THE PATH TO MEDICARE FOR ALL

Recommendations for a well-designed plan: A report of the American Council to Advance Medicare for All

ACAMFA

American Council to Advance Medicare For All

Executive Summary

Introduction

In 1990, our national healthcare expenditures were $1.1 trillion. By 2016 it rose to $3.3 trillion; it is predicted to increase to $5.5 trillion by 2022. And despite having outstanding providers, superb research facilities and rapid development of innovative treatments, by all measures our health is worse than every other advanced country in the world. Unfortunately, all our attempts to improve efficiency and decrease costs have only resulted in the most expensive healthcare system. Healthcare currently takes up 26% of the federal budget and interest on our national debt of $21 trillion consumes another 6%. With a current budget deficit of almost $800 billion and healthcare spending growing faster than the gross domestic product (GDP), healthcare costs and interest on the debt will both increase to levels that will overwhelm the federal budget. According to the Congressional Budget Office (CBO) government debt has doubled in the past 10 years and will increase from 18% to almost 100% of gross domestic product (GDP) by 2028. The risk of unsupportable healthcare costs—to the point of financial collapse—is no longer a possibility, it is inevitable if our current system is not changed. Healthcare costs are now one of the most common causes of severe financial distress and personal bankruptcy. And over 25% of adults in the U.S. report they delayed or did not get healthcare because of the cost. How many people will be unaffected by 2028?

Despite the failure of the U.S. to provide healthcare coverage to 20 million people, other countries that cover 100% of their population have better health outcomes. This attempt in the U.S. to reduce costs by providing less coverage, as we will show, is inefficient and actually makes costs higher. The solution is to do the opposite—to provide health insurance for everyone and to go further by eliminating patient cost-sharing. This potential solution has been overlooked by policy experts because they believe it to be either too expensive or politically impossible to achieve. We show that neither belief is warranted. We show that an appropriately designed *Medicare for All* program will deliver the best outcomes for the population with the most effective cost control. *Medicare for All* can achieve benefits for all Americans and will therefore be able to gain the broadest acceptance throughout the community. Our current system contains so much waste and counter-productive spending that the money to fund *Medicare for All* can be easily obtained.

We have examined the proposals in Congress for Medicare for All, the House and the Senate versions, both of which have some shortcomings. We found that the Senate version can serve as a basic structure on which to base a well-designed *Medicare for All* plan. In addition, we have reviewed proposals for financing *Medicare for All* and have found some ideas suggested by Senator Sanders to have merit. We make recommendations that will create a *Medicare for All* plan with

affordable costs for health insurance coverage for individuals, businesses and government. Everyone in this country will benefit.

Key elements of a well-designed *Medicare for All* plan

- Eliminates all deductibles and copayments ensuring equal access to care and reducing costs by improving compliance with cost-saving care and reducing medical problems associated with chronic diseases.
- Ensures competitive premiums during transition, adjusted according to household income, by subsidizing them from healthcare savings.
- Ensures freedom of choice for patients and doctors.
- Reduces costs for all levels of government, businesses and individuals and provides other significant economic gains.
- Includes coverage for all services that improve health outcomes and reduce overall costs of care.
- Requires no new government bureaucracy.
- Reasonable transition period with provisions to encourage individuals to switch to Medicare allows time for adjustment and for savings to accrue.
- Enlists doctors in cost control by making them more aware of the relative value of services they order.
- Makes all health insurance secondary to Medicare instead of making duplicate insurance illegal—this makes the private insurance industry easier to maintain and relieves the burden of enforcement.
- Specifies the mechanism for claims processing by private insurance companies and provides increased funding for the higher volume of claims.
- Budgets for investments in education, training and infrastructure required for the program to succeed.
- Providers, the pharmaceutical industry and the insurance industry will be more secure compared to continuing our current course and their disruptions will be minimized.

The Problem

Despite the $3.3 trillion spent for healthcare in 2016 we have a lower life expectancy and higher mortality from treatable chronic diseases than any other advanced country. And while most wealthy countries cover almost 100% of their populations with much lower spending, almost 10% of the U.S. population has no health coverage. And although the U.S. has some of the most advanced medical technologies in the world, access to these technologies becomes more limited each year. We have unsuccessfully tried to fix our healthcare delivery system with piecemeal approaches. To have the kind of healthcare system that we should have—with accessibility, affordability and effectiveness—will require an entirely new system.

We looked at several possible solutions and found that all had serious problems. The systems used in Canada and Great Britain are more efficient than ours but

require strict government control of budgets and sometimes limit access to timely care. Those systems were also developed many years ago when healthcare was much simpler. It would be much more difficult to develop the tools our country would need to manage a system like those in these complex times. Although the Affordable Care Act (ACA) was a major advance, providing healthcare coverage for millions of people who never had it before, it has done little to restrain costs or improve efficiency. We looked at the previous proposal before the U.S. House of Representatives, H.R. 676, 2015 (*Medicare for All*) and found a number of drawbacks. It had all the problems of Canada's system, requiring a bureaucracy that does not now exist and will be difficult to create and, by eliminating virtually all private insurance, severely impairs Medicare's billing system, which is currently contracted out to private insurers. In addition, it would likely cause significant disruption of the economy with its rapid timetable for enactment. It also requires unexplained new taxes to pay for its costs. It does have some elements, however, that are worthy.

The newest proposal in the House, H.R. 1384, (*Medicare for All Act of 2019)* improves on H.R. 676 but retains most of its disadvantages, including eliminating most private insurance, an inadequate transition period, reliance on national budgets for cost control, and a failure to account for costs and savings.

We found the Senate version of *Medicare for All*, S. 1804, 2017, to have some attractive features, especially its 4-year transition and lack of additional bureaucracy. However, it had a number of problems that also needed to be addressed. We found the structure of S. 1804 provided a good starting point for a practical *Medicare for All* program. Senator Sanders introduced a revised version of this plan in May 2019, S. 1129, 2019. The only major change introduced in S. 1129 is the inclusion of home-based long-term care coverage in Medicare instead of Medicaid. However, the plan he proposed for financing *Medicare for All* during his campaign for presidency included reasonable concepts for basing individual premiums on household income above an initial threshold and similarly basing employer premiums on payroll above an initial threshold (although the amounts he used are unrealistic without resorting to other sources of revenue). [*]

Although the new versions of *Medicare for All* in the House and Senate are somewhat closer to each other than the previous versions were, major differences remain. Both bills still lack details essential for implementation. For simplicity, we present some recommendations here based on the previous version of the Senate bill, S. 1804, 2017. We consider these recommendations to be important considerations for an improved, well-designed *Medicare for All* plan.

[*]His financing plan specifically calls for individuals and employers to pay premiums as an option. He does not mention continuing payroll taxes, but since he does not account for the loss of $1.4 trillion in revenue over 10 years, we assume that his plan also assumed that these would continue.

Recommendations for a well-designed *Medicare for All* plan:

1. **Encourage Medicaid expansion during transition.** The current formula for federal sharing of Medicaid expenses will be changed from one based on income level of a state's residents to one based on the percentage of residents eligible for Medicaid under ACA expansion who are actually enrolled, using enrollment status before enactment of ACA as a baseline. This more correctly aligns the incentives of the state and federal governments. The federal share for previous enrollees would vary proportionately from 40% for no expansion to 60% for full expansion. New enrollees would continue to receive 90% federal sharing. The exemption allowing 90-day temporary insurance (or longer policies) will also be repealed. **Rationale**: Too many households will have inadequate healthcare insurance, both during transition and after full implementation, without full expansion of Medicaid.
2. **Allow private health insurance after implementation.** All private health insurance will be *secondary* to Medicare. Providers will have *no* obligation to file secondary claims on behalf of patients or provide any information other than a receipt with complete description of services provided. The provider will be responsible for ensuring that sufficient information is provided to Medicare so that the patient receives an explanation of benefits from Medicare promptly. Workers' Compensation, no-fault and all liability medical loss coverage will be secondary to Medicare. This will avoid confusion about responsibility for payment and ensure prompt treatment and provider reimbursement. There will be no need to have any of these policies reimburse Medicare for covered expenses. Instead, their costs will decrease. **Rationale**: Making duplication of Medicare coverage illegal, as in other plans, would cause a regulatory burden that would be difficult to enforce. It would also require elimination of many current policies and does not address delayed reimbursement and lack of access to care related to confusion about who the primary payer is. Although *Medicare for All* will significantly reduce out-of-pocket costs for individuals, there will still be out-of-pocket costs for some of the new additional services that will be covered only within limits (see below). Since premium costs will also be lowered, a market for secondary insurance will be guaranteed.
3. **Medicare billing.** Claims for Medicare will continue to be billed by contract with private insurance companies. Due to the increase in volume of claims and the increased importance of Medicare billing as a component of private insurance company business, the administrative budget for Medicare will be *increased*. One part of this increased budget will be for increased payments for the contracts to private insurers. **Rationale**: This will ensure continued access to quality claims processing.
4. **Medicare Advantage Plans.** Standard Medicare will be adding new benefits each year during transition. Therefore, Medicare Advantage Plans (Part C) will be required to inform all current and future enrollees of the differences in benefits offered between Medicare Parts A, B, and D, and Medicare Part C, including any additional restrictions, such as pre-approval requirements and restrictions on use of providers. Incentives for Part C may be revised by the Secretary to ensure program goals are met. **Rationale**: Part C plans currently

extract savings by negotiating lower rates from providers, reducing patients' choice of providers and increasing costs to patients. The Medicare Payment Advisory Commission (MedPAC) notes the costs to the Medicare program are 4% higher for Part C plans than for standard Medicare. Part C plans detract from the value of *Medicare for All* by increasing administrative complexity. Their administrative costs are much higher than standard Medicare (19.4% vs. 2.7%). Their value to patients is likely to decrease considerably throughout transition and after full implementation. Patients should be given all the information required to make the choice that is best for them. The Secretary should be given the authority to ensure, at the least, that Part C plans save Medicare money, if they are continued.

5. **Drug benefits**. Eliminate Part D as a separate benefit and include drug reimbursements in Part B as of the first day of transition. **Rationale**: Part D plans extract savings by negotiating discounts from drug companies. The Medicare trustees note that the bulk of savings from price reductions negotiated by Part D plans is retained by the plans, resulting in higher costs to the Medicare program and its beneficiaries. Part D plans also detract from the value of *Medicare for All* by increasing administrative complexity. However, Medicare may want to continue to contract with a Part D facilitator or with a pharmacy benefit manager on a competitive basis to administer the drug benefit on a cost-efficient basis. There is also no reason why several sponsors and/or managers could not achieve this goal in different regions, as long as there is one coordinated approach to drug benefits across the country.
6. **Transition of Medicaid services to Medicare.** Transfer all Medicaid services, including long-term care and home health care, from Medicaid to Medicare by the implementation date. At full implementation, Medicaid and CHIP will be discontinued as separate benefit programs. Payments for services for everyone on Medicare, regardless of original service plan, will be equal, although additional benefits may be available to those eligible for Medicaid and CHIP. Anyone eligible for Medicaid or CHIP will have, at a minimum, the same benefits under *Medicare for All* as they had previously (e.g., subsidized premiums, transportation costs reimbursed, additional dental services covered). Eligibility criteria for these supplemental benefits will be uniform, regardless of state of residence and will be determined by the Secretary in accordance with expanded access under the ACA. **Rationale**: Using a separate system to pay healthcare costs for the disabled and low-income families leads to reduced access to care, poorer health and, as a result, higher costs. Different criteria for coverage and reimbursement depending on state of residence allows for too much variability in the quality and cost of care and difficulties accessing care out-of-state. Inclusion of long-term care is critical to lower costs. Patients who have access to nursing home care have shorter hospital stays. Patients whose nursing home care is paid for without a skilled need use fewer physical therapy visits and other skilled care. Patients with access to personal care at home use fewer nursing home days. Medicaid and CHIP also have higher administrative costs than Medicare does (10.9% vs. 7%).
7. **Cost control.** Beginning with year 2 of transition, the Secretary will develop a Sustainable Health Index Fund Target (SHIFT) to measure the average cost of

services ordered by providers exclusive of their own fees, including imaging, laboratory, drugs and medical devices. The information will be collected into quarterly reports and forwarded to providers with comparisons to their peers. Significant outliers, adjusted for patient mix, may be considered for targeted chart review by CMS, which may result in suggested changes in practice and/or further follow-up. In addition, reports may be forwarded to appropriate medical specialty societies to assist with their own educational programs on value-based medical care. This will replace any specific national budgets and will replace the current Merit Based Incentive Payment System (MIPS). We recommend using Germany's model as a fair way to negotiate drug prices.

8. **Rationale**: SHIFT will ensure that providers help patients make the best choices regarding the value of care received by giving them relevant information about costs. SHIFT will also provide motivation to keep drug prices in line with value. A most favored nation approach to drug pricing will allow drug companies to continue high-quality research and development to provide innovative products while spreading the cost more fairly around the world.
9. **Funding.** The current funding process for Medicare will remain unchanged during transition, except that a new Medicare **Part E** Plan will be created to fund costs for those newly eligible as of the first day of transition. The Secretary will also be authorized to use surplus Part A funds (as determined by the Congressional Budget Office) to provide additional funding to Part B and/or Part E services as necessary to achieve the highest standards of care, including ensuring adequate reimbursement for underserved specialties, such as primary care, mental health and addiction services, with the advice of the Directors of the National Institutes of Health and the Centers for Disease Control and Prevention. **Rationale**: Changing the funding to a universal fund has its attractiveness, but we feel the less that is changed initially the better. Retaining Medicare Part A as a separate fund allows for continued funding of hospital and hospice payments while program costs and savings are assessed. Giving control of the flow of funds to the Secretary, after appropriate consultation, minimizes the risk of Congressional changes based on political expediency. However, after transition, creation of a universal fund may be desirable.
10. **The following are recommendations for the four-year transition plan:**
    a) **Eligibility.** All adults age 18-64 will be eligible for Medicare beginning the first day of transition (Enhanced Eligibility Medicare—EEM). Dependent children will also be eligible. **Rationale**: Making everyone eligible for Medicare from the first day of transition will improve the effectiveness of the transition to a balanced patient population.
    b) **New services.** A new coverage benefit for patient education by nurses, nutritionists and other health professionals will be available beginning with the first year of transition as will dental services (preventive care, fillings and extractions) and vision (up to one refraction and one pair of glasses each year, as medically necessary). Long-term care will be added by year 2 and hearing (up to one pair of hearing aids with audiologist follow-up for one year, with replacements every 5 years, as medically indicated) by

implementation. **Rationale**: Early addition of these new services will make it more attractive for people with private insurance to transition to Medicare. The time course of added services is based on a combination of benefits and costs.

c) **Copayments** will be gradually reduced each year from 20% to 15%, then 10%, then 5%, then eliminated. **Rationale**: Some cost-sharing during transition will be needed to reduce program costs as savings accrue, but all coinsurance will be eliminated by the time of full implementation due to their discriminatory nature and lack of effectiveness in affecting behavior appropriately. Cost-sharing is a major barrier to care that must be eliminated to enhance cost savings by other methods.

d) **Tax exemptions** for employer-sponsored health insurance premiums and tax deductibility for other private health insurance will be gradually decreased during transition to 90% in year 1, 75% year 2, 50% in year 3, 25% in year 4 and eliminated after implementation. **Rationale**: This will encourage the move from private health insurance to Medicare during the transition. These tax subsidies will be diverted to help pay for additional services for everyone.

e) **Health Savings Accounts**, Health Reimbursement Accounts and Flexible Savings Accounts will be eliminated as of the first day of transition. **Rationale**: These arrangements are designed to offer tax savings that supplement health insurance plans with high deductibles. They unfairly favor those with higher incomes and lack transparency.

f) **Premiums.** During transition, the Secretary will be authorized to calculate premiums for Part B and EEM to ensure that they are both affordable and sufficient to maintain program integrity. Premiums for children will be 40% of adult premiums. The Part B premium paid by those eligible for standard Medicare will be calculated by adding a small cost to account for elimination of deductibles and copayments and the average current Part D premium. EEM premiums will be calculated by the Secretary to be not significantly above the current cost to individuals available through an employer, considering the additional coverage offered. *After transition, premiums will be calculated as 5% of household adjusted gross income, after excluding an amount equal to 138% of the federal poverty level.* Premiums for workers on payroll will be billed through payroll deductions. Individuals not on payroll deduction or Social Security may be given the option to pay premiums monthly or to have an annual amount calculated as an addition to their income tax at the end of the year, which will be the default. Low-income individuals will be eligible for subsidies that will lower or eliminate their premiums (see below). **Rationale**: This will ensure that *Medicare for All* does not have the same problem that the ACA has been plagued with—the inability to attract people who want adequate coverage at an affordable price. *Medicare for All* will be competing against the health insurance plans available through employers, which are now subsidized both by employers and by the federal government (since they are tax exempt). These plans are getting more expensive for both employers and workers and harder to

sustain, but *Medicare for All* must be able to provide coverage at a cost to workers that is reasonably close to the same price.

g) **Premium reductions** (*not tax credits*) during transition will be available for EEM for all families with incomes <400% federal poverty level, using the same guidelines as the ACA, as appropriately amended to include the "coverage gap," during transition. (When the ACA was written, it was assumed that anyone with a family income below 138% of federal poverty level would receive Medicaid, since they would qualify for coverage under the expanded ACA guidelines. It was not anticipated that some states would resist accepting 90-100% federal cost-sharing for these families and not expand their Medicaid coverage. This left some families with children with incomes as low as 17% of federal poverty level without coverage and those without children ineligible for Medicaid regardless of income. The ACA provided premium subsidies for families with incomes between 138% and 400% of federal poverty level, but not lower.) After transition, the calculation based on income excluding the threshold below 138% of federal poverty level will ensure affordability for all. **Rationale**: Low-income households cannot afford to wait for tax credits. It is more appropriate to reduce their premiums.

h) **Employers** will continue to pay premiums for their employees newly enrolled in EEM during and after transition, just as they pay for their private insurance. However, the total premiums will be much lower. Employers will pay 6% of payroll after the first $500,000 as opposed to the current average of 8.3% of total payroll. In addition, small businesses (with fewer than 100 employees) have an average payroll of $300,000 so very few of them will pay any premiums at all. Currently, about 53% offer health insurance for their workers at an average cost of 8.3% of payroll. In addition, payments for Medicare Part E premiums will be authorized on unearned income similar to the current Medicare Part A tax on unearned income (for filers above set income levels) at the rate of 5%. Medical care under workers compensation will be covered by Medicare, reducing the cost of workers compensation to employers. **Rationale**: It is reasonable for employers to continue to take some responsibility for the health of their workers during and after transition. Employers need their workers to be healthy and productive. Employers' costs will be much lower than the amount they currently pay. Exempting the first $500,000 of payroll will ensure that all businesses will be able to afford even these lower costs. Concerns about rising costs will be eliminated. Payments on unearned income will prevent an unfair burden on workers and avoid the shifting of income from payroll to investment income merely to avoid payments.

