Medicare for All: Beyond the Politics

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The Covid-19 pandemic has been a stress test for the U.S. health system and has demonstrated to us the following weaknesses:

1) For many Americans (50-60%), their health insurance is tied to their employment. This was an outgrowth of WWII wage controls.

2) Public health is mostly public, Health care is largely private. Hence, service coordination and financial incentives are not well aligned.

3) Fee-for-service payment to hospitals and clinics does not work well in the midst of a pandemic.

4) Certain populations have much poorer health outcomes from Covid-19.

Jim -

This all sounds logical enough, but we could never afford Medicare for All and there is no way to pay for it.

A Review of Reports on the Cost and Funding of Medicare-for-All

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What is Medicare-for-All (M4A)?

- A new way to organize funding for all US health care, public health and related activities
- All payments to hospitals & physicians would come from the federal government
- All Americans would be covered
- No co-payments or other cost-sharing
- New benefits would be added to the list of benefits now provided by Medicare
- A single, unified national health budget
- Further details in H.R. 1384 and S. 1129

Assumed in this talk

- The US needs Medicare-for-All (M4A)
- Principal reasons to enact M4A
  - ¬ To improve the health of Americans who are now uninsured or underinsured
  - ¬ To spare everyone financial hardship caused by the need for health care

Aim of this talk

- Not to make the case for M4A
- The aim is to provide an answer to a statement commonly made in discussions of M4A:

  “This all sounds logical enough, but we could never afford Medicare-for-All and there is no way to pay for it.”

Questions to be answered in this talk

1. How much will US health care cost under M4A?

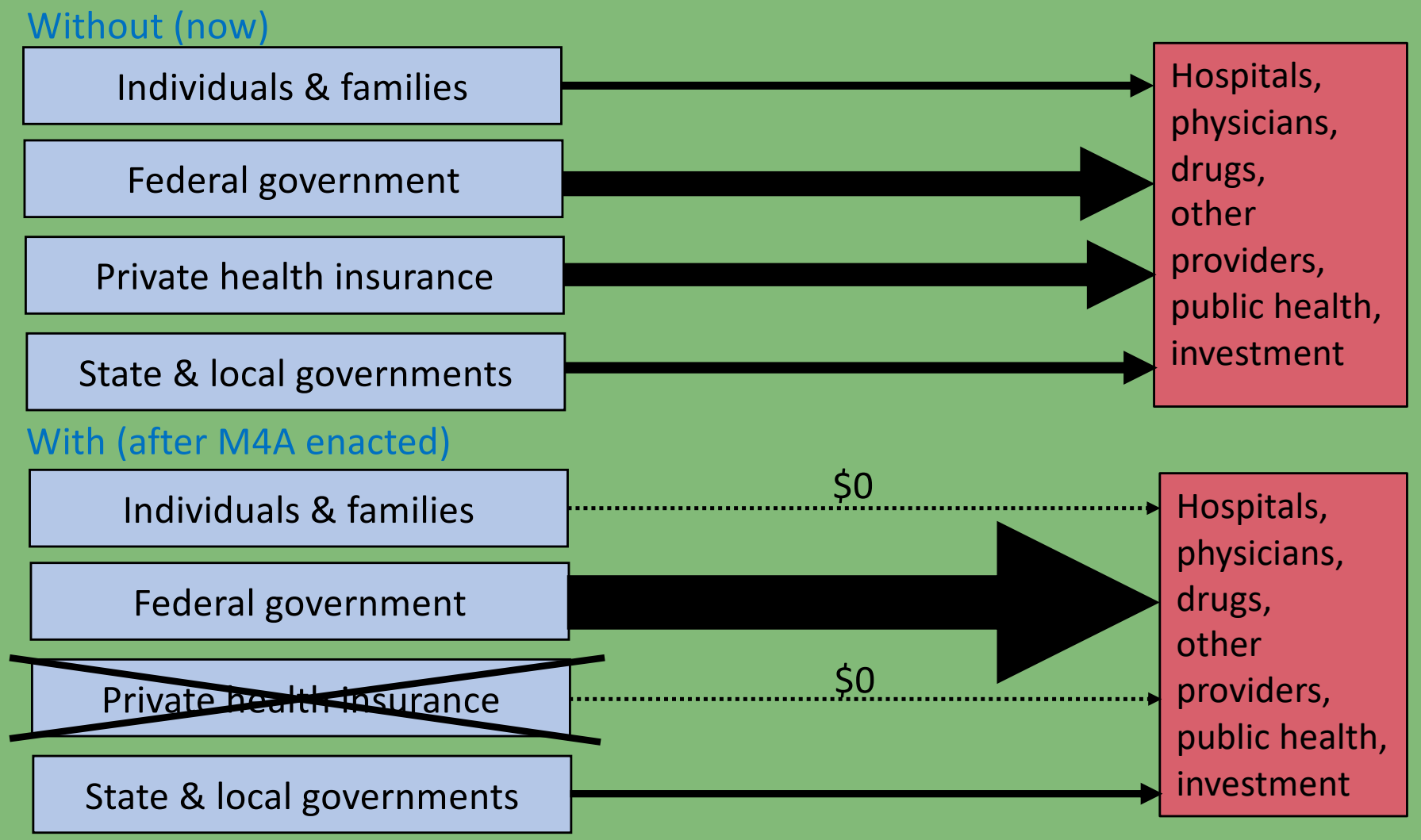
2. How much new federal revenue will be needed to replace money that will cease to come from households and insurance companies?

