Medicare for All cost analysis primer

Acknowledgements: PNHP Minnesota, Dr. Nyman and Dr. Mosser, Dr. Engelhart

This primer has been created in conjunction with an up-to-date list of Medicare for All cost analysis studies. We've set forth a series of questions below that are designed to give background on important considerations in a single payer cost analysis. The information provided below should give you the foundation to begin critically thinking about these studies and deeming what assumptions are valid and which seem implausible.

We want to recognize on the outset that the implications of economic and cost analyses are thinly veiled assumptions about larger ethical questions. Before beginning this process, it's important to think about "Who should have access to care: only those who can afford it, children, childless adults, undocumented immigrants? How much care should we have access to?" and "What should we as a nation consider *affordable*?" After deciding the answer to these questions, you'll find the studies are a wealth of information. Both on how ideological beliefs play into the way the numbers are presented as well as the complex web of tradeoffs that will exist under M4A. You'll encounter significant cost-savings, but also increase in costs from expanding access and shift of healthcare costs from state to federal budgets. By studying these tradeoffs and planning for the changes to come under Medicare For All, we can strengthen the argument for living in a country that ensures everyone has access to quality healthcare.

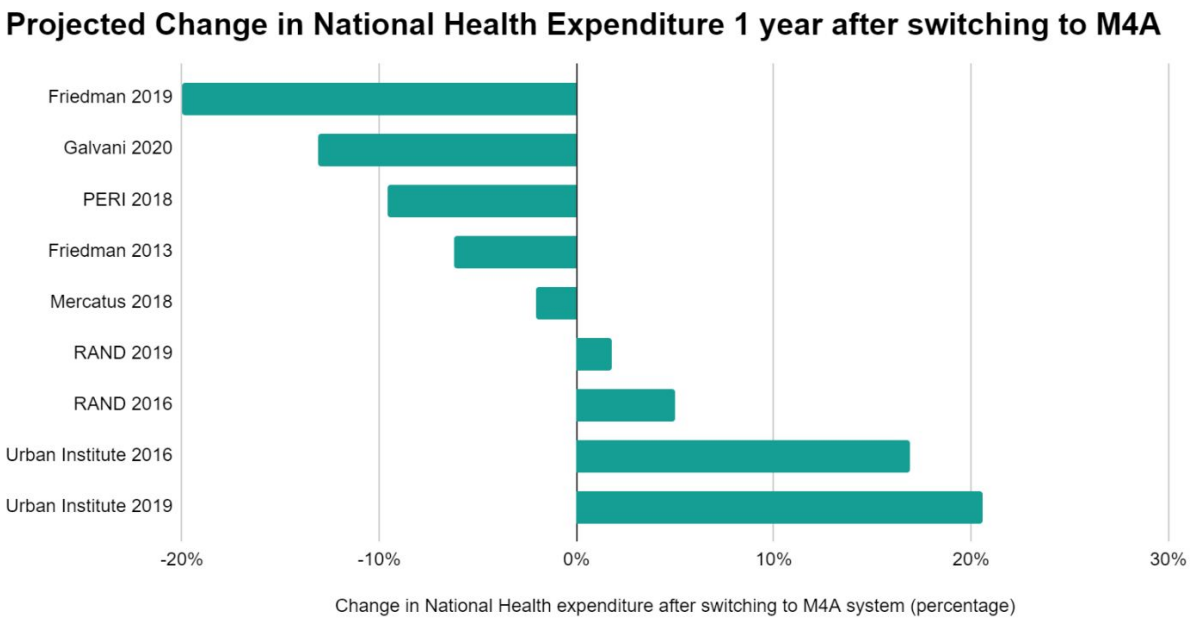
1. **What is the difference between Universal Healthcare and Single Payer Systems?**

Universal healthcare describes a system that grants all citizens (and sometimes residents) adequate healthcare. A single payer healthcare system is a means to achieve universal healthcare. A single entity, usually the government, serves as the sole health insurance provider for all residents. In many countries the terms universal coverage and single-payer go hand-in-hand because they both refer to expanding access to health care. However, universal healthcare simply ensures everyone has access, but doesn't necessitate getting rid of for-profit private insurers.