11. **Budgets.** Although we do not recommend a global health care budget, we do recommend the Secretary be given authority to recommend specific budgetary expenses to promote improved healthcare utilization. The specific recommendations included here are initial recommendations that should be reviewed at least every 5 years by the Secretary with input from the Congressional Budget Office and the Center for Disease Control and Prevention (CDC).

a) **Increase funding for biomedical research, including healthcare outcomes research, through the NIH.** We recommend increased research funding beginning with the second year of implementation, increasing to $15 billion by implementation. **Rationale**: Private companies should not bear the burden of research costs for healthcare. Research geared to the needs of the nation, rather than company profits, need to be prioritized.

a) **Funding for advanced practice clinician support.** This should include methods to encourage states to allow increased privileges for advanced practice clinicians (nurse practitioners and physician assistants). We recommend funding beginning with the first year of transition, gradually increasing to $15 billion at implementation and thereafter. **Rationale**: There will be an increased need for clinical services with improved access to care. Advanced practice clinicians are a valuable and cost-effective means to provide those services.

b) **Increase funding for graduate medical education.** This should include loan forgiveness programs, with an emphasis on encouraging increased numbers of primary care providers, dentists, mental health providers and addiction specialists starting during transition, increasing gradually to $15 billion at implementation and thereafter. **Rationale**: This will provide a method to encourage career choices that meet community needs while simultaneously reducing the burden of educational debt faced by many practitioners.

c) **Provide funding to support other professionals.** In anticipation of shortages of trained clinicians due to improved reimbursement and access we recommend funding to support other professionals providing patient education in doctors' offices (such as nurses and nutritionists). We recommend funding beginning with the first year of transition, gradually increasing to $15 billion at implementation and thereafter. **Rationale**: This is a missed opportunity for considerable cost savings. These services are currently bundled into physician services, limiting their availability since it requires physician practices to pay extra for services for which they receive no additional reimbursement. The physician practice effectively loses money when it provides these services even though the patient benefits from them. These services lower healthcare costs by improving patient compliance, reducing physician visits, procedures, emergency room visits and hospitalizations.

d) **Provide funding for job training.** We recommend a specific allocation for healthcare administrators in insurance and providers' offices for job training for workers who may need to change jobs, beginning during transition, increasing to $15 billion at implementation and continuing for another 5 years. **Rationale**: Changes in the need for administrative personnel will be inevitable under *Medicare for All*, which is designed to lower administrative complexity.

a) **Provide funding for a Home Health Corps.** We recommend a new nationwide Home Health Corps be developed and funded beginning during transition, increasing to $15 billion at implementation and continuing

thereafter. **Rationale**: Increased access to care will increase the need for home health services, and more trained personnel will be needed. The funds will be allocated to help train, deploy and support these personnel.

As an additional cost control measure, we recommend a "Medical Products and Services Sunshine Act" that would require provider organizations, hospitals, health insurance companies, pharmaceutical and medical device companies and their lobbyists to report expenditures relating to any federally elected official or federal election campaign to the Federal Elections Commission, which would be required to report such contributions annually to the Secretary. This would become part of the information considered when the Secretary updates Medicare reimbursement rates for drugs and devices. **Rationale**: This will help guard against inappropriate political interference in healthcare policy, without limiting free speech.

A final measure we recommend to protect providers is an amendment to the Health Insurance Portability and Privacy Act. It would require all insurance providers, on request, to verify insurance eligibility with a termination date. A verification of insurance will serve as a guarantee of payment of any valid claim for services performed up to the termination date. **Rationale**: This will improve appropriate reimbursement to providers during transition by preventing insurance companies from inappropriately denying claims.

Key Cost and Savings Analysis of *Medicare for All* with proposed recommendations: It is reasonable to ask, "How can we pay for *Medicare for All* without raising taxes? The following is an outline of the estimated costs associated with implementing the major features of a well-designed *Medicare for All* program:

Costs for *Medicare for All*[*]

Provide Medicare to new enrollees:	about $1,600 billion
Increase Medicare administrative budget:	$20 billion
Cover short-term and long-term care:	about $270 billion
Cover dental, vision, hearing:	about $50 billion
Reduce coinsurance:	about $170 billion
Patient education by nurses and other health professionals:	about $15 billion
Increase basic and clinical research budget:	$15 billion
Advanced practice clinician training and support:	$15 billion
Other professional/dental training and support	$15 billion
Job training (up to 5 years after implementation)	$15 billion
Home health corps	$15 billion
Total costs over 5 years:	***about $2.2 trillion***

Where do we find the money needed to fund this program? By simplifying our healthcare system into one with less complexity we will be able to decrease waste and improve efficiency. The money is buried in the current dysfunctional U.S. healthcare system.

A number of features of our healthcare system are responsible for much of this waste. Its disjointed nature results in a lack of coordination of care. Patients may see multiple providers who have little or no communication between them. Electronic medical records are different from one office to another and one hospital to another. Tests performed may be reported to one provider and not another. These miscommunications lead to repeated and unnecessary services, inaccurate diagnoses and missed opportunities for preventing illness. Areas of the country that have more abundant supply of a particular service have higher utilization than other areas, without improvement in patient outcomes, only increased cost. The need for income also leads providers of all types—physicians, hospitals, home care services—to find ways to refer patients to facilities with which they are affiliated. Although the Stark Law limits these arrangements, there are exceptions that allow for continued excesses.

Simplifying our healthcare delivery into a less complex system will improve efficiency and create immediate savings. Here is a rough breakdown of some savings that can be expected:

[*] These represent additional costs compared to our current system assuming no other changes, including increases or changes in population or increases in healthcare costs over time.

Savings for *Medicare for All*[*]

Recover tax subsidy for private insurance premiums:	about $130 billion
Decrease cost of uncompensated care	about $60 billion
Decrease providers' administrative costs:	about $75 billion
Eliminate providers' excessive prices:	about $135 billion
Improve efficiency in detecting fraud and excess services:	about $300 billion
Improve efficiency of disease management and use of improved practice and payment models:	about $220 billion
Decrease hospital costs due to better access to care:	about $120 billion
Improve efficiency of negotiation of drug and device prices:	about $110 billion
Promote use of advance practice clinicians	about $40 billion
Use funds previously dedicated to other programs	about $450 billion
Total savings at implementation:	***about $1.6 trillion***

(About $150 billion in savings from decreased cost of providing insurance is included in the discounted cost of new enrollees.)

New premium contributions about $650 billion

NET SAVINGS APPROXIMATELY EQUALS NET COSTS
Annual savings after completion of job training support about $10 billion (beginning after transition)

We recommend businesses continue to pay a portion of their workers premiums during transition. However, they will pay only 5% of payroll (after the first $500,000) compared to the current average of 8.3%. In addition, since small businesses (with fewer than 100 employees) have an average payroll of $300,000, the vast majority of them will not have to pay any premiums (compared to 53% of small employers now paying premiums for their employees' health insurance). All businesses will be able to contribute to the health and productivity of their employees without having to worry about budgeting for rising healthcare costs or managing complex decisions about healthcare insurance. We also recommend that individuals currently subject to Medicare Part A tax on unearned income (those earning more than $200,00 for an individual or $250,000 for those filing jointly) should also contribute part of their unearned income to Medicare Part E premiums, at the rate of 5%. This is to ensure that those who have a significant source of unearned income pay their fair share into Medicare. In order to reduce bureaucracy, medical care provided for workers compensation claims will be covered by Medicare so premiums for this portion of workers compensation will be considerably reduced.

Additional Benefits of a well-designed *Medicare for All* plan: With net savings during every year of transition, *Medicare for All* would wind up with *cumulative savings* after expenses of almost $600 billion after transition

[*] Savings and net savings (after costs) are in comparison to our current system assuming no other changes, including increases or changes in population or increases in healthcare costs over time. True savings are likely to be much larger.

compared with our current system and over $630 billion 5 years later (we project $9 billion in additional annual savings compared to our current system during this time). Included in these calculations are costs for additional healthcare research, graduate medical education and training for nurse practitioners and physician assistants. The savings would be enough to support job training programs during transition and for the first 5 years after implementation. It would also allow for a major investment for development and support of a new Home Health Corps to ensure the availability of properly trained personnel needed to care for people in their homes, ensuring the expansion of this important job market.

Other benefits, not directly related to improving healthcare delivery, are immediately obvious. Private businesses will be relieved of over $240 billion in medical expenses with $136 billion going to small businesses. They will never have to worry again about rising healthcare costs. As a result, businesses will be better able to compete in the world market, provide more jobs to U.S. employees and increase wages. And employers will no longer be involved in decisions about what healthcare services are provided—decisions that never belonged in the workplace.

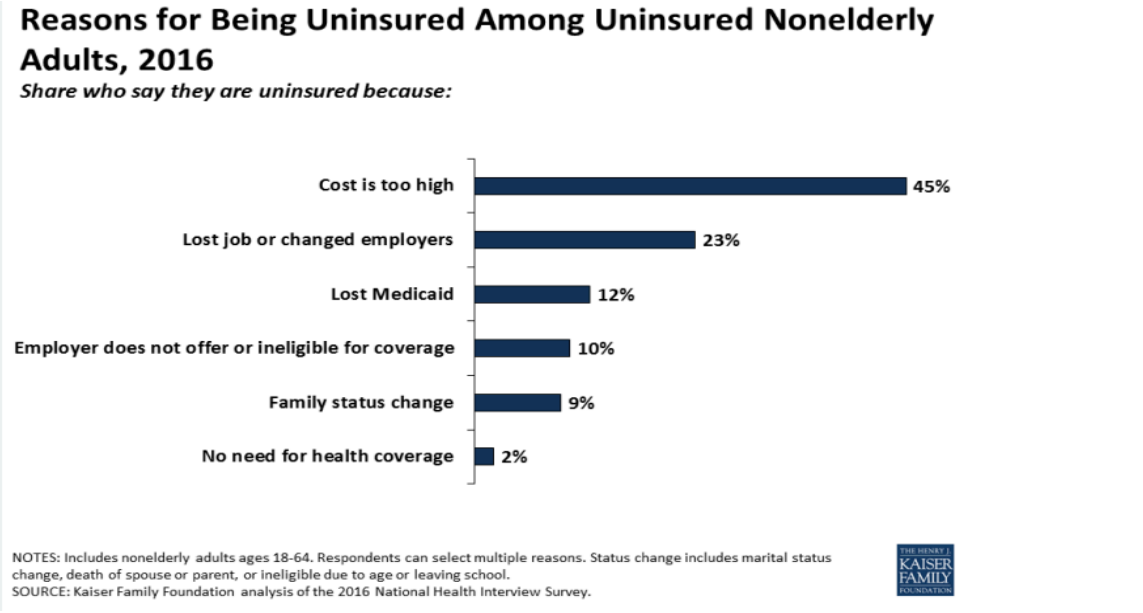
Other direct beneficiaries will be state and local governments. By eliminating the costs of Medicaid and CHIP completely from state and local governments, over $200 billion will be eliminated from their budgets. In addition, private health insurance costs for employees are a major item in virtually every state and local government budget. This includes not only government workers, but those paid indirectly by the government, such as teachers, police, firemen, legislators, healthcare workers and others. Total savings to state and local governments would be over $290 billion. The savings to individuals in state and local taxes will be significant. This could actually *increase* federal revenues through a decrease in personal deductions for taxes. (States would have more savings and lower taxes; individuals would pay less taxes, but relatively more to the federal government than to states than they do now.)

Related to this would be an overall improvement in the financial health of state and local governments. Benefit programs that are now in danger of default would have much lower medical costs (since all insurance would be secondary to Medicare) and their financial outlook would dramatically improve. State and local bond rates would likely improve as a result, further improving state budgets.

Individuals would have over $270 billion less in out-of-expenses. They could see other insurance premiums decrease as well. With Medicare as the primary insurer for all medical problems, medical liability insurance, such as for auto and homeowners' insurance, and workers compensation insurance premiums should all be lower.

Unlike the ACA, *Medicare for All* will truly provide affordable healthcare insurance for all. With *no* out-of-pocket costs and premiums for coverage that are *lower* than

the current average cost of a policy a worker can currently get from an employer* there will be no concerns about millions of people not wanting to pay for health insurance. Medicare premiums would be no more than current costs, but without deductibles or coinsurance. When asked why they do not have health insurance now, almost half say it is because the cost is too high. Only 2% say it is because they have no need for coverage. That amounts to less than 1 million people. It is clear that the overwhelming majority of Americans disagree with them.



Finally, everyone will benefit from the improvement in the healthcare system. With a healthier population and no barriers to care, productivity will improve. With better access to long-term care, including home care, family members will not need to take time off from work to care for the chronically ill. With medical care no longer a financial burden, the most common cause of financial distress and personal bankruptcy will disappear, improving the nation's economy. And we will have a less stressful nation.

Summary: The current U.S. healthcare system is facing rising costs that are unsustainable. Bowing to pressures to contain these costs, both public and private payers are reducing covered services, decreasing reimbursements and increasing premiums and coinsurance. The same pressures are driving an increasing number of hospital mergers and acquisitions resulting in patients having to pay more while reducing their choices. Despite this, costs keep rising. More people decide not to get needed care because they cannot afford it, worsening healthcare outcomes and intensifying the healthcare crisis in America. These problems are insurmountable

* Based on family coverage. Since insurers provide group policies to employers, they cannot charge different premiums to employees based on risk factors, such as age. However, they can charge different premiums for single and family coverage. Since single employees tend to be younger than married employees, their premiums are discounted and family coverage is disproportionately more expensive. Under *Medicare for All*, this imbalance would be erased.

if we maintain the current system of financing healthcare in the U.S. Our recommendations use many tools that are demonstrated to work in our current system. Our plan takes full advantage of a less complicated system to decrease wasteful spending and increase the savings that have been impossible to achieve in our current system.

When asked if they think health insurance costs for the average American is reasonable only 30% of those with private insurance from their employers said yes. And less than half said they thought most Americans be better off with the plan they have. Almost 80% think costs will go up in the next two years. That is a problem. So when the insurance industry says most people are satisfied with the plan they get from their employer, what does that really mean? Plans are getting more confusing—and many employees never have any health care visits for an entire year. Too often, only when someone gets a serious illness do they find out about hidden rules that result in treatment delays or large out-of-pocket costs. Most employees really have no way of knowing what they are paying for.

Our recommendations for a well-designed *Medicare for All* plan address a number of problems that will ensure lasting success of the program:

- Costs will be lowered for everyone: individuals, employers, government and providers.
- Comprehensive coverage that is critical to improved access to care and lowered healthcare costs will be ensured and offered early in the transition.
- Patients and providers will be guaranteed freedom of choice.
- Initiatives to ensure a gradual transition from our current system to *Medicare for All* will be ensured. There will be immediate availability of the program to all, a gradual increase in benefits, gradual decrease in government support for private insurance, and competitive premiums.
- No new administrative systems or bureaucracy and no changes to the health insurance industry structure will be required.
- Changes to our current methods for paying for healthcare are minimized during a reasonable transition period to clarify the importance of changing the method of funding and the amount of time needed to make the change.
- Specific plans for savings are addressed, including limiting the influence of lobbyists on healthcare costs.
- All costs and savings have been carefully evaluated and accounted for, with sufficient savings found to ensure that *Medicare for All* is affordable for everyone.
- Investments in education, training and infrastructure required for the program are budgeted.
- The costs of healthcare to the states and local governments will be reduced allowing for significant reductions in state and local taxes.
- The burden of medical care currently carried by employers will be drastically reduced.
- Additional benefits beyond healthcare alone have been evaluated.

The Path to Medicare for All: Recommendations for a Well-Designed Plan

Report of the American Council to Advance Medicare for All

BACKGROUND

Growth in healthcare expenditures

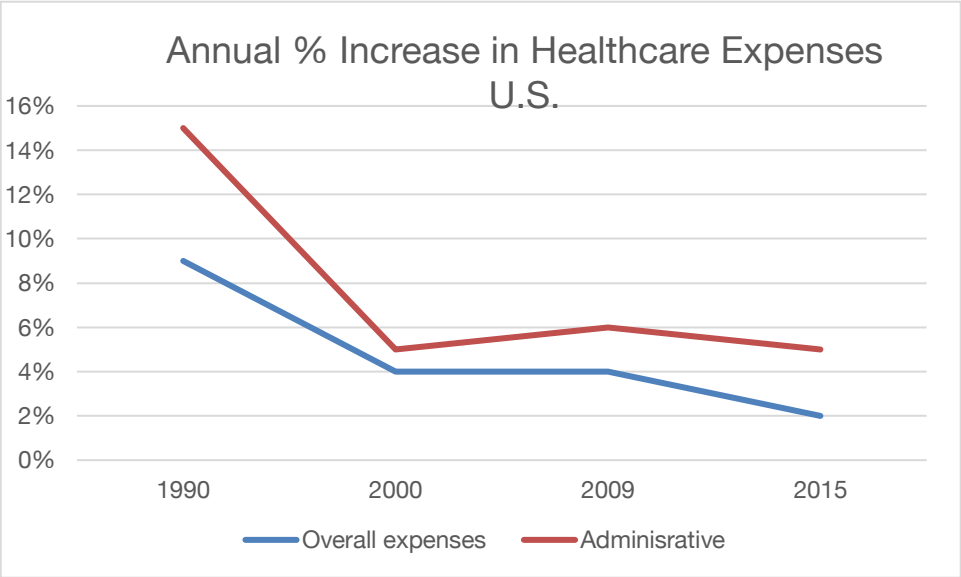
1) Total healthcare expenditures

Total healthcare expenditures have continued to grow faster than inflation, taking up more of our Gross domestic product (GDP) every year. Adjusting expenditures for GDP (using 2009 as a baseline) the Centers for Disease Control and Prevention (CDC) has shown an increase from $1.1 trillion in 1990 to $3.3 trillion in 2016. The rate of increase of growth has slowed more recently. From 1970 to 1990 it averaged 12% a year, whereas more recently it decreased to 5% and has now come down to 3% a year. But that is still 3% more than the rate of inflation. And healthcare expenditures are still expected to increase to $5.5 trillion by 2022.

We spend more on healthcare than any other developed country. And not just because of our larger population—we spend on average over $10,000 per person for healthcare, almost twice the amount in comparable countries. Spending this kind of money should buy us the best healthcare system in the world. But a recent study by the Commonwealth Fund ranked the U.S. last of 11 advanced countries in overall performance, mostly related to poor scores on healthy lives, equal access and efficiency of care. We have lower life expectancy and higher mortality from treatable chronic diseases than any other advanced country. Our prescription drug costs are higher than those of any other country and half of all Americans rely on prescription drugs as part of their healthcare. Over 25% of adults report that they delayed or did not get health care because of cost.

2) Drivers of growth

It is important to look also at healthcare expenditures per person, to make sure the increase in expenditures is not just due to population growth. In fact, for every range of years the rate of increase of healthcare expenditures per person has been somewhat lower than the overall increase healthcare expenditures. If we look at the individual categories of expenditures, the only one that has increased at a rate higher than overall healthcare expenditures is administrative expenses. Administrative costs have increased consistently more than overall expenses—from 2009 to 2015 the rate has been twice as high (6% vs. 3%; 5% per person vs. 2% per person).