3. How might this revenue be raised?

“Cost of M4A” invites confusion

- The phrase “Cost of M4A” echoes the phrase “cost of Medicare”
- Medicare was an addition to US health care; it had a cost, which increased the cost of US health care
- M4A is not an addition; it is a replacement of the whole
- Under M4A, US health care might cost more or less than it does now, but there will not be an add-on cost because nothing is being added

Flow of payments without & with M4A*



* Other payers not included here: employers paying providers directly, private sources (philanthropy)

Methods of the review

1. Identify reports that answer the 3 questions
2. List their methods, assumptions, and conclusions
3. Evaluate the reports and set aside any with deficiencies important enough to warrant not including them in answering question 1
4. Average the %-age change (increase or decrease) under M4A reported in the reports that are not set aside

5. Using CMS's projection for the cost of health care under the current system, calculate what the cost would be under M4A
6. Identify all current revenues that would continue under M4A ("old revenue")
7. Calculate new federal revenue needed by subtracting old revenue from the cost of US health care under M4A
8. List possible taxes & fees that could be used to raise the new revenue
9. Select taxes & fees sufficient to provide the necessary new revenue

Reports identified (2003 onward)

- Thorpe, 2016
- Blahous (Mercatus Center), 2018
- PERI (Pollin), 2018
- Friedman, 2019
- Urban Institute, 2019
- RAND, 2019
- Yale (Galvani), 2020

Methods of the reports

- All of the reports seek to take into account the factors that could increase or decrease cost under M4A
- All but the Urban Inst. report begin with CMS's projections and modify them for these factors
- The Urban Inst. report uses instead a computerized microsimulation model
- All reports make assumptions about key factors affecting cost change: utilization, insurance administrative cost, drug cost, hospital and physician payment

Areas of potential savings with M4A

- Elimination of private insurance administrative expense, replaced by M4A administrative expense
- Reduction in prescription drug expense, achieved by negotiation between M4A and pharma
- Decreases in payments to hospitals and physicians, achieved by M4A by fiat

Assumptions of the reports

- Utilization:

  +2.9% (Friedman), +3% (RAND), +8% (Yale), +10% (Thorpe), +11.3% (Blahous), +12% (PERI), not stated (Urban Inst.)

- Insurance administrative expense with M4A, vs. current 2.3% for Medicare & 13.2% for private insurance:

  2% (Friedman), 2.2% (Yale), 3.5% (PERI), 4.3% (Thorpe), 5.3% (RAND), 6% (Blahous & Urban Inst.)

- Decrease in drug costs:

  10% below Medicare (RAND), -16% (Blahous), -0% (PERI), 40% below Medicare (Yale), not stated (Thorpe & Urban Inst.)

- Hospital payment:

  Medicare rates (Blahous, PERI & Yale), Medicare + additional (Thorpe, Friedman, Urban Inst. & RAND)

- Physician payment:

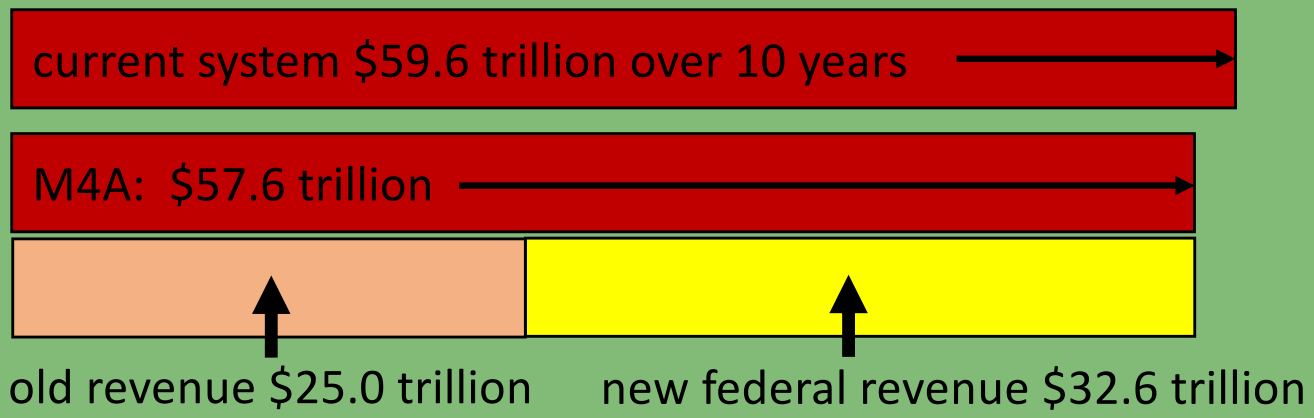
  Medicare rates (Blahous, PERI, Friedman, Urban Inst., Yale), Medicare + 7% (RAND), not stated (Thorpe)

