bills swiftly transform the entire \$3.7 trillion health care system, touching on everything from building primary and rural health care capacity to addressing socioeconomic disparities to getting all health care providers to use the same electronic billing format." Alice Miranda Ollstein and Joanne Kenen, "From Abortion to Immigration, Things You Didn't Know Were in Medicare for All," *Politico*, April 10, 2019, p. 1, <https://www.politico.com/story/2019/04/10/sanders-medicare-for-all-1341799> (accessed July 8, 2019).
3. Niran S. Al-Agba, "Medicare for All' a Far Cry from Other Nations' Universal Care," *Medpage Today*, May 9, 2019, <https://www.medpagetoday.com/blogs/kevinmd/79740> (accessed July 8, 2019).
4. U.S. Census Bureau, American Community Survey, Tables S2701, S2702, S2703, and S2704 for the year 2017, <https://factfinder.census.gov> (accessed March 24, 2019).
5. Among some strong supporters of the legislation, the destruction of Americans' employer-sponsored health plans is a reasonable price for securing a government monopoly: "A vocal minority of people with employer provided coverage they actually like doesn't mean you should ignore what's best for everyone." Watson, "A Public Option Isn't Good Enough."
6. Cited in Shefall Luthra, "There's a New 'Medicare-for All' Bill in the House. Why Does It Matter?" *Kaiser Health News*, February 27, 2019, <https://khn.org/news/theres-a-new-medicare-for-all-bill-in-the-house-why-does-it-matter/> (accessed July 8, 2019).
7. Ollstein and Kenen, "From Abortion to Immigration, Things You Didn't Know Were in Medicare for All."
8. Medicare for All Act of 2019, Title VII, Section 701 (a), (3), p. 91.
9. According to analysts with the National Right to Life Committee, "Working in tandem, Sections 103 and 104 and 301 are likely to be interpreted to require physicians to perform an abortion, even if they are morally opposed to them, as this would constitute discrimination under this definition." See The National Right to Life Committee, "NRLC Strongly Opposes H.R. 1384, the 'Medicare for All Act of 2019,'" April 29, 2019, <https://www.nrlc.org/federal/ahc/nrlc-strongly-opposes-h-r-1384-the-medicare-for-all-act-of-2019/> (accessed July 8, 2019).
10. The previous version of the House bill (H.R. 676) specified that the financing would come from "existing federal revenues" for health care. It would require new personal income taxes on the "top five percent of income earners"; "modest and progressive excise taxes on payroll and self-employment income"; and a "modest tax" on unearned income, plus a "small tax" on stocks and bond transactions. See H.R. 676, Section 211. Such legislative language, however, was unamenable to econometric analysis.
11. Luthra, "There's a New 'Medicare for All' Bill in the House."
12. Charles P. Blahous, testimony before the Committee on Rules, U.S. House of Representatives, April 30, 2019, p. 2, <https://docs.house.gov/meetings/RU/RU00/20190430/109356/HHRG-116-RU00-Wstate-BlahousC-20190430.pdf> (accessed July 8 2019).
13. *Ibid.*, p. 1.
14. *Ibid.*, p. 2.
15. Rand Corporation analysts estimate that the total cost of the program, if implemented in 2019, would amount to \$3.89 trillion, or a 1.8 percent increase in total spending over the status quo. However, it would amount to a 221 percent increase in federal health spending. Moreover, in the absence of a serious constraint on the supply of health care services, in the face of a rising demand, total health care spending could rise from \$3.89 trillion to \$4.2 trillion, a 9.8 percent increase. Jodi L. Liu and Christine Eibner, "National Health Spending Estimates Under Medicare for All," RAND Corporation, 2019, https://www.rand.org/pubs/research_reports/RR3106.html (accessed July 8, 2019).
16. Medicare for All Act of 2019, Title VI, Section 601, (a) (8), p. 62.
17. Adam Shaw, "Medicare for All Sponsor Says Plan Would Gut 1 Million Private Jobs," *FoxNews*, May 3, 2019, <https://www.foxnews.com/politics/medicare-for-all-would-gut-a-million-private-insurance-jobs> (accessed July 8, 2019).