3) Government share

The government pays the bulk of the nation's healthcare expenditures. In 2016, the Centers for Medicare and Medicaid (CMS) spent over $1.2 trillion of the $3.3 trillion in national healthcare expenditures. Other government programs, including the Veterans Administration, Bureau of Indian Affairs, Public Health services, general assistance, and many others, spent over $800 billion. The government also funded $30 billion in research through the National Institutes of Health.

4) Individual share

The amount individuals pay for health care is not completely calculated by the CDC. They monitor out-of-pocket costs, which include amounts paid by individuals without insurance, amounts paid for healthcare costs not covered by insurance and cost-sharing (copayments and deductibles individuals are required to pay when receiving care for covered services). These amounts totaled over $350 billion in 2016, about 11% of healthcare expenditures. Most individuals with insurance also pay premiums. These premiums are very variable and depend on whether coverage is obtained through an employer, in a non-group plan, through an Affordable Care Act exchange (see below), on the quality of the coverage and whether they cover an individual or a family. The average cost to individuals for single coverage for employer-based insurance is about $1200 a year and for family coverage about $5500 a year. In the Affordable Care Act exchanges, average costs, without subsidies, are about $2800 per individual covered. According to the Bureau of Labor Statistics, total spending on private health insurance premiums in 2016 was $327 billion.

The Current Health Insurance System

Medicare is provided for all individuals over 65 years of age. Some disabled individuals also qualify for Medicare. There are 58 million people in the U.S. who rely on Medicare for their primary source of health insurance.

Standard Medicare requires deductibles and co-payments. Part A covers the cost of hospitalization and hospice benefits. It is paid for primarily (88%) from payroll deductions paid by workers and employers over the years. Part B covers services in physicians' offices and most other services and is covered by premiums paid by individuals (25%) and from general tax revenues (73%). The cost of the premium depends on the individual's income. Part D covers prescription drugs not given in physicians' offices and is covered by a separate premium (14%), also priced according to income, general revenues (73%) and taxes on Social Security benefits (13%). Individuals also have to pay deductibles and copayments for each part (except for hospice benefits).

Medicare Advantage programs (Part C) account for approximately 30% of Medicare enrollees. Medicare Advantage offers some increased benefits but still requires some co-payments and fees. It also reduces choice and flexibility compared to standard Medicare. Billing is completely separate from standard Medicare as are the premiums, which vary according to the plan. Medicare Advantage plan participants pay whatever Part C premium the plan requires plus their standard Part B premium.

Medicaid covers individuals and families up to 138% of the federal poverty level (currently $20,783 a year for an individual, $35,218 for a family of three). However, eligibility for Medicaid varies from state to state. In states that did not expand eligibility under the Affordable Care Act (see below) the average income limit for eligibility is only 49% of the federal poverty level ($6,626 a year for an individual, $12,229 for a family of three) and in all but one state, only households with children are eligible for Medicaid. Almost 59 million people rely on Medicaid as their primary source of health insurance. Almost 12 million people have both Medicaid and Medicare (dual eligible). Those who are dual eligible will usually have their Medicare premium paid by the Medicaid program; they may also receive additional Medicaid payments for deductibles and coinsurance.

Medicaid reimbursement varies across the country. Reimbursement for physician services averages 72% of Medicare reimbursement. In New York, Medicaid reimbursement for physician services is 56% of Medicare rates. Reimbursement rates for long-term care in skilled nursing facilities, continuous care in other settings, personal care and some other care are more difficult to estimate due to complicated formulas in each state but are similarly variable and the difference from Medicare is probably similar. Reimbursement for inpatient hospital services is also variable and complex but is similar on average to Medicare reimbursement due to various subsidies.

CHIP (Children's Health Insurance Program) covers children whose families make too much money for Medicaid but cannot afford insurance for the child. There are 6.7 million children who receive benefits under CHIP in the U.S.

Employer insurance plans cover employees through a variety of group and individual plans. The coverage and responsibility for payment varies significantly.

Most employers who do offer health insurance offer it to all employees in order to comply with federal guidelines that allow them to deduct the cost of the insurance premiums from their taxes. Most employers now ask their employees to pay a portion of their health insurance premium: those premiums are also exempt from income tax. Currently, only 53% of employers offer health insurance. As of 2016, about 155 million individuals (workers and their dependents, including children) were covered by these plans.

Non-group insurance is private health insurance purchased by individuals who are not part of a group, such as employees of a company that does not offer insurance or those who are self-employed. This type of insurance has become more expensive and is now less common than before the Affordable Care Act (see below). It now covers about 3 million people.

The Affordable Care Act (ACA) provides for health insurance exchanges in each state. Individuals can purchase affordable insurance with mandated insurance coverage for ten key categories of health. It also provides subsidies to help individuals with incomes ranging from 138% to 400% of the federal poverty level ($20,783 to $60,240 a year for an individual; $35,218 to $102,080 for a family of three) pay for the premiums for these insurance policies . The amount of premium support varies depending on the income. Currently about 11.8 million people receive their health insurance through the ACA marketplaces.

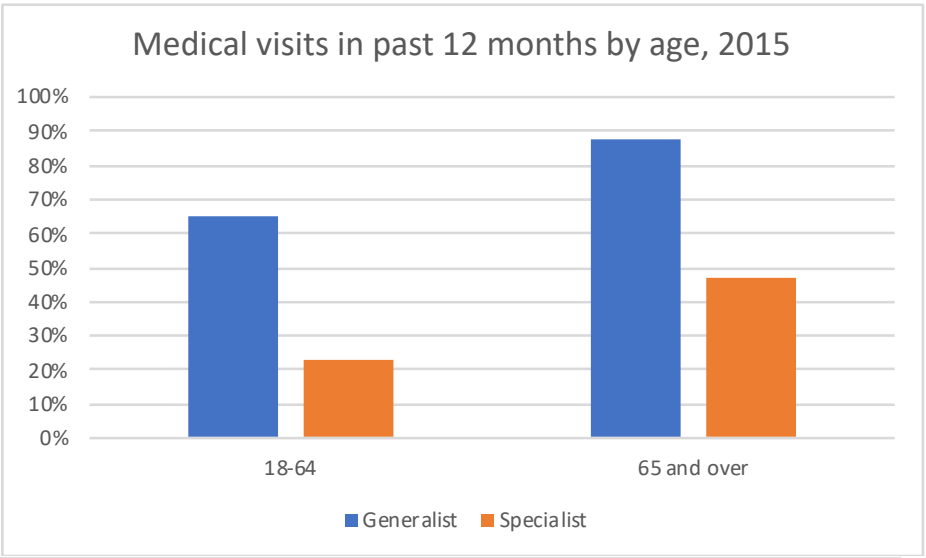
PROBLEMS WITH OUR CURRENT HEALTHCARE INSURANCE SYSTEM

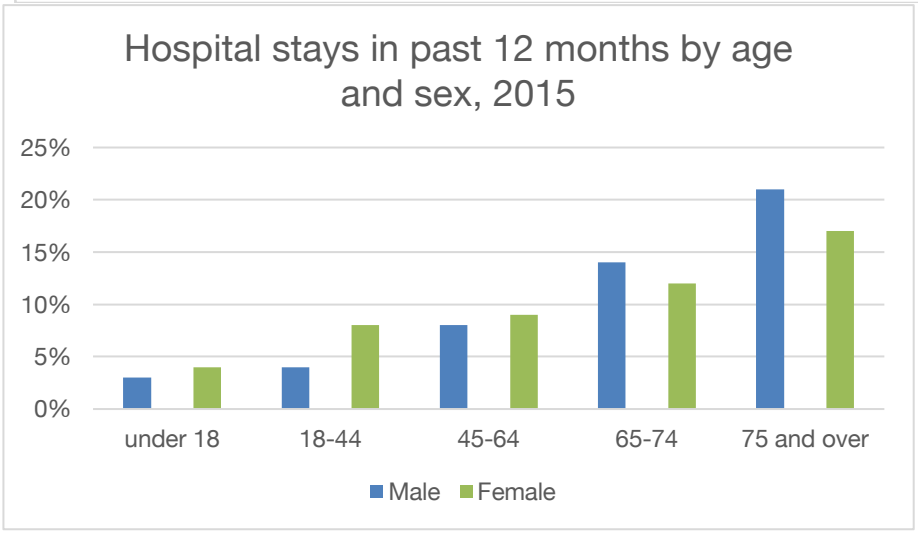
Increasing complexity of private insurance

Health insurance industry surveys show that only 30% of people who get their private health insurance from their employer think the cost of health insurance for most Americans is reasonable. Yet only 42% of them think Americans would be better off with their employer's plan. Even more alarming, 79% of them expect health insurance costs to increase over the next two years. And those costs have not been matched by increased wages. Despite these results, the insurance industry says that most people are satisfied with the private health insurance they receive from their employer. How can they make this statement? Most likely, when they ask that simple question, most people think they are satisfied, but could do better. Also, many working people have no real experience with their health insurance. They pay their premiums, but 40% never see a doctor over the course of a year and over 90% have not had a hospital stay. Private insurance plans have also become more complicated. Almost 20% of firms have plans with different tiers of provider networks, an increasing number offer narrow network plans, limiting the choice of providers, and almost all have annual deductibles, which have been increasing in size each year, often combined with a confusing array of health savings plan options. When these people say they are satisfied with their health insurance, many of them are satisfied with what they *think* their health insurance will provide them. But when they experience serious illness with large out-of-pocket costs, or treatment delays because they need prior approvals they were unaware were required, or can't see a consultant their doctor recommends because the doctor is not in their network, their satisfaction with their insurance disappears. These are

problems that do not need to exist. And the administrative burden on providers is enormous.

Another question the insurance industry asked was, "If you had a medical emergency and were required to go the hospital, which of the following would you expect to occur? A. My coverage will protect me from the majority of my medical costs. B. My coverage will not protect me from the majority of my medical costs." If you earn $75,000 a year and a hospitalization costs $75,000, does protecting you from the majority of those costs mean your health plan has your back? If fewer than 10% of those surveyed have ever been hospitalized, do they have any idea whether their health plan has their back?



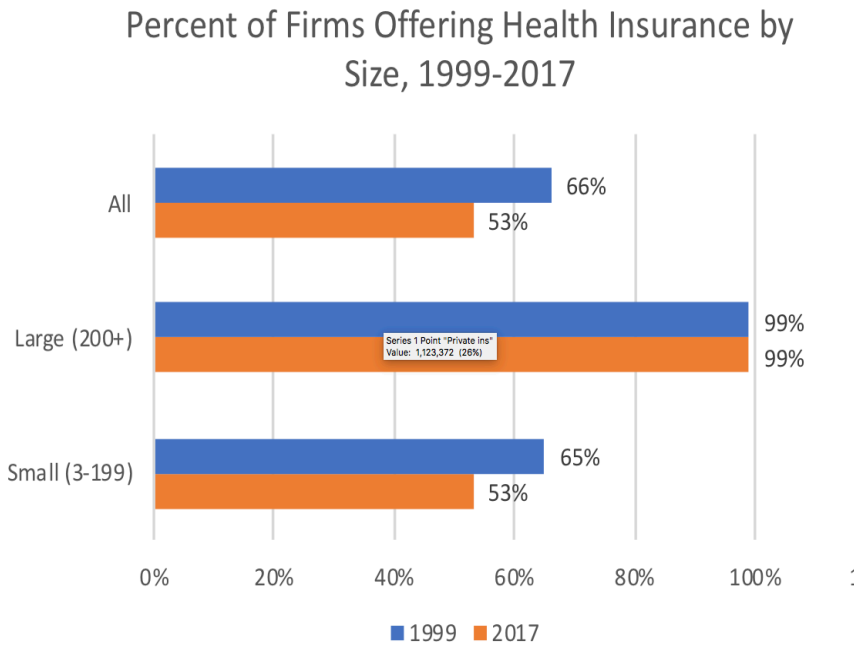


Source: Health United States, 2016, CDC, National Center for Health Statistics.

The uninsured

With increasing health care costs, ensuring that everyone has affordable health insurance has become a financial necessity. With the recognition that retirees and

low-income families and children had urgent unmet healthcare needs, Medicare, Medicaid and CHIP were established starting in the 1960s and now cover 137 million people. Insurance offered to workers by their employers (employer-sponsored health insurance) has been the most common source of health insurance in this country, covering 155 million individuals, 53% of all those with insurance. It was initially used to attract workers when the U.S. instituted a wage freeze after World War II in an attempt to prevent inflation. But as the costs have increased, fewer companies are offering health insurance. Since 1999 the percentage has decreased from 66% to 53%, all of the decrease accounted for by smaller companies.



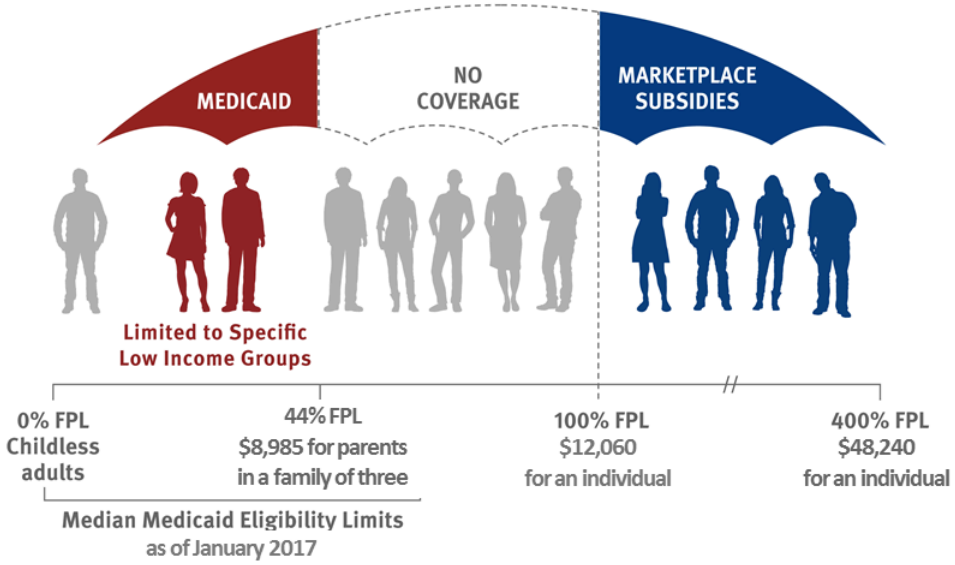
In response to rising costs and budget constraints, some states have also made eligibility requirements for Medicaid stricter, leaving more and more people uninsured. This led to the enactment of the ACA, resulting in a dramatic reduction in the uninsured. Unfortunately, strong opposition from some has led to failure of the ACA to achieve its desired goal: affordable health insurance for all. This has left over 28 million people still uninsured, 9% of the population. We cannot achieve adequate health outcomes with so large a population of uninsured. A large proportion of uninsured also increases healthcare costs, as will be shown.

When the ACA was passed states were given the option to expand Medicaid eligibility with additional health benefits. Due to the difference in eligibility requirements in the different states, some households with children with incomes as low as 17% of the federal poverty level did not qualify for Medicaid (only $8,895 for a family of three) and in states that did not expand, except for Wisconsin, those without children are not eligible regardless of income. The ACA guarantees coverage for anyone at or below 138% of the federal poverty level. Many states took

that opportunity and optimized its benefits. Nineteen states (89% in the South) did not, resulting in 2.4 million citizens with no Medicaid coverage and no subsidies in the ACA marketplace. (When the ACA was passed, it was not envisioned that any state would deliberately choose to leave its citizens without coverage.)

Figure 1

Gap in Coverage for Adults in States that Do Not Expand Medicaid under the ACA



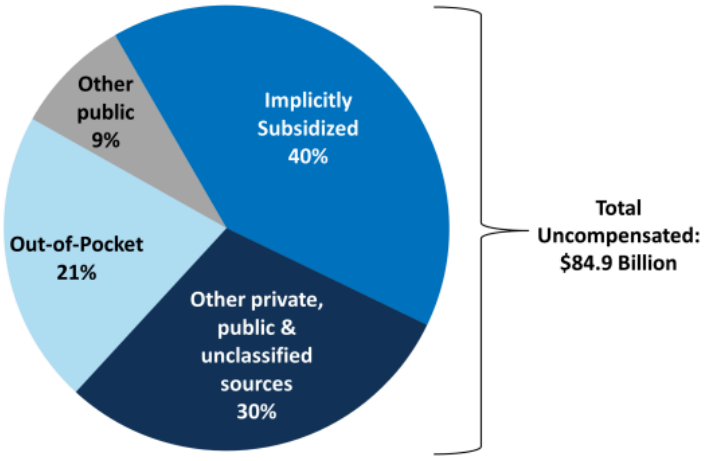
The ACA allows exemptions for individuals otherwise eligible for Medicaid to purchase 90-day policies with limited coverage to give them time to find other healthcare insurance options other than Medicaid. The current Administration is allowing states to extend this option to a full year, thus diverting additional individuals out of the ACA marketplace. Although this is intended to allow innovative management of Medicaid programs, it is more likely to lead to degradation of coverage and access, reinforcing greater differences among states with more individuals with inadequate health insurance.

The ACA also required all individuals who did not otherwise have health insurance to participate in the ACA marketplace. This was done in an attempt to guarantee the lowest cost to all individuals by including people who did not expect to have major healthcare expenses and those who might have higher expenses in the same insurance group. However, the penalty for not participating was set low enough that many healthy individuals have chosen to go without insurance. The current administration has also decided not to enforce this requirement. Congress passed legislation to reduce the penalty to $0. The result of this lack of participation of healthy individuals in the ACA marketplace is an increase in the cost of insurance for the remaining individuals. Insurance companies have to calculate the risk of

their expenses and the fewer healthy people who are buying insurance, the higher the risk of large payments. Not only do they have to plan on higher payments each year, but they have to have to have more money set aside in case of particularly large payments in any given year. This problem is made worse by the decision not to enforce the requirement that everyone without insurance must participate in the ACA marketplace and to reduce the penalty to $0. Many people now find that the cost of ACA marketplace insurance, even with subsidies, is more than they can afford. This leads to even more people choosing not to participate, creating a vicious cycle.

The thinking behind requiring everyone to have health insurance is not unreasonable. People don't think twice about paying for insurance for their home. They know they can't afford to risk losing their home in a fire, even if the likelihood is low. Most people never file a claim for a loss on their home from a fire, but they would not give up their insurance. And if they have a mortgage, their bank would not let them—because they have a stake in their property, too. The government is in a similar situation with healthcare. Even though it may seem like a person is the only one taking a risk by not buying health insurance, this is not true. People without health insurance spend, on average $2,785 per person each year on health care. Only 21% of those expenses are paid for out-of-pocket by the uninsured person. Most of the rest is uncompensated care (70% of the total) and two-thirds of that is paid for by federal, state and local government programs. Hospitals and many community clinics are required to provide medical care regardless of a person's ability to pay. Many physicians also provide care to those without insurance without getting paid. On average, a person who does not buy health insurance costs other taxpayers over $1,300 and providers and other private sources another $900 every year.