Range of conclusions in the reports

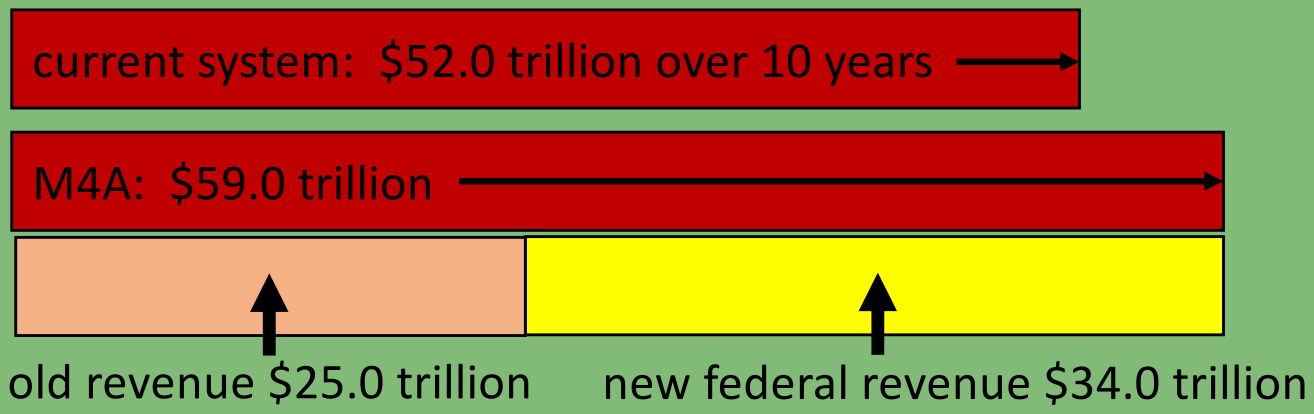
- Change in cost of US health care in first year with M4A:
  -20.0% (Friedman) to +20.6% (Urban Inst.)
- Cost of US health care over 10 yrs. with M4A:
  $37.2 trillion (Friedman) to $59.0 trillion(Urban Inst.)
- Change in cost over 10 yrs. with M4A:
  -20.6% (Friedman) to +13.5% (Urban Inst.)
- New federal revenue needed over 10 yrs.:
  $13.5 trillion (PERI) to $34.0 trillion (Urban Inst.)

Cost of M4A ≠ new revenue needed

- Blahous



- Urban Institute



Conclusion about M4A's effect on cost

- Critique of reports*
  - ¬ Friedman: minimizes utilization increase with M4A, exaggerates private insurance administrative cost
  - ¬ Urban Institute: highly implausible conclusion about utilization increase
- Changes in 1-year cost in the remaining 4 reports
  - ¬ Yale: -13.1%
  - ¬ PERI: -9.6%
  - ¬ Blahous: -2.0%
  - ¬ RAND: +1.8%

  Average of these reports: -5.7%

* Thorpe report does not include cost estimates

Cost of US Health Care 2019-2028

- Without M4A cost would be $49.0 trillion, according to CMS
- M4A would reduce the cost by 5.7%
- Thus the cost with M4A would be $46.2 trillion

Continuing revenue (old revenue)

For 2019-2028, these revenues will continue:

- $18.4 trillion from the federal government for clinical care & public health (+ more below)
- $1.0 trillion from state and local governments for public health (+ more below)
- $2.3 trillion for “investment” from various government and private sources
- $1.0 trillion from “other third-party payers”