18. Medicare for All Act of 2019, Title I, Section 101, p. 4.
19. Among economically advanced nations, the House bill, covering foreign residents regardless of their legal status, would be unprecedented: "[T]he majority of universal health care systems in the developed world are considerably less 'universal' when covering immigrants, who are mostly excluded." Al-Agba, "Medicare for All' a Far Cry from Other Nations' Universal Care."
20. Congressional Budget Office, "Key Design Components and Considerations for Establishing a Single-Payer Health Care System," May 1, 2019, p. 3, <https://www.cbo.gov/publication/55150> (accessed July 8, 2019).
21. Medicare for All Act of 2019, Title I, Section 102, p. 5. The Senate bill embodies the same general eligibility policy.
22. *Ibid.*, Section 105 (b), p. 8.

23. *Ibid.*, Title I, Section 102, pp. 4 and 5.
24. *Ibid.*, Title I, Section 103, p. 5.
25. *Ibid.*, Title I, Section 104, p. 5.
26. *Ibid.*, Title I, Section 104, (c), p. 7.
27. Insurance enrollment is based on 2017 data, compiled by the Kaiser Family Foundation, “Health Insurance Coverage of the Total Population,” 2017, <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed July 8, 2019). Medicare enrollment is taken from the *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, April, 2019, p. 173, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf> (accessed July 8, 2019).
28. Medicare for All Act of 2019, Title I, Section 107 (a), p. 9.
29. *Ibid.*, Title VII, Section 701, (a), p. 93.
30. *Ibid.*, Title VII, Section 701 (2) (A), pp. 89 and 90.
31. “Private health insurance plays a major role in most developed countries with universal coverage.” See Al-Agba, “‘Medicare for All’ a Far Cry from Other Nations’ Universal Care.”
32. Congressional Budget Office, “Key Design Components,” p. 13.
33. “The Department of Health and Human Services would have significant discretion in interpreting what specific services are ‘medically necessary.’ That means political leaning or scientific debates could sway what’s covered, even from administration to administration.” Luthra, “There’s a New ‘Medicare for All’ Bill in the House.”
34. Medicare for All Act of 2019, Section 201 (c) (1) (2), p. 12.
35. *Ibid.*, Section 201, (e), p. 14.
36. *Ibid.*, Title II, Section 203 (b), pp. 14 and 15.
37. *Ibid.*, Section 203 9c) (1), pp. 15 and 16. The legislative text is unclear as to how certain likely problems would be resolved, particularly in cases where the best professional judgment of physicians clashes with provisions of the “non-discrimination” clause, patient preferences, or physicians’ professional ethical obligations under the Hippocratic Oath. The consequence is likely to be the creation of an authoritarian administrative system where transient political fashions would govern medical ethics, rather than traditional ethical or moral norms. In any case, these provisions are pregnant with intense conflict and court litigation.
38. “Most universal coverage systems offer narrow benefit packages and incorporate cost-sharing for patients.” Al-Agba, “‘Medicare for All’ a Far Cry from Other Nations’ Universal Care.”
39. Congressional Budget Office, “Key Design Components,” pp. 10 and 11.
40. Medicare for All Act of 2019, Title II, Section 204 (a), pp. 17 and 18.
41. *Ibid.*, Title II, Section 204, (c), pp. 18 and 19.
42. *Ibid.*, Title II, Section 204, c (s), pp. 18 and 19.
43. *Ibid.*, Title II, Section 204 (d), p. 20.
44. The previous House version had 10 benefit categories. See H.R. 676, Title I, Section 102.
45. Congressional Budget Office, “Key Design Components,” p. 10.
46. *Ibid.*
47. *Ibid.*, p. 10.