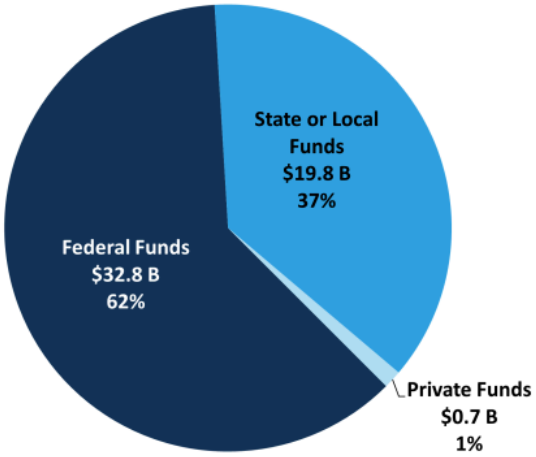
Aggregate Medical Spending for Nonelderly Uninsured, by Source of Payment, 2013



Total Medical Spending = $121.0 Billion

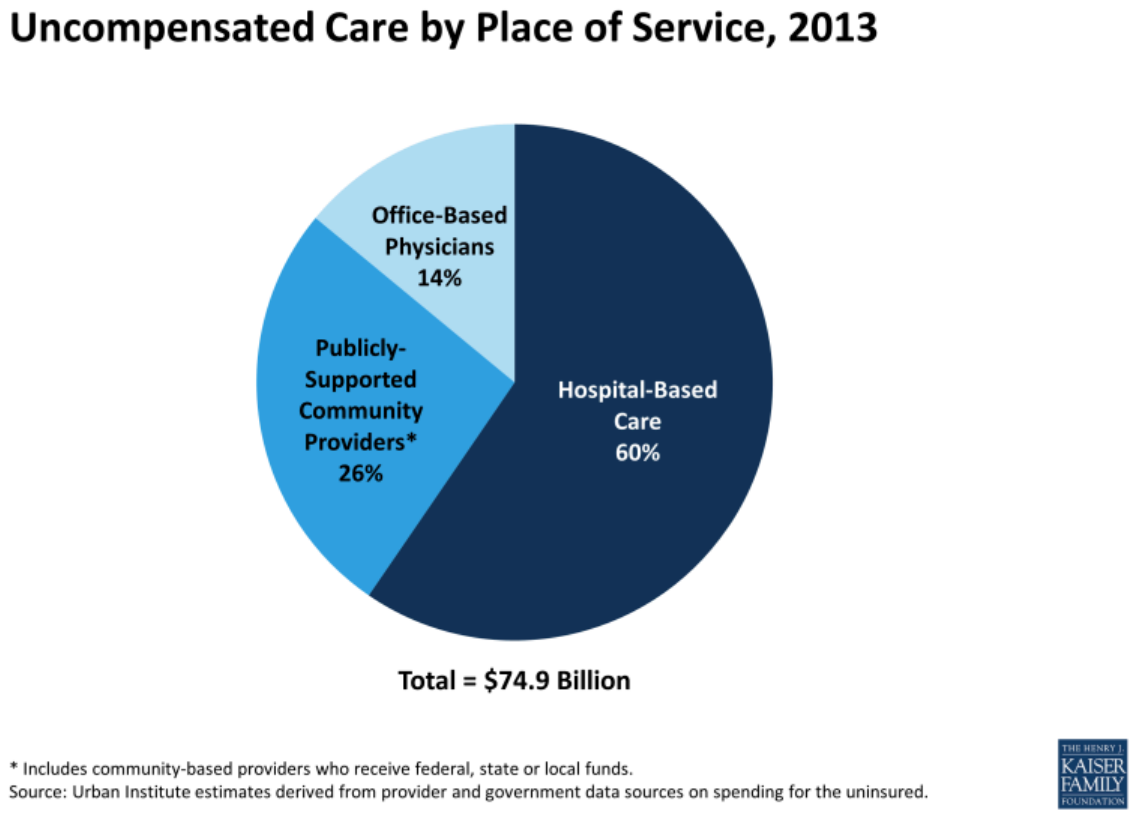
Note: Includes only spending that occurred while uninsured. "Other Public" spending includes retroactive Medicaid payments.
SOUCRE: Urban Institute estimates based on 2008-2010 Medical Expenditure Panel Survey.

Sources of Funding for Uncompensated Care, 2013

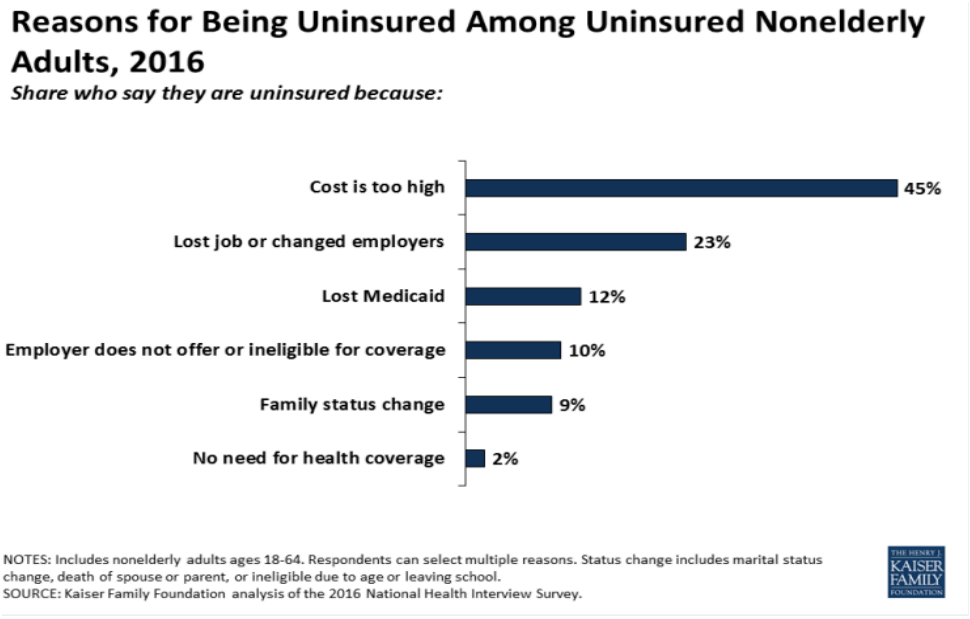


Total = $53.3 Billion

Source: Urban Institute estimates derived from provider and government data sources on spending for the uninsured.



However, when asked why they do not have health insurance now, almost half say it is because the cost is too high. Most of the remainder say it is due to loss of or unavailability of insurance. Only 2% say it is because they have no need for coverage. That amounts to less than 1 million people. The answer to the problem of the uninsured is therefore not to convince people who do not think they need insurance to participate. The answer is to ensure that health insurance is truly affordable and available.



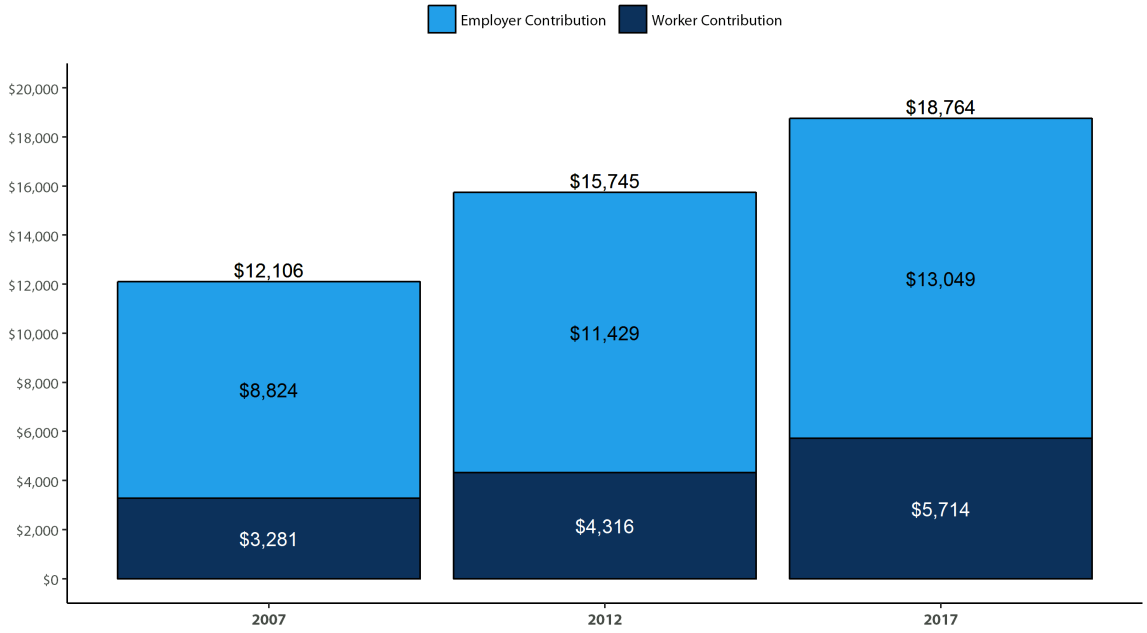
The underinsured

There are currently 44 million people who say that paying for healthcare is a financial burden. A recent Gallop poll showed that Americans borrowed $88 bilion to pay for healthcare and 65 million adults said they did not seek treatment for a health issue due to cost over the prior 12 months. These are the underinsured. They have insurance, but it doesn't cover enough of their costs to make them financially secure. This affects not only their financial well being, it affects their emotional, social and physical well being. Financial burdens are major barriers to care that are responsible for poor health outcomes in this country. One should not have to choose between buying food and going to the doctor. Or paying a utility bill or buying a prescription drug. Or getting a test your doctor ordered or taking care of your sick child. These barriers are a major reason our high healthcare expenditures do not translate into better health outcomes.

There are three causes of underinsurance: deductibles and copayments (also called coinsurance), high premium costs, and uncovered services. Coinsurance is designed to change patient behavior. It is supposed to reduce unnecessary use of healthcare services by making the patient pay part of the cost. This may seem to make sense, but if coinsurance does not vary according to a person's income, the incentives will rarely have the desired effect. Someone with little income to spare will avoid even necessary services, usually without consulting with the doctor (who often has no idea how much the services ordered cost the patient). Someone with high income will not care about the cost. Decisions will rarely be made based on the medical value of the service. Deductibles are the least sensible part of coinsurance. They may make sense as a way to reduce claims for damage from minor auto accidents, but it makes no sense to give a patient an incentive not to file a claim for medical services unless they reach a threshhold value. As one might expect, coinsurance has been shown not to work well as a method to reduce unnecessary utilization. Unfortunately, many policymakers fail to appreciate the considerable shortcomings of coinsurance and continue to view it as a useful method of controlling costs.

The problem of high premiums was discussed above in relation to the ACA. It has become an increasing problem in health insurance obtained at work, as companies have been using multiple methods to decrease their cost of workers' benefits. Asking workers to share the premium cost is one method companies have used to decrease their cost, and that share has increased over the years. The average worker now pays $5,714 for family coverage compared to $3,281 in 2007 (an increase to 30% from 27% of the premium cost).

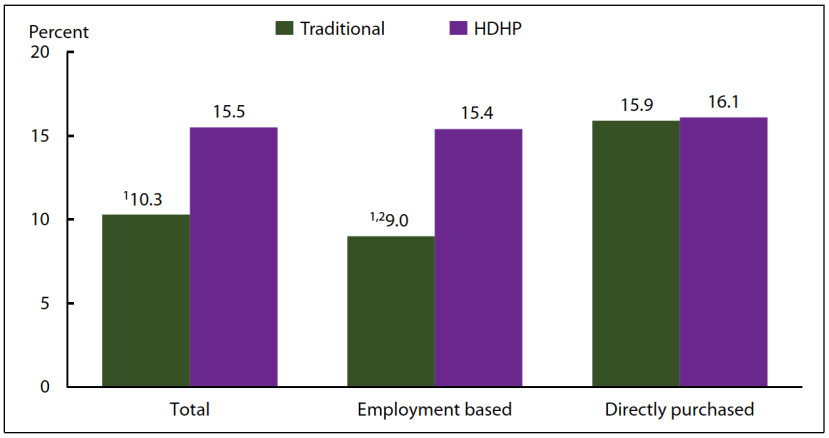
Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2007-2017



NOTE: Since 2007, the average family premium has increased 55% and the average worker contribution toward the premium has increased 74%.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Another cost-sharing method is the use of high-deductible plans. These plans are attractive to workers because of lower premiums, but their deductibles are much higher, $1,000-$2,000 a year or higher. Even more individuals who purchase their own insurance are choosing these plans because of their lower cost. Not unexpectedly, workers with employment-based, high-deductible plans are more likely to have problems paying medical bills than those in traditional plans (15% vs. 9%). Perhaps it is also not surprising that those with directly purchased insurance are just as likely to have problems paying medical bills whether they choose high-deductible or standard coverage—they have difficulty keeping both premium costs and out-of-pocket costs low regardless of their choice.

Figure 3. Percentage of privately insured adults aged 18–64 in families having problems paying medical bills in the past 12 months, by source and type of private coverage: United States, 2016



[1]Significantly different from those with HDHP ($p < 0.05$).
[2]Significantly different from those with directly purchased traditional and directly purchased HDHP ($p < 0.05$).
NOTES: HDHP is a high-deductible health plan. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2016.

Care that is not covered by insurance not only increases out-of-pocket costs, it also increases the overall costs of healthcare. Our insurance system has evolved over time. Healthcare insurance developed gradually when it became evident that medical costs could get very expensive. At first, the most expensive care was hospitalization, and this was the first healthcare cost to be covered by insurance. Soon, the cost of outpatient care started to rise and many companies started to offer insurance to cover this. As drug costs soared this became another important addition to insurance coverage, as did long-term care insurance for home care and nursing home care, which is much less common.

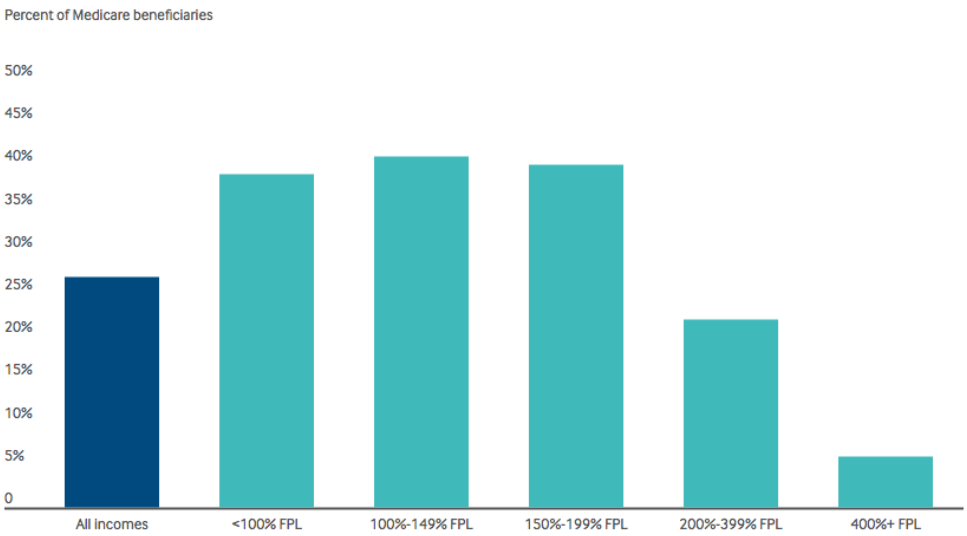
Medicare, for example, has only limited benefits for nursing care, essentially considering it an extension of the treatment of an illness requiring hospitalization. The cost of room and board at a nursing home is only covered if there is a skilled nursing need for the patient, usually physical therapy following a hospitalization of at least 3 days. The result is an artificial use of hospitalization, an increase in hospital days, and unnecessary use of physical therapy in order to have a patient's room and board paid by Medicare. Many patients also have unnecessarily prolonged nursing home stays because of Medicare's limited coverage for home care. Only a limited number of nursing visits are allowed for a limited period of time, and only if a skilled need is identified. Personal care aides, covered by Medicaid, are not covered by Medicare. But in the current economy, where 61% of families with children have both parents working, it is very difficult for most people with a significant disability from an acute or chronic illness to manage at home without help. Currently, 27% of the cost of nursing home care is paid for out-of-pocket. Only 3% of personal care costs are out-of-pocket with 8% covered by private insurance and 60% by Medicaid (only 16% of those over 65 have private insurance coverage for long-term care). This shows how often more expensive sites of care are used due to financial constraints. MedPAC has noted evidence of inefficient use of these services but has looked no further than the payment

methods for explanations and solutions. Although MedPAC makes reasonable suggestions for change, changes in provider payments will not solve the problem of costs to patients and their families.

Another healthcare expense that causes large out-of-pocket costs is dental care: 40% of the $124 billion in expenditures. Untreated dental problems can lead to infections that can cause serious medical illness. Chronically inflamed gums (gingivitis) has also been linked to an increased risk of heart disease. The vast majority of these problems could be avoided if low-cost preventive care were covered by insurance. Medicare includes virtually no coverage for dental care.

Although Medicare is overall an excellent insurance plan, these and other coverage gaps can cause significant hardships for beneficiaries. The coinsurance for prescription drugs has become a particular problem for many, especially for cancer patients whose drug costs can be staggering. On average, beneficiaries spend $3,024 a year on out-of-pocket costs. More than one-fourth of people on Medicare spend 20% or more of their incomes on premiums plus medical care, including coinsurance and uncovered services. Those with income below 200% of the federal poverty level and with multiple chronic conditions or functional limitations are at particular financial risk, as are those without any other insurance coverage.

Medicare Beneficiaries Spending 20 Percent or More of Income on Premiums and Care, by Poverty Level



Note: FPL = federal poverty level.
Data: Roger C. Lipitz Center analysis of 2012 Medicare Current Beneficiary Survey projected to 2016.

Many people do not purchase health insurance because they cannot afford it. And 72% of the health insurance programs offered to the American public carry a significant financial burden that impacts when and how people are able to seek

healthcare. The major cause of personal bankruptcy in the U.S. is the inability of people to pay health care bills. Even when patients are willing and able to make personal sacrifices in order get the best care they can, knowing the financial burdens of healthcare costs to them can affect the behavior of providers in deciding what treatments to offer them, placing further hidden barriers to care.

The financial burden for healthcare falls heavily on individuals and families above 400% of the federal poverty level ($48,560 a year for a single person) who are under-employed, self-employed or working for employers with fewer than 200 employees. These individuals are not eligible for any benefits or subsidies in our current healthcare system.

Inefficiency and waste

Administrative costs are an important driver of increasing national medical expenditures, rising twice as fast as the overall annual rate of increasing medical costs. Private insurance companies are responsible for most of this increase, as government programs have had persistently lower administrative costs. Private insurance companies have been spending a gradually increasing share of premium dollars on administrative costs compared to actual medical expenses. The administrative cost for insurance grew an average of 15% each year from 1970 to 1990, adjusted for inflation and population growth, with slower increases in the decades after that of 5% to 6% a year. The cost of administration was $57 per person in 1970 and $229 per person in 1990. In 2016 administrative costs consumed $715 of the total inflation-adjusted medical costs per person of $9,082 (8%). The contrast between private insurance and government costs is striking: the costs of administration for private insurance in 2016 were 12% while the costs for Medicare were only 7%. The increased costs of managing the different requirements for each insurance company has driven up costs for providers also.