Total continuing revenue: $22.6 trillion

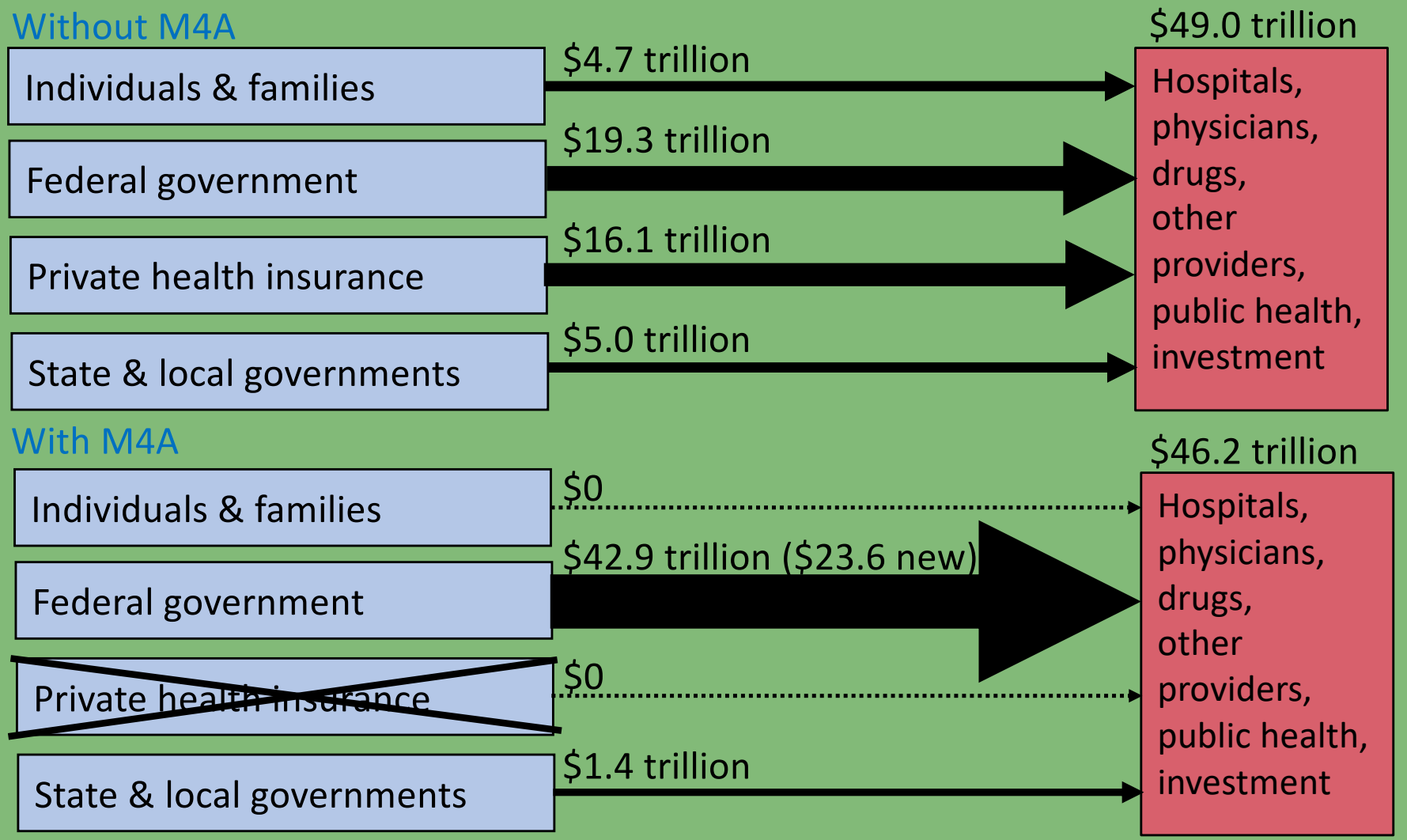
New federal revenue needed

Cost of US health care 2019-2028: $46.2 trillion

Old revenue: - $22.6 trillion

New federal revenue needed: $23.6 trillion

Flow of payments 2019-2028*



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Possible sources of new federal revenue

- Increased tax on ordinary household income
- Increased capital gains tax
- Employer or employee payroll taxes
- Federal sales tax or value-added tax (VAT)
- Increased corporate income tax
- Fees paid by large financial institutions based on their covered liabilities

Etc., etc.

Concluding comments

- How much will M4A cost? Short & accurate answer: Nothing.
- Under M4A, US health care will cost less than we now pay. We are overpaying by 5.7%
- Because households & insurance companies will pay $0, new federal revenue will be needed to cover what they pay now

- This new revenue is NOT the cost of M4A. Since M4A is the whole of US health services, its cost is simply the cost of US health care.
- Cost is not a barrier to adopting M4A
- The barriers are fear of the unknown and the threat of disruption
- The political road ahead will be difficult, but we can stop talking about cost

Further reading

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