48. Medicare for All Act of 2019, Title II, Section 204 (c) (1).
49. Liu and Eibner, “National Health Spending Estimates Under Medicare for All.”
50. For an excellent overview of this problem, see Kevin Pham, “America’s Looming Doctor Shortage: What Policymakers Should Do,” Heritage Foundation *Backgrounders* No. 3343, September 5, 2018, <https://www.heritage.org/health-care-reform/report/americas-looming-doctor-shortage-what-policymakers-should-do>.
51. Kevin Pham and Robert E. Moffit, “Britain’s Inability to Handle Last Year’s Flu Season Shows Perils of Socialized Medicine,” *The Daily Signal*, August 13, 2018, <https://www.dailysignal.com/2018/08/13/britains-inability-to-handle-last-years-flu-season-shows-perils-of-socialized-medicine/>.
52. Medicare for All Act of 2019, Title III, Section 301 (b), pp. 22–24.
53. *Ibid.*, Title III, Section 301 (b), pp. 24 and 25. It is worth noting that current Medicare law has a “prompt payment” requirement, and, in the case of a delay in paying providers’ “paper” claims, the federal government must pay interest after 30 days. It appears that the House bill contains no similar legal requirement.

54. *Ibid.*, Title III, Section 302 (c) (1), pp. 33 and 34.
55. *Ibid.*, Title III, Section 302, (c), (2), pp. 34 and 35.
56. *Ibid.*, Section 502 (a) (b) (c), pp. 53–55. Administrative standard setting is, however, often incompatible with personalized patient care. “Standardization of care in a medical condition, though advocated by many, belies the complexity of care delivery and the variety of patient circumstances.” Michael E. Porter and Elizabeth Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston: Harvard Business School Press, 2006), p. 178.
57. Medicare for All Act of 2019, Title V, Section 502 (a), (b), (c), pp. 55–57.
58. *Ibid.*, Title III, Section 303, p. 36.
59. *Ibid.*, Title III, Section 303, pp. 36–38.
60. *Ibid.*, Title III, Section 303, p. 42.
61. According to the CBO, “In England, private insurance gives people access to private providers, faster access to care or coverage for complementary or alternative therapies, but participants must pay for it separately in addition to paying their individual required tax contributions to the NHS.” Congressional Budget Office, “Key Design Components,” p. 13. Not surprisingly, with the growth in waiting lists, British private options have expanded in recent years. For an account of this expansion, see Tim Evans, “London Calling: Don’t Commit to Nationalized Health Care,” Heritage Foundation *Backgrounders* No. 3405, May 3, 2019, pp. 6 and 7, <https://www.heritage.org/health-care-reform/report/london-calling-dont-commit-nationalized-health-care>.
62. Anne Gulland, “Will Private Practice Remain an Attractive Option for Doctors?” *British Medical Journal*, Vol. 356 (March 2017), <https://www.bmj.com/content/356/bmj.j1258> (accessed July 9, 2019).
63. Under the House bill, the congressional grant of power to the HHS Secretary would be unprecedented, and yet so would the politicization of health care decision making. Professors Porter and Teisberg thus warn: “It simply strains credulity to imagine that a large government entity would streamline administration, simplify prices, set prices according to true costs, help patients make choices based on excellence and value, establish value-based competition at the provider level, and make politically neutral and tough choices to deny patients and reimbursement to substandard providers.” Porter and Teisberg, *Redefining Health Care*, pp. 89 and 90.
64. Medicare for All Act of 2019, Title IV, Section 401, (a), (1), pp. 43 and 44.
65. Medicare for All Act of 2019, Title IV, Section 401, (a) (3), p. 44.
66. *Ibid.*, Title IV, Section 401 (b) (10), p. 45.
67. *Ibid.*, Title IV, Section 401, (c) (1), pp. 48 and 49.
68. *Ibid.*, Title IV, Section 403 (c), pp. 50 and 51. In short, these regional directors would take over the local health-planning responsibilities that are now mostly exercised by state agencies.
69. “Single-payer health systems typically include some form of global budgeting. Most hospitals in Canada operate under annual global budgets. Some countries define global budgets more broadly to cover total health care spending or spending for major categories of services.” Congressional Budget Office, “Key Design Components,” p. 19. The House bill defines the global budget in the broad sense of covering total health care spending.