A study by the Institute of Medicine in 2009 identified $765 billion in wasted medical expenses. Adjusting for inflation and increased medical costs, that translates into $1.02 trillion dollars in 2016 (about one-fourth was administrative waste). The study identified the following sources of waste (values reported in 2016 dollars):

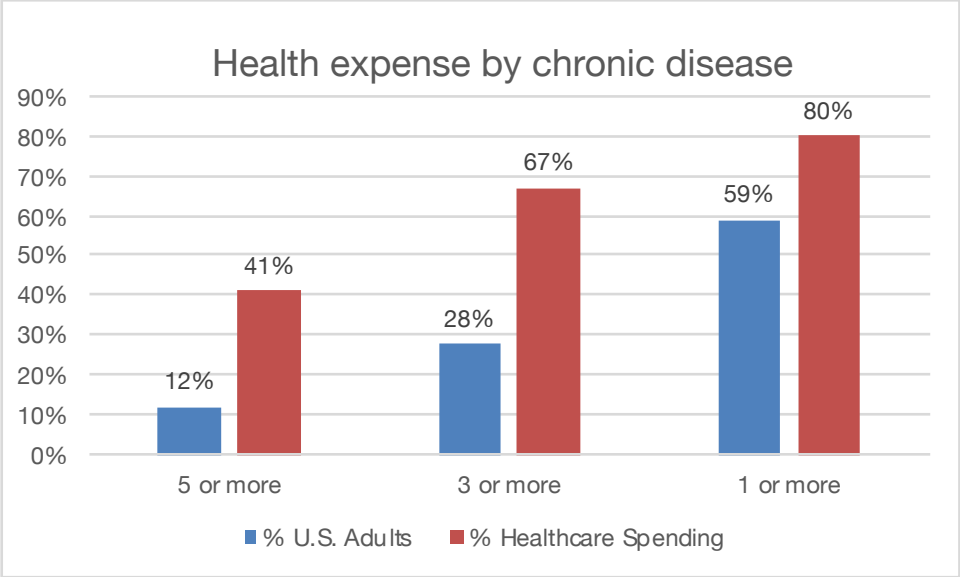
Unnecessary services:	$270 billion
Inefficiently delivered services:	$174 billion
Excess administrative costs:	$256 billion
Excessive prices:	$140 billion
Missed prevention opportunities:	$73 billion
Fraud:	$100 billion

A number of features of our healthcare system can be identified that are likely to be responsible for much of this waste. Due to the disjointed nature of our healthcare system there is a lack of coordination of care. Patients often see multiple providers who have little or no communication between them. Electronic medical

records are different from one office to another and one hospital to another. Tests performed may be reported to one provider and not another. All of these lead to repeated and unnecessary services, inaccurate diagnoses and missed opportunities for preventing illness.

Most services are also paid on a fee-for-service basis. This also encourages unnecessary services. Surveys have shown that areas of the country that have more abundant supply of particular services have higher utilization than other areas, without any improvement in patient outcomes, only increased cost. The need for income also leads providers of all types—physicians, hospitals, home care service—to find ways to refer patients to facilities with which they are affiliated. Although the Stark law limits these arrangements, there are exceptions that allow for continued excesses.

One of the most important elements of healthcare, patient education, is shortchanged because it is not paid for by insurance. This problem is most significant for individuals with chronic diseases, which are responsible for 80% of healthcare expenditures.



Source: Price and Prevalence; Health Payer Intelligence, July 2017.

Cardiovascular disease accounts for 31% of U.S. deaths per year. There are 29 million Americans with diabetes; 86 million have pre-diabetes. People with diabetes spend 16 times more on healthcare during their lifetime than people without diabetes. The medical costs of patients with asthma is more than twice that of people without asthma. The healthcare costs of overweight people are almost 10% higher than people at a normal weight. Those who are obese have costs almost 50% higher than patients at a normal weight. With 70% of Americans now classified as overweight and almost 40% as obese, this translates into nearly 5% of

national healthcare expenditures each year: close to $150 billion. The seriousness of this problem is highlighted by the 26 million 17-24-year-olds who are unfit for military service because of obesity, chronic illness or drug dependence. All of these chronic diseases represent opportunities for prevention, early identification and improved management. This could result in substantial cost reductions, especially as our population ages.

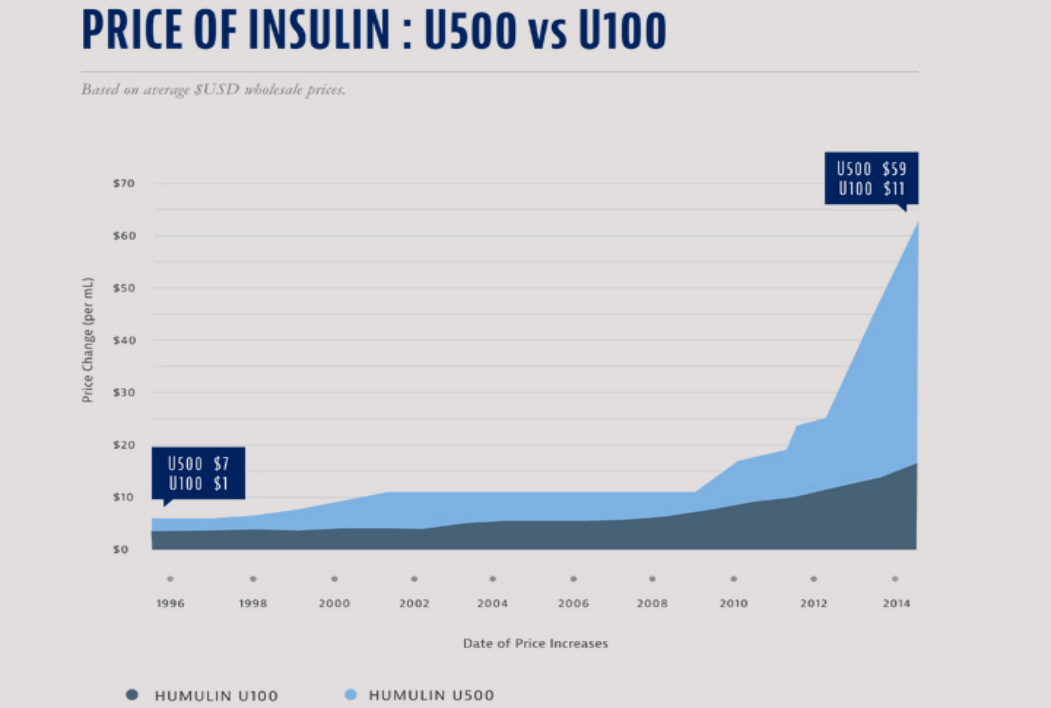
Nursing education and follow-up plays a vital role in management of these chronic diseases. Diabetes education is critical to adequate disease control. Nursing education and follow-up can dramatically reduce the need for emergency room visits and hospital admissions for patients with cardiovascular disease and asthma. Adequate personal care assistance in the home can improve disease management and prevent complications. Yet none of this is covered by most insurance policies. Our fractured system of care also results in lack of coordination among providers, resulting in further missed opportunities for early follow-up and intervention to prevent complications, emergency room visits and hospital admissions. The result is utilization of more expensive care than necessary, duplication of tests and worse health outcomes.

The need for improved quality and efficiency has been evident for some time. As a result, a number of excellent tools have been developed to make the healthcare system better. These tools include auditing claims that are outside of normal practice patterns, rejecting claims with procedures that are not linked to approved diagnoses, development of evidence-based guidelines by medical societies, national experts and U.S. agencies that recommend appropriate diagnosis and treatment protocols, and development of quality programs to document adherence to recommended initiatives. Medicare has developed a number of initiatives, including one to promote the adoption of meaningful electronic records. Unfortunately, the lack of coordination of efforts, multiple sources of payment, and lack of adequate incentives have hindered the process. Most significantly, the failure to develop a system-wide electronic database for storage of all patient medical information has been a serious hindrance.

Profit motives also have a distorting effect on our healthcare system. Although the Stark Law was enacted to protect patients from self-referral practices to influence providers' decision-making, there remain exemptions that allow profit incentives to persist. Whether conscious or not, whenever the potential for self-referral exists, evidence shows that utilization is characteristically higher.

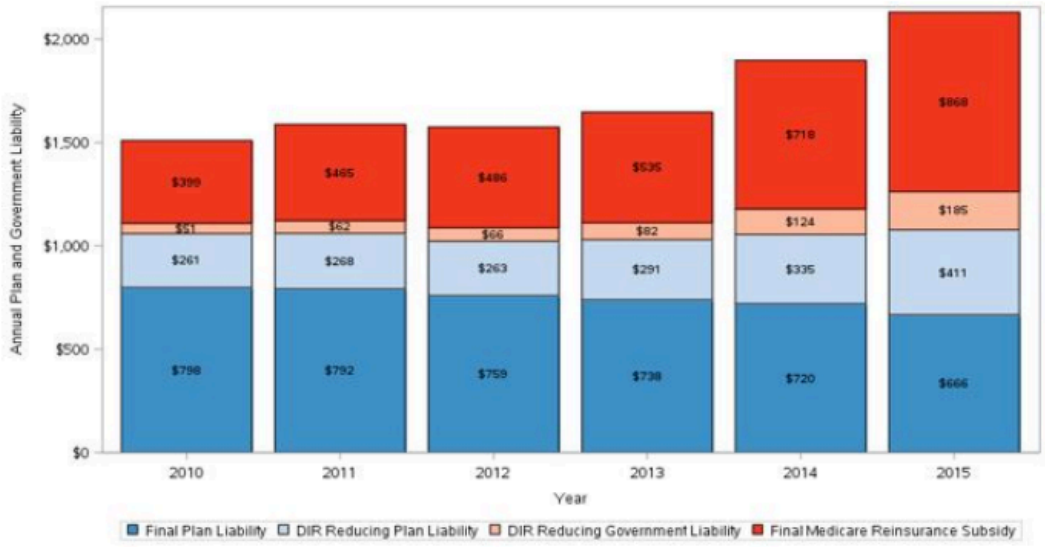
Drug companies have come under scrutiny for some recent examples of profit-making at the expense of patients. Drugs that have been on the market for years with no increase in manufacturing costs have seen dramatic increases in prices when medical use has risen. An example is the price of doxycycline, a generic drug used to treat Lyme disease that has risen only in response to increased demand. Insulin is another example. This life-saving drug for the treatment of diabetes has been available for almost a century, but it is made by only one company, Lily.

Without explanation, the price of insulin has soared over the past decade, especially in its more concentrated form.



Drug costs increased rapidly through the middle of the last decade, but the rate of increase has decreased now. The reasons for this lull are not clear but may relate to expiration of patents and a number of drugs that are in development but not yet approved. It is therefore possible that prices may increase again at previous levels. In the meantime, expenditures on drugs remain stubbornly high. Americans now spend over $328 billion on prescription drugs, almost 10% of all national healthcare expenditures. Our ability to decrease these expenses or even limit their increase is hampered by the influence of the pharmaceutical industry, which spends hundreds of millions of dollars every year on lobbying and contributions to political candidates. One sign of this influence is legislation that prohibits Medicare from having any influence over negotiations regarding drug prices. Although insurance companies, usually through pharmacy benefit managers, have been able to negotiate discounts and rebates with drug companies for Part D plans for Medicare beneficiaries, they have kept the bulk of those savings for themselves, leaving patients with higher copayments and the government with higher costs than if Medicare were able to negotiate separately.

Increase in Medicare subsidies, decrease in insurance plan costs as a result of direct and indirect remuneration (DIR) from pharmaceutical companies in relation to increased retail prescription drug prices.



Sources: Analysis of DIR, reinsurance subsidy, and enrollment data from the CY 2016 Medicare Trustee's Report and cost data from PDE records.

WHAT NEEDS TO BE DONE TO IMPROVE OUR HEALTHCARE SYSTEM

We developed our recommendations for a well-designed *Medicare for All* plan after careful analysis of other options. Our first approach was to review other methods for providing comprehensive health care around the world. We first looked to the National Health Service in the United Kingdom. The U.K. scores well compared to the U.S. on many measures of healthcare and has considerably lower costs. However, setting up a similar system in the U.S. at this time would be extremely difficult. The National Health Service was instituted 80 years ago when the medical system was much less complex. It has grown over that time to adapt to the necessary changes. It is doubtful that such an endeavor could be accomplished from scratch today. The system is also burdened with stringent government controls in which all providers work for the government. The wealthier are able to receive care separately from private providers. There is little enthusiasm for such a system in the U.S.

Canada's system has also been looked to as a potential model for the U.S. to consider. This system, however, has global budgets for each province and a large degree of government control, with an entirely different system from the one we currently have in the U.S. It would require significant changes to our system. Canada's system also started many years ago—in the 1940s—when healthcare was much simpler. An attempt to duplicate this system in the U.S. at this time would be a much more difficult process than the one Canada went through.

An examination of the different health insurance models in Europe shows that public health services have not fared well. Canadian researchers reported that for British Columbia patients with aortic valve disease the waiting time for surgery was

more than 3 times longer than officially reported. In Great Britain it is common for the wealthy to buy private health insurance to bypass the problems in the National Health Service (NHS). As noted in a commentary in the British Medical Journal, "The NHS addresses the social ethic of pursuing the maximum gains within a limited budget. Voters appreciate the policy in the abstract, but it does not always work for the individual."

The previous universal healthcare plan in the House of Representatives was *Medicare for All*, H.R. 676, 2015. This plan had a number of serious drawbacks. This bill does not account for the fact that the governmental component of Medicare is entirely regulatory. Medicare has contracts with twelve insurance companies to process all its claims for Part A and B (four of them also process claims for hospice benefits and four others process claims for durable medical equipment). Multiple private insurance companies manage claims for Part D and about 30% of patients have their claims processed by private insurance companies with Medicare Advantage plans (Part C). Medicare spends $2 billion a year for contracts with the Part A and B and durable medical equipment (DME) claims processors. Those contractors also develop specific claims rules based on Medicare guidelines and are responsible for monitoring all claims for correctness. Medicare also spends over $36 billion on administrative costs for Part C and D private plans. H.R. 676 does not address the need to retain at least the Part A and B and DME contractors to process claims. H.R. 676 also requires an entirely new administrative process to deal with regional and national healthcare budgets and regulations. There is currently no process for this in the U.S. This bill assumes that the current Medicare administration could assemble this system, starting with their current directors. However, this would require an entirely different skill set and organization, for which these directors would be ill prepared. It makes arbitrary recommendations for a series of new taxes, without any rationale and with no guarantee that the taxes will provide sufficient revenue. This bill also creates a government bureaucracy, similar to Canada's, that would control the entire healthcare system, rather than just provide a less complex healthcare system. It would create regional budgets that would limit payment for services overall, eventually leading to pressure to eliminate expensive services and/or drugs. It does not give any estimates for the actual costs or savings related to the plan. The suggested sources of savings (administrative, bulk drug purchasing and improved disease prevention) are unlikely to generate more than $250 billion. This is less than a third of the likely program costs. The bill also calls for full implementation of the plan in less than two years, an unreasonably short timeline.

The newest proposal in the House, H.R. 1384, (*Medicare for All Act of 2019)* improves on H.R. 676, but retains most of its disadvantages, including eliminating most private insurance, an inadequate transition period, reliance on national budgets for cost control, and a failure to account for costs and savings.

The Senate version of *Medicare for All*, S. 1804, 2017, introduced by Senator Sanders, has many attractive features, especially its 4-year transition and lack of additional bureaucracy. However, there are some issues that also need to be

addressed. S. 1804 is sound enough, though, to provide a good starting point for a practical *Medicare for All* program. Senator Sanders introduced a revised version of this plan in May 2019, S. 1129, 2019. The only major change introduced in S. 1129 is the inclusion of home-based long-term care coverage in Medicare instead of Medicaid. However, the plan he proposed for financing *Medicare for All* during his campaign for presidency included reasonable concepts for basing individual premiums on household income above an initial threshold and similarly basing employer premiums on payroll above an initial threshold (although the amounts he used are unrealistic without resorting to other sources of revenue). [*]

Although the new versions of *Medicare for All* in the House and Senate are somewhat closer to each other than the previous versions were, major differences remain. Both bills still lack details essential for implementation. For simplicity, we present some recommendations here based on the previous version of the Senate bill, S. 1804, 2017. We consider these recommendations to be important considerations for an improved, well-designed *Medicare for All* plan.

Recommendations for a well-designed *Medicare for All* plan:

1) **Encourage Medicaid expansion during transition.** The current formula for federal sharing of Medicaid expenses will be changed from one based on income level of a state's residents to one based on the percentage of residents eligible for Medicaid under ACA expansion who are actually enrolled, using enrollment status before enactment of ACA as a baseline. This more correctly aligns the incentives of the state and federal governments. The federal share for previous enrollees would vary proportionately from 40% for no expansion to 60% for full expansion. New enrollees would continue to receive 90% federal sharing. The exemption allowing 90-day temporary insurance (or longer policies) will also be repealed. **Rationale**: Too many households will have inadequate healthcare insurance, both during transition and after full implementation, without full expansion of Medicaid.
2) **Allow private health insurance after implementation.** All private health insurance will be *secondary* to Medicare. Providers will have *no* obligation to file secondary claims on behalf of patients or provide any information other than a receipt with complete description of services provided. The provider will be responsible for ensuring that sufficient information is provided to Medicare so that the patient receives an explanation of benefits from Medicare promptly. Workers' Compensation, no-fault and all liability medical loss coverage will be secondary to Medicare. This will avoid confusion about responsibility for payment and ensure prompt treatment and provider reimbursement. There will be no need to have any of these policies reimburse Medicare for covered expenses. Instead, their costs will decrease. **Rationale**: Making duplication of Medicare coverage illegal, as in other plans, would cause a regulatory burden that would be difficult to enforce. It would also

[*] His financing plan specifically calls for individuals and employers to pay premiums as an option. He does not mention continuing payroll taxes, but since he does not account for the loss of $1.4 trillion in revenue over 10 years, we assume that his plan also assumed that these would continue.

require elimination of many current policies and does not address delayed reimbursement and lack of access to care related to confusion about who the primary payer is. Although *Medicare for All* will significantly reduce out-of-pocket costs for individuals, there will still be out-of-pocket costs for some of the new additional services that will be covered only within limits (see below). Since premium costs will also be lowered, a market for secondary insurance will be guaranteed.

