

# Medicare for All sounds expensive. How expensive? Here are three questions you need to answer.

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As the debate around single-payer healthcare in the United States has heated up, it has inevitably turned to the question of how much it will cost and how to pay for it. The Urban Institute has pegged the additional 10-year cost of an expansive solution, such as those proposed by Sens. Elizabeth Warren and Bernie Sanders, at \$34 trillion, and most estimates fall between \$25 and \$36 trillion.

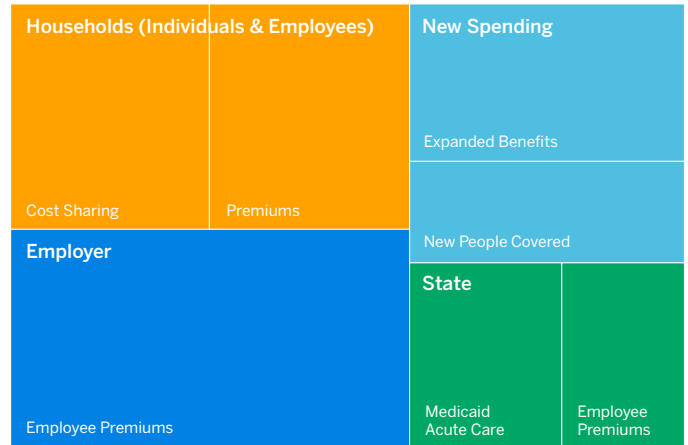
It is easy to get lost in the minutiae of these varied estimates—to quote Saturday Night Live’s Kate McKinnon playing Sen. Warren, “When the numbers are this big, they’re just pretend.” Regardless of the assumptions one makes, it is clear that Medicare for All will add significant costs to the federal budget.

In this paper, we use an average increase of \$3 trillion per year in federal costs (or about \$30 trillion over 10 years). This added annual cost under a generous Medicare for All approach will be driven by five primary sources:

1. Expanding coverage (more Americans will have healthcare coverage).
2. Eliminating member premiums (transferring the premiums public and private employers and individuals already pay for healthcare coverage to the federal government).
3. Eliminating cost sharing paid by individuals (providing care to participants at no out-of-pocket cost, i.e., no deductibles, copayments, or other cost sharing).
4. Expanding covered benefits (providing added benefits like long-term care,<sup>1</sup> dental, vision, and hearing in addition to medical and pharmacy coverage).
5. Transitioning the acute care component of Medicaid (states currently fund about one-third of Medicaid expenses, which would shift to the federal government).

Figure 1 shows our estimate of how the \$3 trillion in new annual federal government costs may be shared among the five sources and where these expenses are currently funded.

**FIGURE 1: BREAKDOWN OF ADDED FEDERAL GOVERNMENT COSTS UNDER MEDICARE FOR ALL AND CURRENT SOURCE OF FUNDING**



As outlined in Figure 1, while a comprehensive Medicare for All proposal will add significant new cost to the federal government, many of these costs already exist within the current healthcare system, but are paid by other entities, such as employers, states, and households. In question 3 of this paper below, we discuss potential ways in which the government will finance these costs.

Of course, any estimate of the cost depends on what “Medicare for All” actually means. So far that definition has been elusive, with different 2020 presidential candidates describing different scenarios for the scope of universal coverage. In the paper, “Congress asked nine questions about single payer. Here are 27 answers,” Milliman identified at least three flavors of single-payer proposals,<sup>2</sup> each with different implications and price tags.

As the multi-trillion-dollar estimates make clear, universal healthcare coverage will cost a lot of money. But answering the question of how much money and whether that amount is reasonable requires answering a few more questions, none of which has straightforward answers.

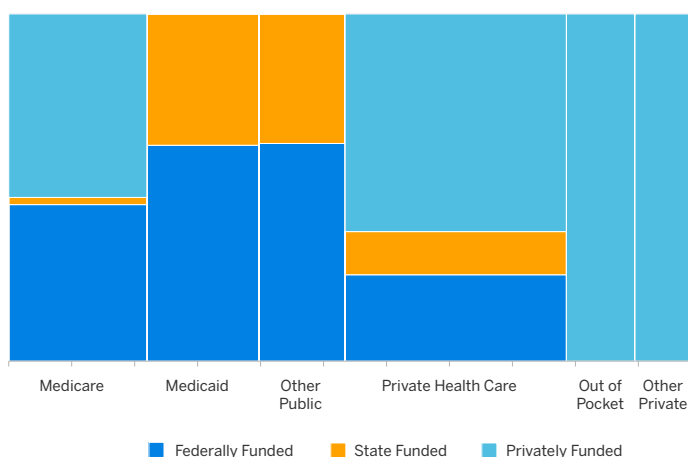
1 As outlined, the Medicare for All proposal supported by Sens. Sanders and Warren would provide home and community long-term supports under Medicare while leaving institutional long-term care under Medicaid. See S. 1229 as introduced in the Senate on April 10, 2019, at <https://www.congress.gov/116/bills/s/1229/BILLS-116s1229is.pdf> (retrieved December 8, 2019).