70. Medicare for All Act of 2019, Section 601, (a), p. 59.
71. *Ibid.*, Title VI, Section 613, pp. 74–77.
72. *Ibid.*, Title VI, Section 612, p. 73.
73. *Ibid.*, Title IX, Section 903, pp. 98–101.
74. *Ibid.*, Title VI, Section 614 (c), p. 80.
75. *Ibid.*
76. *Ibid.*, Section 616 (1), pp. 83 and 84.
77. *Ibid.*, Title VI, Section 616, (3) (A), p. 85.
78. *Ibid.*, Title VI, Section 616 (A), p. 86.
79. *Ibid.*, Title VI, Section 616 (3) (D), p. 87.
80. Blahous, testimony before the Committee on Rules, U.S. House of Representatives, p. 4.
81. Medicare for All Act of 2019, Title X, Section 1001, p. 101.
82. *Ibid.*, Title X, Section 1002, (b) (4), p. 104.
83. *Ibid.*, Title X, Section 1002, (c) (2), p. 105.
84. *Ibid.*, Title X, Section 1002, pp. 103–106.
85. Paying for Senior Care, “2019 Health & Human Services Poverty Guidelines/Federal Poverty Levels,” May 2019, <https://www.payingforseniorcare.com/longtermcare/federal-poverty-level.html> (accessed July 9, 2019).

86. Medicare for All Act of 2019, Title X, Section 1002, pp. 107–111.
87. Congressional Budget Office, “Key Design Components,” p. 3.
88. Liu and Eibner, “National Health Spending Estimates Under Medicare for All.”
89. On this point, the congressional sponsors are clear: “There is a moral imperative to correct the massive deficiencies in our current health system and to eliminate profit from the provision of care.” Sense of the Congress, Medicare for All Act of 2019, p. 78. So, too, are the inevitable consequences: “If the economic decision mechanisms of the market are abolished, they must be replaced by political (governmental) mechanisms for distribution. Just as the market rewards economic services, political distribution systems will reward political services, that is, services in the production and distribution of power.” Ernest van den Haag, “Confusion, Envy, Fear and Longing,” in Van den Haag, ed., *Capitalism: Sources of Hostility* (New Rochelle, NY: Epoch Books, 1979), p. 28.
90. For an excellent discussion of the ACA’s impact on market concentration, see Christopher M. Pope, “How the Affordable Care Act Fuels Health Care Market Consolidation,” Heritage Foundation *Backgrounders* No. 2928, August 1, 2014, http://thf_media.s3.amazonaws.com/2014/pdf/BG2928.pdf.
91. “Taxes that could finance a single payer system include income taxes (both individual and corporate), payroll taxes, and consumption taxes, all of which have different implications for progressivity of the financing system. A system financed by debt might require additional taxes in the future.” Congressional Budget Office, “Key Design Components,” p. 28.
92. “The relatively slow growth in (Britain’s) global budget since 2010 has created severe financial strains on the health care system. Provider payment rates have been reduced, many providers have incurred financial deficits, and wait times for receiving care have increased.” Congressional Budget Office, “Key Design Components,” p. 26.
93. Reflecting on the April 30, 2019, House Rules Committee hearing, Blahous, a witness, observed: “Multiple experts who testified at the hearing agreed that most of these new federal costs would arise from the federal government’s taking on spending currently done by the private sector, e.g., through private health insurance and individual payments out of pocket. Under M4A the federal government would also assume health spending obligations currently financed by state and local governments. The fact that most of this spending is really being done by someone else does not, however, imply that the federal government could successfully finance it without causing significant damage to the U.S. economy.” Charles Blahous, “The Winners and Losers of ‘Medicare for All,’” *Economics 21*, May 22, 2019, <https://economics21.org/medicare-for-all-winners-and-losers> (accessed July 9, 2019).
94. For an overview of this approach, 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 *Backgrounders* No. 3330, July 11, 2018, https://www.heritage.org/sites/default/files/2018-07/BG3330_0.pdf.