3) **Medicare billing.** Claims for Medicare will continue to be billed by contract with private insurance companies. Due to the increase in volume of claims and the increased importance of Medicare billing as a component of private insurance company business, the administrative budget for Medicare will be *increased*. One part of this increased budget will be for increased payments for the contracts to private insurers. **Rationale**: This will ensure continued access to quality claims processing.
4) **Medicare Advantage Plans.** Standard Medicare will be adding new benefits each year during transition. Therefore, Medicare Advantage Plans (Part C) will be required to inform all current and future enrollees of the differences in benefits offered between Medicare Parts A, B, and D, and Medicare Part C, including any additional restrictions, such as pre-approval requirements and restrictions on use of providers. Incentives for Part C may be revised by the Secretary to ensure program goals are met. **Rationale**: Part C plans currently extract savings by negotiating lower rates from providers, reducing patients' choice of providers and increasing costs to patients. The Medicare Payment Advisory Commission (MedPAC) notes the costs to the Medicare program are 4% higher for Part C plans than for standard Medicare. Part C plans detract from the value of *Medicare for All* by increasing administrative complexity. Their administrative costs are much higher than standard Medicare (19.4% vs. 2.7%). Their value to patients is likely to decrease considerably throughout transition and after full implementation. Patients should be given all the information required to make the choice that is best for them. The Secretary should be given the authority to ensure, at the least, that Part C plans save Medicare money, if they are continued.
5) **Drug benefits**. Eliminate Part D as a separate benefit and include drug reimbursements in Part B as of the first day of transition. **Rationale**: Part D plans extract savings by negotiating discounts from drug companies. The Medicare trustees note that the bulk of savings from price reductions negotiated by Part D plans is retained by the plans, resulting in higher costs to the Medicare program and its beneficiaries. Part D plans also detract from the value of *Medicare for All* by increasing administrative complexity. However, Medicare may want to continue to contract with a Part D facilitator or with a pharmacy benefit manager on a competitive basis to administer the drug benefit on a cost-efficient basis. There is also no reason why several sponsors and/or managers could not achieve this goal in different regions, as long as there is one coordinated approach to drug benefits across the country.
6) Transition of Medicaid services to Medicare. Transfer all Medicaid services, including long-term care and home health care, from Medicaid to Medicare by the implementation date. At full implementation, Medicaid and

CHIP will be discontinued as separate benefit programs. Payments for services for everyone on Medicare, regardless of original service plan, will be equal, although additional benefits may be available to those eligible for Medicaid and CHIP. Anyone eligible for Medicaid or CHIP will have, at a minimum, the same benefits under *Medicare for All* as they had previously (e.g., subsidized premiums, transportation costs reimbursed, additional dental services covered). Eligibility criteria for these supplemental benefits will be uniform, regardless of state of residence and will be determined by the Secretary in accordance with expanded access under the ACA. **Rationale**: Using a separate system to pay healthcare costs for the disabled and low-income families leads to reduced access to care, poorer health and, as a result, higher costs. Different criteria for coverage and reimbursement depending on state of residence allows for too much variability in the quality and cost of care and difficulties accessing care out-of-state. Inclusion of long-term care is critical to lower costs. Patients who have access to nursing home care have shorter hospital stays. Patients whose nursing home care is paid for without a skilled need use fewer physical therapy visits and other skilled care. Patients with access to personal care at home use fewer nursing home days. Medicaid and CHIP also have higher administrative costs than Medicare does (10.9% vs. 7%).

7) **Cost control.** Beginning with year 2 of transition, the Secretary will develop a Sustainable Health Index Fund Target (SHIFT) to measure the average cost of services ordered by providers exclusive of their own fees, including imaging, laboratory, drugs and medical devices. The information will be collected into quarterly reports and forwarded to providers with comparisons to their peers. Significant outliers, adjusted for patient mix, may be considered for targeted chart review by CMS, which may result in suggested changes in practice and/or further follow-up. In addition, reports may be forwarded to appropriate medical specialty societies to assist with their own educational programs on value-based medical care. This will replace any specific national budgets and will replace the current Merit Based Incentive Payment System (MIPS). We recommend using Germany's model as a fair way to negotiate drug prices. **Rationale**: SHIFT will ensure that providers help patients make the best choices regarding the value of care received by giving them relevant information about costs. SHIFT will also provide motivation to keep drug prices in line with value. A most favored nation approach to drug pricing will allow drug companies to continue high-quality research and development to provide innovative products while spreading the cost more fairly around the world.
8) **Funding.** The current funding process for Medicare will remain unchanged during transition, except that a new Medicare **Part E** Plan will be created to fund costs for those newly eligible as of the first day of transition. The Secretary will also be authorized to use surplus Part A funds (as determined by the Congressional Budget Office) to provide additional funding to Part B and/or Part E services as necessary to achieve the highest standards of care, including ensuring adequate reimbursement for underserved specialties, such as primary care, mental health and addiction services, with the advice of the Directors of the National Institutes of Health and the Centers for Disease Control and

Prevention. **Rationale**: Changing the funding to a universal fund has its attractiveness, but we feel the less that is changed initially the better. Retaining Medicare Part A as a separate fund allows for continued funding of hospital and hospice payments while program costs and savings are assessed. Giving control of the flow of funds to the Secretary, after appropriate consultation, minimizes the risk of Congressional changes based on political expediency. However, after transition, creation of a universal fund may be desirable.

9) **The following are recommendations for the four-year transition plan:**
   a) **Eligibility.** All adults age 18-64 will be eligible for Medicare beginning the first day of transition (Enhanced Eligibility Medicare—EEM). Dependent children will also be eligible. **Rationale**: Making everyone eligible for Medicare from the first day of transition will improve the effectiveness of the transition to a balanced patient population.
   b) **New services.** A new coverage benefit for patient education by nurses, nutritionists and other health professionals will be available beginning with the first year of transition as will dental services (preventive care, fillings and extractions) and vision (up to one refraction and one pair of glasses each year, as medically necessary). Long-term care will be added by year 2 and hearing (up to one pair of hearing aids with audiologist follow-up for one year, with replacements every 5 years, as medically indicated) by implementation. **Rationale**: Early addition of these new services will make it more attractive for people with private insurance to transition to Medicare. The time course of added services is based on a combination of benefits and costs.
   c) **Copayments** will be gradually reduced each year from 20% to 15%, then 10%, then 5%, then eliminated. **Rationale**: Some cost-sharing during transition will be needed to reduce program costs as savings accrue, but all coinsurance will be eliminated by the time of full implementation due to their discriminatory nature and lack of effectiveness in affecting behavior appropriately. Cost-sharing is a major barrier to care that must be eliminated to enhance cost savings by other methods.
   d) **Tax exemptions** for employer-sponsored health insurance premiums and tax deductibility for other private health insurance will be gradually decreased during transition to 90% in year 1, 75% year 2, 50% in year 3, 25% in year 4 and eliminated after implementation. **Rationale**: This will encourage the move from private health insurance to Medicare during the transition. These tax subsidies will be diverted to help pay for additional services for everyone.
   e) **Health Savings Accounts**, Health Reimbursement Accounts and Flexible Savings Accounts will be eliminated as of the first day of transition. **Rationale**: These arrangements are designed to offer tax savings that supplement health insurance plans with high deductibles. They unfairly favor those with higher incomes and lack transparency.
   f) **Premiums.** During transition, the Secretary will be authorized to calculate premiums for Part B and EEM to ensure that they are both affordable and sufficient to maintain program integrity. Premiums for children will be 40%

of adult premiums. The Part B premium paid by those eligible for standard Medicare will be calculated by adding a small cost to account for elimination of deductibles and copayments and the average current Part D premium. EEM premiums will be calculated by the Secretary to be not significantly above the current cost to individuals available through an employer, considering the additional coverage offered. *After transition, premiums will be calculated as 5% of household adjusted gross income, after excluding an amount equal to 138% of the federal poverty level.* Premiums for workers on payroll will be billed through payroll deductions. Individuals not on payroll deduction or Social Security may be given the option to pay premiums monthly or to have an annual amount calculated as an addition to their income tax at the end of the year, which will be the default. Low-income individuals will be eligible for subsidies that will lower or eliminate their premiums (see below). **Rationale**: This will ensure that *Medicare for All* does not have the same problem that the ACA has been plagued with—the inability to attract people who want adequate coverage at an affordable price. *Medicare for All* will be competing against the health insurance plans available through employers, which are now subsidized both by employers and by the federal government (since they are tax exempt). These plans are getting more expensive for both employers and workers and harder to sustain, but *Medicare for All* must be able to provide coverage at a cost to workers that is reasonably close to the same price.

g) **Premium reductions** (*not tax credits*) during transition will be available for EEM for all families with incomes <400% federal poverty level, using the same guidelines as the ACA, as appropriately amended to include the "coverage gap," during transition. (When the ACA was written, it was assumed that anyone with a family income below 138% of federal poverty level would receive Medicaid, since they would qualify for coverage under the expanded ACA guidelines. It was not anticipated that some states would resist accepting 90-100% federal cost-sharing for these families and not expand their Medicaid coverage. This left some families with children with incomes as low as 17% of federal poverty level without coverage and those without children ineligible for Medicaid regardless of income. The ACA provided premium subsidies for families with incomes between 138% and 400% of federal poverty level, but not lower.) After transition, the calculation based on income excluding the threshold below 138% of federal poverty level will ensure affordability for all. **Rationale**: Low-income households cannot afford to wait for tax credits. It is more appropriate to reduce their premiums.

h) **Employers** will continue to pay premiums for their employees newly enrolled in EEM during and after transition, just as they pay for their private insurance. However, the total premiums will be much lower. Employers will pay 6% of payroll after the first $500,000 as opposed to the current average of 8.3% of total payroll. In addition, small businesses (with fewer than 100 employees) have an average payroll of $300,000 so very few of them will pay any premiums at all. Currently, about 53% offer health insurance for their workers at an average cost of 8.3% of payroll. In addition, payments

for Medicare Part E premiums will be authorized on unearned income similar to the current Medicare Part A tax on unearned income (for filers above set income levels) at the rate of 5%. Medical care under workers compensation will be covered by Medicare, reducing the cost of workers compensation to employers. **Rationale**: It is reasonable for employers to continue to take some responsibility for the health of their workers during and after transition. Employers need their workers to be healthy and productive. Employers' costs will be much lower than the amount they currently pay. Exempting the first $500,000 of payroll will ensure that all businesses will be able to afford even these lower costs. Concerns about rising costs will be eliminated. Payments on unearned income will prevent an unfair burden on workers and avoid the shifting of income from payroll to investment income merely to avoid payments.

10) **Budgets.** Although we do not recommend a global health care budget, we do recommend the Secretary be given authority to recommend specific budgetary expenses to promote improved healthcare utilization. The specific recommendations included here are initial recommendations that should be reviewed at least every 5 years by the Secretary with input from the Congressional Budget Office and the Center for Disease Control and Prevention (CDC).
    a) **Increase funding for biomedical research, including healthcare outcomes research, through the NIH.** We recommend increased research funding beginning with the second year of implementation, increasing to $15 billion by implementation. **Rationale**: Private companies should not bear the burden of research costs for healthcare. Research geared to the needs of the nation, rather than company profits, need to be prioritized.
    b) **Funding for advanced practice clinician support.** This should include methods to encourage states to allow increased privileges for advanced practice clinicians (nurse practitioners and physician assistants). We recommend funding beginning with the first year of transition, gradually increasing to $15 billion at implementation and thereafter. **Rationale**: There will be an increased need for clinical services with improved access to care. Advanced practice clinicians are a valuable and cost-effective means to provide those services.
    c) **Increase funding for graduate medical education.** This should include loan forgiveness programs, with an emphasis on encouraging increased numbers of primary care providers, dentists, mental health providers and addiction specialists starting during transition, increasing gradually to $15 billion at implementation and thereafter. **Rationale**: This will provide a method to encourage career choices that meet community needs while simultaneously reducing the burden of educational debt faced by many practitioners.
    d) **Provide funding to support other professionals.** In anticipation of shortages of trained clinicians due to improved reimbursement and access we recommend funding to support other professionals providing patient education in doctors' offices (such as nurses and nutritionists). We

recommend funding beginning with the first year of transition, gradually increasing to $15 billion at implementation and thereafter. **Rationale**: This is a missed opportunity for considerable cost savings. These services are currently bundled into physician services, limiting their availability since it requires physician practices to pay extra for services for which they receive no additional reimbursement. The physician practice effectively loses money when it provides these services even though the patient benefits from them. These services lower healthcare costs by improving patient compliance, reducing physician visits, procedures, emergency room visits and hospitalizations.

e) **Provide funding for job training.** We recommend a specific allocation for healthcare administrators in insurance and providers' offices for job training for workers who may need to change jobs, beginning during transition, increasing to $15 billion at implementation and continuing for another 5 years. **Rationale**: Changes in the need for administrative personnel will be inevitable under *Medicare for All*, which is designed to lower administrative complexity.

11) **Provide funding for a Home Health Corps.** We recommend a new nationwide Home Health Corps be developed and funded beginning during transition, increasing to $15 billion at implementation and continuing thereafter. **Rationale**: Increased access to care will increase the need for home health services, and more trained personnel will be needed. The funds will be allocated to help train, deploy and support these personnel.

As an additional cost control measure, we recommend a "Medical Products and Services Sunshine Act" that would require provider organizations, hospitals, health insurance companies, pharmaceutical and medical device companies and their lobbyists to report expenditures relating to any federally elected official or federal election campaign to the Federal Elections Commission, which would be required to report such contributions annually to the Secretary. This would become part of the information considered when the Secretary updates Medicare reimbursement rates for drugs and devices. **Rationale**: This will help guard against inappropriate political interference in healthcare policy, without limiting free speech.

A final measure we recommend to protect providers is an amendment to the Health Insurance Portability and Privacy Act. It would require all insurance providers, on request, to verify insurance eligibility with a termination date. A verification of insurance will serve as a guarantee of payment of any valid claim for services performed up to the termination date. **Rationale**: This will improve appropriate reimbursement to providers during transition by preventing insurance companies from inappropriately denying claims.

We discuss our rationales more fully below.

Medicaid expansion

By making sure everyone has insurance, we can improve opportunities for care, reduce costs by decreasing government expenses for uncompensated care, and spread the cost of healthcare expenditures fairly among all Americans over a longer period of time.

One of the most important issues for *Medicare for All* should therefore be to expand Medicaid as it was initially intended under the ACA. There are currently 2.4 million people eligible for Medicaid under ACA regulations who are unable to receive benefits because they live in states that did not expand benefits. The Supreme Court ruled that since the ACA required states to expand or lose all Medicaid funding, the expansion could not be enforced because it did not allow the states any choice.

Medicaid is a shared government program. Under current law, the federal government guarantees matching funds to states for qualifying Medicaid expenses that vary according to a state's average personal income compared to the national average. The federal share is currently guaranteed to be a minimum of 50% of eligible costs and is highest for the poorest state, Mississippi, at 74%. Additional payments are also made to hospitals that serve a large number of Medicaid and low-income uninsured patients. (Many of the states that receive enhanced federal matching payments under these formulas are the ones that elected not to expand Medicaid eligibility under the ACA.) The ACA increased the federal share of costs to 100% for newly enrolled beneficiaries from 2014 to 2016, decreasing to 90% in 2020 and remaining stable after that. This would have made sure that all individuals living in households with an income below 138% of the federal poverty level would receive Medicaid benefits, rather than the varied eligibility levels, which average only 107% of the federal poverty level. Among the 19 states that did not expand eligibility, eligibility is limited to families with children, except for Wisconsin, which provides Medicaid benefits to all households with income below 100% of the federal poverty level. The average income level for eligibility in non-expansion states is only 49%, with the lowest limit in Texas at 17%. Rather than using the current all-or-none formula in the ACA that the Supreme Court ruled was unconstitutional, we recommend amending the current formula for federal matching funds to the states, adding a factor based on the proportion of citizens eligible for coverage to the full extent allowed by the Medicaid expansion under the ACA. The federal share for previous enrollees will vary proportionately from 40% for no expansion to 60% for full expansion. New enrollees would continue to receive 90% federal sharing *if they are enrolled according to enhanced eligibility guidelines*. This will more correctly align federal and state incentives.

*90% match for non-expansion states only for new enrollees under enhanced eligibility guidelines.

	% Eligible enrolled	Federal match current enrollees before Medicare for All	Federal match current enrollees after Medicare for All	Federal match new enrollees*
Expansion state	100%	55%	60%	90%
Non-expansion state 1	75%	70%	55%	90%
Non-expansion state 2	90%	50%	58%	90%
Non-expansion state 3	0%	65%	40%	90%

With this amendment of the law, those states that expand eligibility will not have to pay unfairly for the cost of the underinsured of other states. The money the federal government saves from decreased Medicaid matching to non-expansion states would be used to subsidize premiums for the individuals who were not given Medicaid to obtain Medicare or ACA insurance with subsidies. (This allows for correcting the "income gap" in the ACA so that anyone with an income below 138% of the federal poverty level could get subsidies.) This would avoid the problem identified by the Supreme Court, since states opting out of expansion could still maintain their Medicaid funding, they would just receive less money. They would not be forced to opt in. The right to healthcare that was due to the 2.4 million individuals currently denied to them, primarily in Republican-dominated states, will be restored. The expectation is that the incentives will be strong enough that all states will expand Medicaid fully as originally intended. We expect this to be accomplished in the first two years of transition. One argument that was made by some states is that the federal government would gradually decrease reimbursement for new Medicaid enrollees as time went on. The newest proposals in Congress both call for bringing all expenses currently paid by Medicaid and CHIP under *Medicare for All*. This would allow both these programs to be discontinued. There could be no further concern about states being required to assume any increased costs. (See discussion below for costs and calculations.)

Even if some states with Republican governors remain determined to deny their needy citizens the opportunity to enroll in Medicaid under the generous conditions of these new incentives, the impact would be minor. This is true even in the unlikely event that the Supreme Court ruled that even the proposed amendment did not afford the states enough choice and was not constitutional. With the additional amendment proposed, the individuals in those states who would otherwise have been eligible for Medicaid will have access to affordable health care by ensuring that they will be able to obtain insurance either in the ACA marketplaces or under Medicare, with appropriate subsidies. Although initially the coverage they will have will not be as comprehensive as if they were able to enroll in Medicaid, they would still have good health coverage. In addition, as can be seen from the discussion below, the difference in cost to the federal government will be minimal. And after the 4 year transition, their coverage will be the same as if they had been enrolled in Medicaid (see below).

We also recommend that the regulation allowing for exemptions for policies with limited coverage lasting only 90-days (now extended in some cases to 365 days) should be repealed. This exemption was presumably intended to allow states to save money by avoiding more expensive Medicaid coverage for individuals who might need insurance for only a limited period of time. This cost-saving measure short-changes these vulnerable individuals who should be entitled to the same benefits as everyone else. It is unnecessary and endangers the health of our society. The cost of eliminating this regulation would be trivial.

Strengthening the ACA

The next most important part of the transition process is to provide affordable health insurance to the remaining 25.8 million people who currently lack insurance. Offering these people Medicare will not help if they cannot afford it. This has been the problem with the ACA because not enough people signed up for insurance. Unfortunately, the individual mandate that requires everyone to have insurance or pay a penalty has not been well received. However, the benefits of having health insurance have become obvious—especially after politicians tried to take it away.

The best approach to ensure full participation in health insurance is to make it truly competitive. Medicare is affordable because it is supported by a payroll tax for Part A that is paid over a long time and by generous tax support. Employer-sponsored health insurance is supported by approximately 70% premium payments by employers and $260 billion in tax benefits from the government. A similar benefit needs to be offered to new enrollees in *Medicare for All* to make it affordable (see "Cost considerations," below). This can be accomplished by using the power of a less complicated system to generate savings and by diverting the tax benefits that were given to private insurance to benefit Medicare instead. A smaller contribution by employers (see "Methods of Payment," below) will allow enough support for premiums and additional programs to enable *Medicare for All* to pay for itself. We advise extending a small equivalent of those contributions to unearned income, as is currently done for the Part A payroll taxes (see "Methods of Payment, below).