2. **What is the difference between National Health Expenditure and federal health expenditures?**

Single-payer cost analyses focus on the distinction between national and federal health expenditure. National Health Expenditure (NHE) is the total healthcare spending in the United States. This includes the annual expenditures for health care goods and services, public health activities, government administration, the net cost of health insurance, and investment related to healthcare. Federal health expenditure is the total health care spending that is paid for by the *federal government.*

Increases in federal health expenditure would need to be funded by tax increases, federal deficit spending, or the reallocation of funds from the other programs. The delineation is made in single payer cost analysis because almost all of the point-of-contact payments for healthcare will be shifted away from states to the federal government. There is considerable contention regarding the level of funding that can be expected to continue from states under Medicare For All because of the 2012 *National Federation of Independent Business v. Sebelius* case which limited the extent to which states could be required to pay for healthcare costs.



3. What are potential avenues of costs and savings that are expected under a single payer system?

Causes for Increases in Cost

Transition Costs: Transitioning from our current healthcare delivery system to a single payer system will leave many workers that make up the "administrative overhead" directly affected. Only a few articles focused on this crucial transition. Allocating funding and retraining programs for these workers will be important cost considerations and components in financing Medicare for all discussions. Both the PERI (2018) and the RAND (2016) study give estimates for the transition costs. The PNHP proposal also calls for a one-time buy-out of all for-profit healthcare delivery centers to then be changed to a non-profit status.

Healthcare Utilization: The single payer plans currently in Congress (S 1129 and HR 1384 are discussed below) there would be no cost sharing borne by the consumer. Cost analyses tend to attribute the majority of the health care utilization increase under Medicare For All primarily to the

previously under- and uninsured. Many papers also estimate the increase in utilization for the general previously insured population as well citing *moral hazard*, which states by making the price of a service lower than the actual cost, consumers are prone to use more of that service. It's the rationale behind co-payments in healthcare. To this end, studies often utilize the RAND health insurance experiment and recent studies finding's price elasticity of the demand for healthcare with no cost-sharing. There is also contention whether supply side constraints of hospitals and providers will create a ceiling to healthcare utilization. Further reading

Inclusion of previously uncovered services: The inclusion of other services is usually a subset of increased cost due to utilization. Based on current legislature most studies make adjustments in utilization for the coverage for long term care, dental, and vision services.

Study	PERI	Mercatus	Yale	RAND (2016)	RAND (2019)	Thorpe	Friedman (2013)
Increase Cost d/t Utilization (%)	12%	11.3%	8%	?	Services paid by Medicare = 2.2%; Commercial insurance = 2.6%	10%	3% for most activities 20% for dental care 40% for home health care

Table 1. Estimated Percent Increases in Healthcare Utilization under Medicare For All.

Cost Savers

Administrative costs (eliminating for-profit insurance): In 2018, private for-profit insurance companies paid for $1.2 trillion of our $3.6 trillion in national health expenditure. The ACA now requires insurance companies to operate at 80% medical loss ratio, meaning for every $1 in premiums that private insurance companies collect, only $0.20 can go to overhead costs and profit for shareholders. Medicare and Medicaid operate at a considerably lower administrative overhead than for-profit insurance companies, so cutting out the for-profit insurance companies presents an opportunity to lower costs. Some contention lies in the extent to which we would see these lower administrative overheads after expanding these programs to the entire country.

Administrative costs (hospital/physician perspective): Under the current patchwork of health insurance systems, billing and insurance related (BIR) costs are substantial for hospitals and clinics. Wrestling with a multi-payer system, obtaining prior authorization, and coordinating with managed care organizations all contribute to BIR for hospitals and Medicare For All lessens this burden by replacing a profit-driven multi-player insurance industry with a single payer and billing system. This will drastically cut back the administrative needs of hospitals. It's important to note that these savings do not apply to the larger single payer system, and should only be considered as savings for the

hospitals. However, the savings produced by decreased administrative function will make decreasing the physician and hospital payments to Medicare rates more financially feasible.

PERI	Mercatus	Yale	RAND (2019)	UI	UI	Thorpe	Friedman (2019)
3.5%	6%	2.2%	5.3%	6%	6%	4.3%	2%

Table 2. Estimated Percent of Total National Health Care Expenditure for Administrative Tasks under Medicare For All.