2 Milliman. Congress asked nine questions about single payer. Here are 27 answers. Retrieved December 8, 2019, from [http://www.milliman.com/insight/2019/Congress-asked-nine-questions-about-single-payer\\_-Here-are-27-answers\\_/](http://www.milliman.com/insight/2019/Congress-asked-nine-questions-about-single-payer_-Here-are-27-answers_/).

## 1. How can Medicare for All cost estimates be compared to current healthcare costs?

The level of current spending on healthcare is one of the main drivers of today's healthcare reform debate. The United States (US) spends more per capita on healthcare than any country, with costs approaching 18% of the gross domestic product (GDP). That was about \$3.8 trillion dollars in 2019. Figure 2 shows the distribution of US healthcare spending by coverage source and funder for 2019.

**FIGURE 2: 2019 US HEALTHCARE SPENDING<sup>3</sup>**



Medicare and Medicaid contribute about \$1.4 trillion, funded through a combination of federal payroll taxes, federal and state general tax revenues, and beneficiary premiums. Other public health programs—such as the Children's Health Insurance Program (CHIP), TRICARE, Veterans Health Administration, Indian Health Service, active duty military spending by the U.S. Department of Defense, and other programs—add another \$0.5 trillion per year to federal and state spending.

Private health coverage as shown in Figure 2 encapsulates both employer-sponsored coverage and coverage obtained in the individual market. Employer-sponsored coverage is the most common way Americans obtain health insurance, covering approximately 156 million people or nearly half of the country's total population.<sup>4</sup> This represents about \$1.2 trillion in 2019

3 Centers for Medicare and Medicaid Services (February 20, 2019). CMS Office of the Actuary releases 2018-2027 projections of national health expenditures. Press release. Retrieved December 8, 2019, from <https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2018-2027-projections-national-health-expenditures>. Note that these costs do not include bad debt and charity care, but do include all benefits discussed in Medicare for All proposals.

4 eHealth (October 31, 2019). How Many Americans Get Health Insurance From Their Employer? Retrieved December 8, 2019, from <https://www.ehealthinsurance.com/resources/small-business/how-many-americans-get-health-insurance-from-their-employer>.

healthcare spending across both public and private employers, excluding out-of-pocket payments such as deductibles and copayments paid by plan participants, while individual health coverage represents another \$0.1 trillion. Member out-of-pocket spending across all lines of coverage (e.g., Medicare, employer, and individual coverage) represents an additional \$0.4 trillion. In 2019, the cost of healthcare for a hypothetical American family of four covered by an average employer-sponsored preferred provider organization (PPO) plan was \$28,636, according to the 2019 Milliman Medical Index.<sup>5</sup>

Lastly, other private health costs (including philanthropic and capital investments, among other items) constitute about \$0.3 trillion. Of the \$3.8 trillion in total costs, \$1.4 trillion is paid for directly or indirectly<sup>6</sup> by the federal government, \$0.6 trillion is paid by the states, and the remaining \$1.8 trillion is borne by private payers (primarily plan participants and employers). The approximately \$3 trillion annual incremental cost of Medicare for All represents the increase in federal spending, but many of these costs exist within the current system today and are paid by other parties, as shown in Figure 2 and illustrated earlier in Figure 1.

## 2. What are the key factors in determining the cost of Medicare for All?

If Medicare for All is implemented as a single-payer program, it shifts virtually all private healthcare costs to the federal government, and its total cost depends on several key factors. A recent Commonwealth Fund report compares two alternative approaches to a single-payer system, highlighting a \$1.5 trillion annual cost difference between the two proposals, depending on who is covered, the types of benefits provided, and participant cost-sharing requirements.<sup>7</sup>

- **Single-Payer Lite** covers all people legally residing in the US, or about 320 million people, and includes all of the “essential health benefits” currently covered by the Patient Protection and Affordable Care Act (ACA). Cost sharing is based on income (i.e., lower-wage earners have less cost sharing), but no premiums are collected, and private insurance is prohibited. In this scenario, about 26 million uninsured legal residents gain coverage. However, about 4 million

5 Milliman. 2019 Milliman Medical Index. Retrieved December 8, 2019, from <http://www.milliman.com/mmi/>.

6 Indirect expenditures include \$0.3 trillion in subsidies to employer-sponsored coverage through the income tax exclusion, as outlined by the Congressional Budget Office in the report available at [https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies\\_0.pdf](https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf) (retrieved December 8, 2019).