This seems a sensible approach during a reasonable transition period that will minimize disruption of the healthcare economy while *Medicare for All* is phased in.

We also recommend a gradual phase-in of additional coverage, rather than a gradual reduction in the eligibility age. This will allow for a more balanced population to enter Medicare.

We have adopted a transition that offers Medicare as a plan competing in the ACA marketplace. However, we recommend discontinuing Medicare Part D (drug plans) as a separate benefit, instead including the benefit in Part B (outpatient services) starting with the first year of transition. (The Medicare trustees note that the bulk of savings from price reductions negotiated by Part D plans is retained by the plans resulting in higher costs to the Medicare program and its beneficiaries.) We anticipate that Medicare may want to contract with a pharmacy benefit manager or another intermediary on a competitive basis to administer the drug benefit on a cost-efficient basis. This would necessarily require allowing Medicare to negotiate drug prices with drug companies. We recommend a system similar to the one used by Germany. This system would avoid the current situation in which the U.S. pays more for drugs than any other country in the world and would also prevent the unbridled price increases currently seen (see "Source of savings," below and Appendix, Table XIII).

MedPAC favors use of Part C plans (Medicare Advantage) to reduce costs but notes the lack of any translation of cost reductions to savings to the Medicare program for those enrolled in Part C (costs are 4% greater than standard Medicare). For this reason, we recommend the Secretary re-evaluate incentives for Part C plans each year, especially as benefits under Part B increase. In addition, new regulations should ensure that current and new enrollees in Part C plans are fully aware of the differences between Part C and Part B, including all benefits, costs (including out-of-pocket costs) and restrictions, such as pre-approval requirements and restrictions on use of particular providers (of which there are none under standard Medicare). With these changes, we expect enrollment in Part C to become unpopular. To make Medicare an attractive option, even during transition, we would also eliminate all deductibles immediately and continue copayments at 20% during the first year, begin to decrease them beginning in year 2 of transition to 15%, 10%, 5% and then 0%. Although MedPAC and others continue to recommend coinsurance to help control costs, they ignore the negative, discriminatory effects of these methods.

We anticipate with these incentives, given the excellent coverage afforded by Medicare at affordable premiums, with subsidies for those with low income, virtually all of the 25.8 million people without healthcare insurance not eligible for Medicaid will opt-in to Medicare within the first two years of transition.

Methods of payment

We recommend Medicare Part A payroll taxes as they are currently designed, during transition. Part A would continue to be used primarily for inpatient care and the Medicare Hospice Benefit for those previously eligible for Medicare (Standard Medicare), with only surplus funds eligible for use for other services. A new Part E would be created to pay for all services for those newly eligible for Medicare (Extended Eligibility Medicare, or EEM). Medicare Part B would pay for all other services for Standard Medicare, and would also cover drugs, since Part D would be eliminated. Standard Medicare Part B premiums would remain stable during transition (when considering the addition of Part D to the coverage). Those covered under EEM would pay premiums that would be kept competitive, which would be possible because of the program savings (see below). Also, with the premium tax subsidies diverted from private insurance plans, no additional payments from general revenues would be required (see Appendix, Table XX). However, premiums can be a barrier to universal coverage, even when they are affordable. After transition, we therefore recommend that individuals be automatically enrolled in Medicare and that in addition to using automatic deductions from payroll and Social Security, those without access to these methods be given a choice between paying monthly, quarterly or annual premiums and that premiums be adjusted for income, as is currently done for standard Medicare. In addition, an option should be available to have premiums paid as an addition to income tax, either with quarterly estimated taxes or at the end of the year. This should be the default option. In addition, we would change from the current system of a standard premium with subsidies for low-income households and surcharges for higher-income households to the simpler system suggested by Sen. Sanders. We would base premiums on 5% all household adjusted gross income above 138% of the federal poverty level. This would ensure that all households eligible for Medicaid under the expanded ACA guidelines would pay no premiums and everyone eligible for subsidies under the ACA would pay affordable premiums. For example, a family of four with a household income of $75,000 would have an annual premium of $1,974 (with no copayments or deductibles). By the time of full implementation, expected revenues from all individuals, including those on standard Medicare, would be $343 billion. (see appendix Tables XX to XXIII.)

Currently, Medicare Part A is funded 93% by payroll taxes and interest, but 73% of Medicare Part B and D are funded from general tax revenues. Additional sources of income are required. If more people are enrolled in Medicare and pay Medicare Part B and D premiums instead of the much higher employer-sponsored premiums (on which they do not have to pay any income taxes) funding for Medicare will only get worse. We therefore propose that during transition, businesses continue to pay a portion of the premiums for those workers enrolled in *Medicare for All,* just as they pay a portion of the premiums for private insurance (in addition to the employer portion of the Medicare Part A payroll tax, which will continue). The premium contributions to Medicare would be much lower, however. Currently, businesses pay an average of 8.3% of payroll for healthcare. We recommend reducing the amount contributed by businesses to 6% of payroll after excluding the first $500,000. Since the average payroll of small businesses (with fewer than 100

employees) is $300,000, the vast majority of them would pay no premiums. This would offer important protection to this group of companies, only 53% of which currently are able to offer health insurance to their employees. We feel it is important to reduce the cost of medical expenses to businesses and believe the burden is greatest for many small businesses that are increasingly eliminating healthcare benefits from their compensation. We think it is reasonable to ask employers to make a modest contribution to the health and productivity of their workers in a manner that allows all employers to remain competitive and removes concerns about rising costs and complicated decisions about healthcare coverage. This would be a boon to large and small businesses and give a dramatic boost to the economy. Expected contributions from businesses by full implementation would be $394 billion ($276 billion from private employers, $118 billion from government employers). This represents a saving of $243 billion a year for the private business community. (See appendix Tables XXIII and XXIV.)

In addition to this revenue, we also recommend that contributions to Medicare Part E of 5% be made from unearned income for eligible high-income individuals (this rate would be roughly equivalent to the amount that would be paid for earned income). This would be similar to the current Medicare Part A tax on unearned income (before standard Medicare eligibility age), using the same income thresholds ($200,000 a year for individuals, $250,000 a year for married couples filing jointly, and $125,000 each for married couples filing separately). It is only fair to workers to include this income in the calculations for money to be taxed for the purposes of paying for Medicare Part E. It would also ensure that income is not unfairly shifted from earnings to investment income to avoid appropriate contributions. The additional revenue is estimated to be $4 billion a year (see Appendix, Table XX, Note 18).

By having all employers make affordable contributions, no matter what size company someone works for, healthcare coverage and costs will be the same. This will be an advantage to workers who currently have little choice between a job with benefits and lower wages or one without benefits that might pay better—they often have to take what they can get. The tradeoff is also not transparent. Healthcare costs are difficult to assess since they consist of premiums, deductible and copayments, with varying tax benefits depending on many factors. The exact costs are unknown before healthcare is used. And healthcare benefits often change from year to year. Under *Medicare for All,* the process will be transparent, and workers will be able to compare their compensation offers more fairly.

In order to reduce administrative burdens on providers and patients, all healthcare coverage will be secondary to Medicare. This will include Workers Compensation. This will reduce insurance premiums for the healthcare costs of workers' compensation. During transition, this would apply only to those workers enrolled in Medicare; after transition, it would apply to all workers. Since healthcare costs are expected to decline during transition and after full implementation of Medicare for All, we anticipate the current medical costs of $50 billion for Workers

Compensation to decrease to as low as $30 billion (see Appendix, Table XX, Note 8).

Medicaid transition

Medicaid is an excellent health insurance program that this country has recognized as essential to provide all the medical care that is required for those people who would otherwise be unable to afford it. This is in keeping with the basic principles of our country, to take care of those in need or distress, to "ensure the general welfare of ourselves and our posterity," as our Constitution says. We see it every time a community suffers a disaster and people reach out with personal help and donations. This is what we do. Medicaid makes sure that those who have lost their jobs because of layoffs, who cannot find work because of a recession, who are widowed and raising a family, or working minimum wage and can't make ends meet can still have the dignity of having their healthcare needs met. Unfortunately, Medicaid is paid for by federal and state taxes and as George Washington pointed out in his farewell address, taxes are always "inconvenient and unpleasant." Those who control the state budgets generally do not directly benefit from Medicaid and have found ways to reduce the cost of Medicaid to the disadvantage of those who do benefit from it. Since Medicaid is designed for those with low incomes, and those individuals have little political power, this tactic has had been a winning one for politicians.

Since Medicaid covers many services not currently covered by Medicare, many older citizens are forced to spend their life savings on healthcare expenses in order to qualify for Medicaid benefits. As a result, people who always had a good income and saved money for the future find themselves, when they get older and sicker, suddenly part of the group of Americans classified as having low income. They then discover the results of Medicaid policy. By reducing reimbursements to providers, those on Medicaid have difficulty finding anyone to care for them. Quality providers often refuse to accept Medicaid patients. By forcing Medicaid patients into managed care plans, administrative obstacles are placed in the way of their treatment, often preventing them from getting any care at all. Worst of all, the result is an increase in costs due to the need for higher levels of care for sicker patients. The solution is simple. The comprehensive coverage that has been offered to Medicaid beneficiaries is the kind of coverage that all Americans should have. If we extend these benefits to everyone, we can eliminate the distinction between Medicaid and Medicare, other than the requirement to pay premiums and perhaps some extended coverage for services, such as some dental care and transportation reimbursement. This will eliminate the temptation to discriminate against those with lower incomes.

We recommend transferring the responsibility of paying for all services previously paid for by Medicaid and the Children's Health Insurance Program (CHIP) to the federal government under *Medicare for All*. It is a serious error, in our opinion, to exclude long-term care from these services for several reasons. An important reason for transferring all Medicaid services to *Medicare for All* is that Medicaid is administratively burdensome, with complex rules and regulations, requiring

many people to manage it. This adds needless costs to the system that should go to helping people with medical problems (administrative costs of Medicaid are 50% greater than Medicare's). By failing to cover the Medicaid costs for long-term care, this administrative burden on the government and providers is left intact. Other reasons for including long-term care will be discussed below.

The difference between Medicaid reimbursement and Medicare reimbursement, which varies by state, adds to this additional administrative burden for providers, who have to keep track of different rules and regulations. It also decreases patient access to services. Because fees are often so low and hassles are so high, providers are reluctant to accept Medicaid recipients. It causes significant problems for patients who need to access care in a state other in the one the one from which they receive their Medicaid benefits. This is why it is important to make reimbursements the same for all the government programs, Medicare, Medicaid and CHIP. Transferring all Medicaid services to the federal government will ensure adequate payment for services, regardless of state of residence. The total cost of Medicaid to the federal government needs to include the increased numbers of people covered by Medicaid, the increase in reimbursements and the cost savings.

For physician fees, the average reimbursement from Medicaid is 72% of Medicare's rate. Inpatient reimbursements are more complicated, but according to surveys by the American Hospital Association, slightly favor Medicaid, at least for community hospitals (although at about 10% below cost). Payments to skilled nursing facilities and home care agencies and some other facilities are probably lower, but the arrangements are complicated and are difficult to estimate; they are probably significantly higher compared to Medicaid physician fees. However, to be conservative, we have assumed they are 75% of Medicare rates. This would ensure adequate access to care for those previously covered by Medicaid and CHIP alone and reduce unnecessary use of services by allowing patients to receive treatment at home and in nursing homes instead of in more expensive emergency rooms and hospitals. (This cost is included in our calculation of Medicare Part E premiums at the time of implementation by assuming costs that are the same as everyone else on Medicare, with $16 billion of additional expenditures allocated to reimburse for transportation expenses and for dental services not covered under the basic services provided under *Medicare for All*, but covered under Medicaid, see Appendix, Table XX, Note 7.)

Need for comprehensive short- and long-term care coverage

Under our current system, not enough people qualify for long-term-care coverage. A very small minority purchase specific long-term-care coverage. This coverage is expensive unless purchased at a young age, and even then, it is above the means of many people. Medicare covers only short-term nursing care. It will cover a stay in a nursing home only when skilled nursing needs, such as physical therapy, are identified, and only for a specific period of time. It will cover a limited number of nursing visits or physical therapy visits at home, but with the requirement that the person is identified as being "home bound," meaning that it is difficult for the person to leave the home, and again only when a skilled need is identified. The only

exceptions to these rules are people who are eligible for Medicaid in their state or those who are terminally ill with a prognosis of 6 months or less who decide they do not want aggressive treatment and enroll in hospice for comfort care. Unfortunately, many more people need care at home or in a nursing home than those that fit into these rules. Especially in our modern times where so many families have two workers and so many people work more than one job. This leaves nobody at home during the day because they are working. Caretakers are hard to find. Chronic diseases pose a special problem. They are responsible for 70% of medical costs, often due to multiple hospitalizations. Part of this problem is the lack of adequate care in the home.

The result of this lack of coverage is the unnecessary use of more expensive services, such as emergency room visits and hospitalizations, and higher severity of illness. We see people coming to the emergency room because they were too sick to get to the doctor's office and there was no coverage for a nurse's home visit. Or people being admitted to the hospital so they could qualify for a nursing home stay because there is nobody to take care of them at home. And we see people staying in the nursing home receiving physical therapy until the last day they qualify for it under Medicare because they do not qualify for Medicaid, which would pay for their room and board. Only when their number of qualified days run out do they call hospice to enroll. These are some of the reasons it is unwise to avoid paying for long-term care as a way to keep federal costs low at the expense of the states.

Current attempts to control the cost of care after a hospitalization have been largely unsuccessful. For example, The Center for Medicare and Medicaid Innovation (CMMI) launched the Bundled Payments for Care Improvement (BPCI) initiative in 2013. An analysis by CMS showed that of the 48 clinical episodes covered under BPCI, only major joint replacement of the lower extremity was associated with a decrease in overall costs to Medicare. A later independent analysis showed that hospital participation in 5 common medical bundles was not associated with significant changes in Medicare payments, clinical complexity, length of stay, ER use, hospital readmission, or mortality. The authors note that where savings did occur, it was mostly due to the use of home care instead of admission to a rehabilitation or nursing facility to provide care after hospitalization. They suggest that the failure of the hospitals participating in BPCI to reduce allowed Medicare costs may be due to their lack of ability to influence what happens to patients once they enter a post-acute care setting. Our proposal to increase the types of services covered by Medicare after an acute hospital stay, coupled with changes in the way those services are reimbursed, would correct this problem by removing incentives to use more expensive settings of care.

Need to eliminate all coinsurance

Current plans for *Medicare for All* retain some coinsurance with the intent to keep costs low. The effectiveness of this method is dependent on the person's economic status. Coinsurance will have no effect on someone who is very wealthy. Their effect on people will less money may be more important. Only those with moderate resources will be affected by coinsurance in the desired manner—it will make them

think about the cost of the service before they make a choice and decide how important it is to them. But they do not always have enough medical knowledge to know whether their choice will have an impact on their health. This is a very small portion of the population. In many cases the effect of coinsurance is to make people choose to avoid healthcare services entirely rather than pay for something they cannot afford. The result is poor health outcomes and often, increased healthcare costs. This makes coinsurance a very poor method for saving costs or for affecting patient behavior. If the intent is to make healthcare more affordable, the best answer is to increase revenues. If the intent is to keep healthcare costs down, other methods must be used. The worst form of coinsurance is the deductible. Deductibles create significant barriers to care for anyone on limited income. They do not encourage more careful spending on healthcare. Patients rarely have a choice about whether they need to be hospitalized—making them pay a deductible before they are reimbursed for hospital costs will have no effect on their behavior. It only affects their financial health. We recommend eliminating all coinsurance completely by the time *Medicare for All* is fully implemented as outlined above (see "Strengthen the ACA").

Encouraging transition from private insurance to Medicare

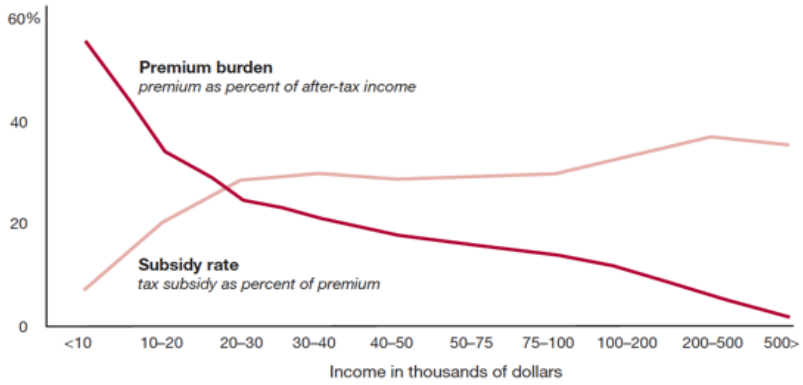
An important part of our plan is a four-year transition from the current system to *Medicare for All*. This will help reduce the impact of the changes that will occur in the healthcare economy by allowing time for adjustment. However, this advantage will have little impact without incentives to encourage the move from private insurance to Medicare. In addition to failing to address the current problems with the ACA, the plans before Congress fail to address the competition from private insurance plans. With the knowledge that providing insurance for services covered by *Medicare for All* will no longer be allowed as of the date of implementation, it is likely that these plans will seek to maintain their market share for as long as possible. Medicare would need to be very competitive to encourage people to choose it over them. Although high-deductible and expensive plans will offer little competition, other plans may be more attractive.

The increased coverage under *Medicare for All*, especially long-term care and lack of deductibles, will make it an appealing option. Decreasing deductibles each year will make it even more so. However, we have three further recommendations to encourage enrollment in Medicare during transition.

The first recommendation is to ensure that premiums are affordable and competitive with private insurance. Given the high percentage of uninsured who say that cost is the reason they do not have insurance, it is essential that Medicare premiums be affordable during transition. That is one reason we have recommended employers continue to contribute to a portion of their workers' premiums, although at a much lower cost. We want to be sure the Secretary will be able to set premiums competitively without unnecessarily increasing costs to general revenues. This much lower cost is a reasonable option to ensure low enough premiums without unduly burdening anyone.

The second recommendation is to gradually decrease the tax-exempt status of private insurance premiums. Currently, employer-sponsored health insurance premiums are the only insurance premiums that can be deducted from income before taxes. Other health insurance premiums, except for Medicare Part B premiums, can only be deducted if the person itemizes deductions and then, only if total medical expenses are more than 7.5% of their adjusted gross income. The Congressional Budget Office estimates the cost of these tax exemptions at $260 billion. Since private insurance will be much less common after implementation of *Medicare for All* and everyone will be paying Medicare premiums that are not tax exempt, it will be best to introduce this change gradually. This will also encourage people to move to Medicare. We would decrease the amount of health insurance premiums for services covered by Medicare that is tax-deductible each year of transition successively to 90%, 75%, 50% and 25%. We would also eliminate all tax-exempt health savings accounts, health reimbursement accounts and flexible savings accounts.

Employer-sponsored subsidy rate versus premium burden (data from 2009).



Source: Urban-Brookings Tax Policy Center Microsimulation Model
Note: Income includes value of employer contributions to health insurance. Subsidy includes income and payroll tax savings.