Pharmaceuticals and medical devices: Pharmaceutical and medical devices cost more in the U.S. than anywhere else in the world. A "single payer" would have more bargaining power to reduce the costs of pharmaceutical prices to levels comparable to other high-income countries. These savings have already been realized in the United States by the VA and IHS. There is discussion within papers if a larger M4A system would need to be more generous than the VA and IHS, so there is a range of how generous the savings might be. Further reading

Physician/hospital payment for service: The studies we explored all assumed a fee-for-service model and extrapolated with Medicare rates (+x%), however recent bills have proposed different payment models for providers and these payments could have different impacts on the cost analysis of a single payer system. There is need in the literature to examine the effects of different budget models, global budgets and capitation on overall cost of single payer.

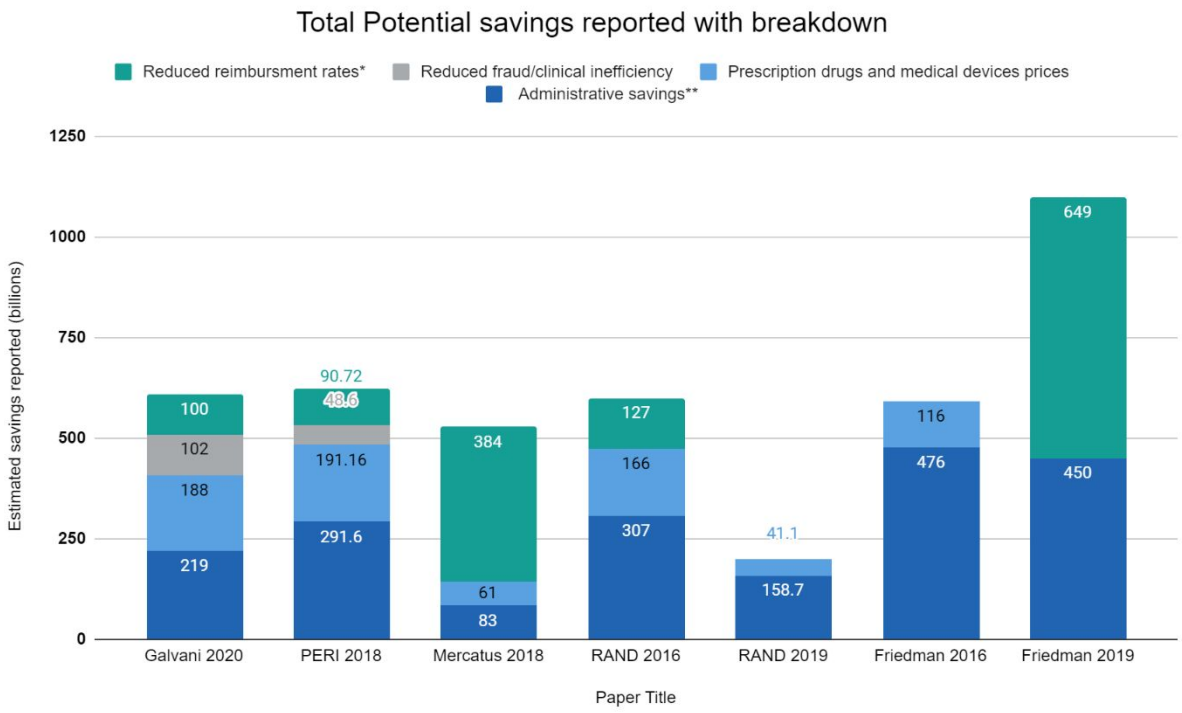
What are the current bills in Congress?

In S. 1129 Medicare for all introduced by Senator Bernie Sanders, a fee-for-service system is utilized such that for every pill, procedure, or test run there is a separate bill. This incentivises providers to increase the amount of care received because they, in turn, will be paid more for it, this money can then be used however hospitals deem fit.

- More information re: S. 1129

The house version of the bill H.R. 1384, introduced by Pramila Jayapal, uses a global operating budgeting system for institutions that separates capital costs such as renovation and expansions. Individual providers are then paid on a fee for service basis without value based payment adjustments

- More information re: H.R. 1384



**Reimbursement rate differs from study to study.*
***includes both reduction of hospital BIR, and elimination private insurance administration*