7 The Commonwealth Fund (October 16, 2019). Comparing Health Insurance Reform Options: From “Building on the ACA” to Single Payer. Retrieved December 8, 2019, from <https://www.commonwealthfund.org/publications/issue-briefs/2019/oct/comparing-health-insurance-reform-options-building-on-aca-to-single-payer>.

undocumented immigrants become uninsured (and about 7 million other undocumented immigrants remain uninsured) because this reform eliminates private insurance. As estimated by the Commonwealth Fund, federal government spending increases by \$1.5 trillion in 2020 (and almost \$18 trillion over 10 years) under the Single-Payer Lite plan.

- **Single-Payer Enhanced** covers all people residing in the US including undocumented immigrants, an estimated 331.5 million people. This plan includes a broader set of benefits than the Single-Payer Lite plan by adding adult dental, vision, and hearing care along with home-based and community-based long-term services benefits. There are no premiums collected from plan participants, no cost sharing, and private insurance is prohibited. The Commonwealth Fund estimates that federal government spending would increase by almost \$3 trillion in 2020 (and about \$34 trillion over 10 years) under the Single-Payer Enhanced plan. This \$3 trillion estimate is consistent with the figure used in this paper to represent the cost of the types of plans proposed by Sens. Sanders and Warren.

In addition to the approaches identified by the Commonwealth Fund, many other approaches to healthcare reform are being discussed, a few of which build on the system currently in place—a view supported by some of the other more moderate 2020 presidential candidates. A Fill the Gap (Gap) scenario would continue many of the private market insurance mechanisms and public programs that exist today, with enhancements to fill in coverage gaps and provide consumers with additional coverage options. The private market would be allowed to continue and many people would still receive coverage through their employers. In addition, Medicaid would continue as a program for covering those with low incomes and the disabled.

Although no state currently has a Gap solution in place, Washington state took steps in this direction with the scheduled introduction of CascadeCare in 2021, which adds an additional publicly sponsored option to the state's ACA marketplace to increase competition and limit premium growth. A Gap scenario would likely work better in a state like Washington that has already expanded Medicaid and developed a state exchange, as compared to states that have less robust state healthcare administrative infrastructure. Under a Gap scenario, much of the current healthcare funding would remain the same but more people could get coverage.

### 3. What are the options for financing Medicare for All?

Notwithstanding the challenges described above, quantifying the cost of the various Medicare for All scenarios is the easy part, compared to figuring out how to finance it. While each scenario presents different cost elements, the funding mechanisms are finite. Virtually all universal coverage

proposals involve at least some additional taxation. For example, Sen. Warren's proposal establishes new taxes on businesses and the wealthiest Americans to fund the majority of her plan. To cover the shortfall between the cost projections and funding, the Warren plan anticipates cost reductions through various measures, including:

- Reduced reimbursement for hospitals and healthcare providers and alignment of physician payment rates with the current Medicare system. While reducing reimbursement should reduce the cost of the healthcare program, this approach comes with a major risk of unintended consequences. Any changes to provider reimbursements must be carefully implemented to avoid disrupting access to care, especially in markets with limited or already underfunded healthcare delivery system capacity.
- Redirecting existing state and local government health spending into the Medicare for All system.<sup>8,9</sup>
- Cutting administrative costs and stemming the growth of medical costs.

It is important to note that a single-payer system would eliminate the need for employers (both public and private) to provide healthcare benefits and the need for individuals to purchase coverage in the non-group market. This incremental cost is valued at approximately \$1 trillion<sup>10</sup> annually (excluding out-of-pocket costs), with costs for obtaining coverage split between employers and households. Warren proposes redirecting this trillion-dollar-per-year funding base into single-payer insurance funding. Given the vast differences in employer-provided coverage today, under this type of approach it will be very important to understand how this redirection will be implemented, particularly how it changes costs for employers that did not previously provide coverage.

While the math is straightforward, the devil is in the details, in particular the distribution of funding sources: additional taxes, lower spending, and perhaps additional borrowing. To reduce the magnitude of needed financing, policy makers could scale back coverage to a less generous and comprehensive plan like Single-Payer Lite or a Gap option. Another alternative would be to adopt policies that more aggressively lower per-person healthcare costs and/or eliminate waste from the healthcare system.

8 This is similar to the Medicare Part D clawback mechanism where Medicare recoups the state portion of Part D costs for Medicaid-eligible enrollees.

9 Warren, E., Ending the stranglehold, op cit.

10 This \$1 trillion is on the same basis as the \$1.3 trillion shown in Figure 2, but represents only the incremental portion of costs (i.e., those that are not currently funded).

## Other considerations

The three questions posed in this article are just the beginning in examining the complex issue of a Medicare for All universal healthcare system in the United States. Additional questions remain around quality of care, potential waste or overutilization of healthcare, managing administrative expenses, potential changes to provider reimbursements, the role of private insurance companies, price transparency, the potential economic impact to the US and the world, and how to effectively transition from today's healthcare system to Medicare for All. As the debate moves forward, it's critical to address not only the questions related to financing, but these other important considerations as well.

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