Another concern addresses an important protection for providers. It is common for private insurers to allow customers a grace period when they fail to pay a premium on time before they cancel a policy. This will often result in the customer paying the premium and remaining on the policy. However, when someone presents to a provider's office for services and requests insurance verification, it is important that the information given to the provider is accurate. Currently, it is common for an insured who has not paid a premium to be kept on a policy and a provider will be given verification of insurance. However, if the insurance company does not receive a premium payment at a later date, it may retroactively cancel the person's policy as of the date the premium was due, *even if that date is before the date that the insurance company verified to a provider that the person had valid insurance*. This can lead to a situation where the provider can bill an insurance company for services and have the bill declined because the patient does not have insurance, even after the provider was told the person did, leaving the patient as the only person to bill. This can happen even if the patient has died and has no estate. The provider then has no way to be compensated for the services given. This should not be allowed. We recommend, an amendment to the Health Insurance Portability and Privacy Act, that all insurance providers, on request, be required to

verify insurance eligibility with a termination date. A verification of insurance will serve as a guarantee of payment of any valid claim for services performed up to the termination date.

Claims processing

It is most important to understand that Medicare is not an insurance agency. It does not process any healthcare claims submitted by providers and does not make any payments to them. Instead, all of that work is done by private insurance companies. Medicare pays $2 billion a year in contracts to those companies for this work, out of a total administrative budget of $8 billion.[*] This means that even after implementation of *Medicare for All*, when there would be no further need for private healthcare insurance covering services that Medicare covers, there will still be an important role for private health insurers. The Medicare contractors will now be processing over $1.5 trillion in claims instead of $1 trillion. Either the number of contractors will need to be increased or they will likely need to hire more workers. The budget for those contracts will need to increase.

There will also be a healthy market for services not covered by *Medicare for All*. By limiting some of the newer services under *Medicare for All* that are not essential for health (those other than long-term care), supplemental policies would remain popular. In addition, the profits made by the insurance industry on private health insurance are small: 1-2% for group markets and -2% to 1% in the individual markets. Concern about disruption of the insurance industry is overstated. The type of insurance business products may change, the business may change, but the industry should continue to prosper.

Regulatory considerations

Although an argument can be made for limiting insurance that duplicates the coverage offered by *Medicare for All,* attempting to make it illegal poses regulatory problems, not least of which is the possibility of a court challenge. We think the need for such constraints will be found to be lacking when the ability of *Medicare for All* to provide quality services at affordable prices becomes evident. With affordable coverage available to all, we recommend all other health insurance be considered secondary to Medicare. We find it difficult to imagine a scenario in which any significant number of providers will fail to participate in Medicare and any significant number of individuals would be willing to purchase alternative private insurance outside the system. Our analysis of costs and savings makes this obvious.

[*] These are the administrative costs as stated in the Annual Report from the Medicare trustees. This my understate the true administrative costs of the program, however. The CDC, National Center for Health Statistics, cites $46.8 billion for "administrative and cost of insurance" for Medicare for 2016. Of this, $10.5 billion is "Federal" expenditures, for salaries and direct costs for administering Medicare, whereas $36.2 billion is for the estimated administrative costs associated with Part C and Part D plans—Medicare Advantage and drug plans. Under *Medicare for All,* administrative costs without Part C and D costs would be 2.2% or $14.8 billion.

An advantage of this regulatory change is that the concept of primary and secondary insurance is well known and commonly used now. It will require no major adjustment to current practice and will be easy to administer. Making Medicare primary to all other insurance will also decrease the administrative burden on providers by avoiding all confusion about coordination of benefits and speeding up the reimbursement process.

Cost considerations

According to CMS, the average cost of new Medicaid enrollees since the ACA expansion is $5,980. It would therefore cost $15.2 billion to expand Medicaid to the 2.4 million eligible residents, assuming a 10% increase in cost due to increased utilization, if all of the current non-expansion states decided to expand Medicaid fully. During transition, the federal government would be responsible for 90% of the cost, or $14.2 billion. After transition, the federal government would assume 100% of costs, but due to the decrease in administrative costs for *Medicare for All* compared to Medicaid (3% vs. 10.7%, see calculations below), the cost would only increase to $14. 5 billion (see Appendix Table Ia).

After transition, all those previously on Medicaid and CHIP (65 million, excluding those newly enrolled) will be enrolled in Medicare. Their average costs are $7,560 per person (CMS). Adjusting for increased utilization and decreased administrative costs makes their cost to $478 billion. An additional cost of $134 billion would be needed to adjust prices to Medicare rates and also cover additional needs of Medicaid and CHIP patients, such as transportation and additional dental services (see Appendix Table I c). The total cost would be $612 billion. This needs to be reduced by funds previously allocated to Medicaid ($410 billion) bringing the cost to general revenues down to $202 billion .

The cost of providing care for those on private insurance and the uninsured (including those on the ACA, but excluding those who are Medicaid-eligible) is estimated by calculating their current cost of care and adjusting for the difference in cost of insurance, using the average cost of private insurance (11.5%) and the cost of insurance for Medicare (3%, see calculations below). This gives a cost of $6,104 per person, multiplied by 201 million to be covered, and adjusting for the number of children (see Appendix Table XX, note 5) gives a total cost of $1,067 billion. Assuming 6% increase in non-hospital costs per the RAND study increases this to $1,091 billion. An additional cost would be low-income subsidies ($72 billion), offset by funds previously allocated to ACA subsidies ($40 billion) for a total of $1,124 billion. We assume that the inducements built into the transition will result in most individuals on ACA or other non-group plans rapidly enrolling in Medicare with a gradual increase in those on employer-sponsored health-insurance enrolling in Medicare: 20 million in year 1, 45 in year 2, 60 in year 3, 84 in year 4 and all 170 million by implementation.

We have assumed a similar cost for those currently without insurance as those enrolled in private insurance. This is likely an overestimate, since their costs are typically about half as large as the cost of those who have insurance. Although the

increase is likely to be less than the 6% seen with full insurance, because of self-selection of healthier people in the uninsured population, we have used this figure to be conservative.

Adding together all the new individuals enrolled on Medicare after transition is completed, costs would amount to $1,340 billion.

The cost of decreasing coinsurance will increase as the percent of coinsurance decreases. We calculate costs starting in the second year of transition, when the coinsurance reduction begins, increasing each year and reaching $168 billion when *Medicare for All* is implemented. We estimate the cost of eliminating deductibles to be about $8 billion (see Appendix, Table VIII).

We recommend limiting dental coverage to prophylaxis, including x-rays, extractions and fillings. We estimate this would cost $14 billion. We would limit vision coverage to up to one refraction and one pair of glasses a year, as indicated. We estimate a cost of $24.2 billion for this. We would limit hearing coverage to a pair of standard hearing aids to those with hearing impairment with replacement every 5 years as needed. The estimated cost for this would be $11.5 billion. We recommend adding dental covering during the first year of transition, adding vision care during the second year of transition and adding hearing coverage at implementation of *Medicare for All*. These recommendations are due to a combination of the importance of the medical need and the costs (See Appendix, Table IV.)

We recommend increasing the administrative budget for Medicare for a number of reasons. We mentioned the need to provide increased reimbursement to contractors for claims processing. We expect increasing the current $2 billion allotment to $6-8 billion would be sufficient by the time of implementation. We would recommend additional amounts to allow Medicare to develop a comprehensive set of standard regulations throughout the country. Currently, each regional Medicare carrier makes regulations based on the Medicare Handbook, known as Local Carrier Determinations. Instead, we recommend that Medicare convene all the Carrier Directors and have them develop a set of National Determinations based on the best practices of all the Local Carrier Determinations. These would provide regulatory guidance for all aspects of the program nation-wide and would prevent variations in program management. An increase in the administrative budget would also allow for improvement in Medicare's information systems and allow it to spend more resources on claims audits of various types that would more than pay for the increased cost by reducing payments for unnecessary services and fraudulent claims (see "Source of savings" below). We recommend increasing the administrative budget by $5 billion in year 1 of transition, $10 billion in year 2, and increase it in $5 billion increments through transition up to $20 billion.

The cost for comprehensive short-term and long-term care coverage includes care provided in nursing homes and other facilities, home care visits by nurses, and

personal care by home health care aides. We conservatively estimated a 45% increase in the cost for care in nursing homes not currently covered, based on the RAND data estimating 40-42% increase in costs with comprehensive coverage over ten years. We added to this 75% increase in expected costs for home health care. We expect the total cost of these services to reach $266 billion dollars. This averages out to a 61% increase, which we gradually increased over the three years of transition during which they will be available (see Appendix, Table VII).

Under *Medicare for All*, Medicare can efficiently gather, analyze, and disseminate information to the public. The information that pertains to the risk and effectiveness of common medical procedures would be very helpful in bringing down costs by helping design better clinical trials. It would also help healthcare teams better educate patients about their conditions and treatment options. However, patient education by nurses, nutritionists and many other healthcare professionals are not reimbursed by any insurance plan, including Medicaid. Nurses and other trained medical professionals provide a critical role in educating patients about their healthcare and helping manage their care. Physicians often lack the time to perform this task, and other professionals often have better skills. Examples include diabetes nurse educators and nutritionists. These professionals often spend a great deal of time with patients at the expense of the physician's practice. They are sometimes the most important part of a patient's care. This resource needs to be encouraged and reimbursed. The estimated additional cost for this is up to $18.7 billion (see Appendix, Table III).

Additional needs

Another important unmet need in our healthcare system is research. Since the federal government has been decreasing the amount of money allocated to medical research, physicians and scientists have become more dependent on pharmaceutical industry and device manufacturers for funding. Although these companies have provided valuable resources, their interests are not always aligned with the needs of the nation. For example, when a new drug is discovered that has a valuable market, several drug companies may spend billions of dollars in research and development to find similar drugs in hopes of gaining part of the market share, even though it may have little new value to the community. There is also growing danger that the results of studies are reported in a biased manner, consciously or subconsciously, due to the importance of the results to the funding source. There has also been a lack of funding for research on medical outcomes. We need to test new ideas and measure their results scientifically instead of moving from one idea to the next without knowing what works. The best way to accomplish both of these goals is to increase the funding for the research budget of the National Institutes of Health. The current budget for healthcare research through the National Institutes of Health is $36 billion. We recommend adding $15 billion, for a total budget of $51 billion, starting gradually during transition.

With the implementation of *Medicare for All,* increased coverage and utilization will increase the need for primary care services. Many areas already have shortages of primary care providers. Medical schools will not be able to fill this need.

Advanced practice clinicians (nurse practitioners and physicians' assistants) have been shown to be valuable assets, of special importance in primary care and especially rural areas. By increasing investment in training and support of advanced practice clinicians in clinical practices we can meet this growing need in primary care. This is a cost-effective solution. Although some states allow advanced practice clinicians to perform many tasks that would be required to meet these goals, there are still some unnecessary gaps that exist. Other states have further to go. Providing incentives for deployment of advanced practice clinicians would be part of this process that would drive states to enact appropriate legislation to permit advanced practice clinicians to take the place in the healthcare system that is needed. We recommend increasing allocations through transition, increasing to $15 billion after transition to support this need.

A similar problem exists for a number of medical specialties that face severe shortages. Most important are mental health professionals, addiction specialists, palliative care specialists, and specialists in geriatrics. We recommend the Secretary be authorized to review these needs annually, after consultation with the Centers for Disease Control and the Director of the National Institutes of Health, and support these specialties with educational grants and loan forgiveness programs to increase the number of professionals going into these and other fields identified as facing shortages. We would allocate increasing amounts to graduate medical education and other support during transition, eventually reaching $20 billion after implementation of *Medicare for All*. Similarly, additional funding for education and deployment of general dentists will be necessary, a group found to be in short supply as a result of Medicaid expansion under the ACA. The separate reimbursement for education by nurses, nutritionists and other professionals may also cause increased demand requiring additional funding. We recommend allocations for these during transition up to $15 billion.

To a great extent, provider shortages reflect under-valuation of services provided under the current system. MedPAC has noted this and recommended changing the basis of reimbursement from the current Relative Value Unit (RVU) to one that better reflects the value of the services. We recommend a straightforward method to achieve this goal. The current RVUs are calculated using three components: work, practice cost and cost of malpractice insurance. We recommend adding a value adjuster to the RVUs as has been proposed by others. However, we recommend that part of the value consideration should include population needs. This would help better align payments with services that are of value to the community (such as primary care, behavioral health and addiction services). These value considerations could vary depending on community need, as determined by the Secretary. Regional variations in such needs are just as important to factor into these value considerations as they are into cost considerations. Regular and timely input from local stakeholders is therefore essential to ensure proper valuation.

As an independent Congressional agency established in 1997 to advise Congress on issues affecting the Medicare program, the recommendations made by MedPAC often have considerable merit. However, MedPAC is hampered by the limited

information available to it, its methodology, its lack of clinical expertise (only 3 out of 17 commissioners are physicians with any clinical background) and the failure of Congress to enact changes. In attempting to fulfill its mandate, MedPAC at times fails to fully consider the implications of its limitations. This leads to some contradictory recommendations. For example, MedPAC recognizes that current reimbursement methods allow providers to steer patients to different settings for the same post-acute-care treatment (such as rehabilitation) and recommends changing to a model that pays according to a patient's diagnosis and care needs instead of paying according to number of treatment days (which leads to overuse of services). This recommendation is made based on high profit margins for post-acute-care services. However, regarding hospice reimbursement, the Commission notes a similar problem but makes a different recommendation. For-profit hospices have longer lengths of stay and more patients with diagnoses for which it is difficult to determine prognosis. This leads to higher payments to for-profit hospices. Rather than recommending payment according to condition and needs as for post-acute care treatment, in this case MedPAC recommends only that prices for hospice services should not be updated since its analysis shows that payments are adequate to cover costs. This recommendation is based on profit margins calculated using cost per day per patient. This, of course, is only valid if the costs increase proportionately with each day, which the Commission notes is not true. Their recommendation serves only to reward for-profit hospices that, as MedPAC noted, likely have many patients in their program who are not really eligible for hospice benefits.

MedPAC also fails to acknowledge the potential for problems with newer payment methods. Although payment according to need may eliminate one type of steering, it may promote another. Rehabilitation facilities could, for example, accept patients with care needs that appear to be high regardless of their actual potential to participate in the program. They could then potentially receive reimbursement for a full course of treatment while the patient might have to stop treatment much earlier than planned. In extreme cases, one could imagine acceptance of patients with very little rehabilitation potential who might be discharged from the program within just a few days.

Nevertheless, the tremendous work done by MedPAC should not be ignored. There is great potential for cost-saving initiatives based on much of the work the Commission has done. That work needs to be reviewed carefully, with full consideration of the clinical impact on patients.

We must also consider the changes required by the *Medicare for All* program itself. Although the private insurance industry will remain intact, its business needs will change. The administrative needs of providers will also be different, with more emphasis on patients and less on billing. We recommend a specific allocation, beginning with the first year of transition and extending to 5 years after implementation, of $125 billion for job training for those in the insurance industry and healthcare administration who may need to change jobs. We also recommend funding a new nationwide Home Health Corps to ensure availability of properly

trained personnel to care for the increased number of people who will need to be cared for at home. The primary role of the Home Health Corps would be to support and fund statewide agencies for enrollment and training of personnel and provide salary support when needed. Funding would begin the first year of transition increasing to $15 billion.

Total additional costs during transition and at implementation are shown below. These costs are calculated on a static basis, assuming no other changes over time, including changes in the population, chronic disease burden, aging or increasing healthcare costs under the current system. This simplifies the calculations and allows us to separate the effect of changes due to demographics from changes due to *Medicare for All*. The purpose of analyzing costs (and savings) in this way is to determine whether *Medicare for All* results is overall costs or overall savings and to get a general sense of the magnitude of any costs or savings, regardless of any demographic changes and without making assumptions about trends in healthcare inflation under the current system.

Additional costs of *Medicare for All* and recommended programs

Cost of additional services (in billions)	**Year**	**1**	**2**	**3**	**4**	**After trans.**
Number of new enrollees (estimated, in millions)		*42*	*89*	*106*	*129*	*268*
Number of previous enrollees (est. in millions)		*53*	*53*	*53*	*53*	*53*
Dental care		$4	$6	$7	$8	$14
Nurse and other professional educational visits		$6	$8	$9	$11	$19
Deductibles		$2	$4	$4	$5	$8
Vision care		$7	$11	$12	$14	$24
Comprehensive short- and long-term care		$0	$88	$115	$150	$265
Hearing care		$0	$0	$0	$0	$12
Reduction of copayments		$0	$19	$42	$72	$169
Additional dental care and transportation Medicaid		$0	$0	$0	$0	$16
Total cost of additional services		$19	$135	$189	$259	$527
Cost of new enrollees						
New enrollee expenses		$235	$497	$589	$712	$1,583
New premiums collected		($111)	($226)	($288)	($375)	($657)
Total cost of new enrollees		$124	$271	$301	$337	$925
Total costs new enrollees and new services		$143	$406	$490	$595	$1,452
Other costs						
Expand Medicaid		$7	$14	$14	$14	
Equalization of Medicaid/Medicare rates						$118
Increased utilization of previous enrollees		$2	$3	$5	$7	$7
Increase in CMS budget		$5	$10	$15	$20	$20
Additional research budget		$5	$10	$15	$15	$15
Advanced practitioner training		$5	$5	$10	$15	$15
Graduate medical training		$5	$5	$10	$15	$15
Additional professional and dental support		$5	$5	$10	$15	$15
Total additional costs		$34	$52	$79	$101	$205
Additional programs (years 1-5)						
Job training		$10	$10	$15	$15	$15
Home Health Corps		$10	$10	$10	$15	$15
Total costs *Medicare for All* and programs		$197	$478	$594	$726	$1,687

Source of savings

Implementation of *Medicare for All* will not be possible if healthcare costs are not reduced. The most attractive part of this plan is that providing health insurance and eliminating financial barriers to care, by themselves, decrease costs. In addition, by creating a less complicated healthcare system, inefficiency and waste

will be decreased resulting in enough savings to offset all the increased costs. The money is there in the healthcare system to pay for what is needed.

By guaranteeing affordable healthcare insurance, *Medicare for All* will eliminate the need to reimburse providers for uncompensated care. Currently, 62% of uncompensated healthcare expenses by the uninsured are paid for by indirect reimbursement to providers. The bulk of these come from specific Medicare and Medicaid allocations for uncompensated care. About $12 billion represents charity care from physicians and private clinics. *Medicare for All* will allow all of this money to be recouped. Even if we assume only 95% of this money is saved, after adjusting for 6% increase in utilization, this amount comes to $64 billion a year (see Appendix, Table IX).

As part of the initiative to ensure enrollment in *Medicare for All* during transition, we recommended gradually phasing out tax incentives for private health insurance (see "Encouraging transition from private insurance to Medicare, above). The increased tax revenues from this would be from $27 billion in year 1 of transition to $131 billion by the end of transition (reduced due to the effect of the Tax Cut Act of 2017 and exempt business expenses for employer contributions to Part E premiums, see Appendix, Table XX, Note 12.) At the time of full implementation, $94 billion of these savings would be from increased tax revenues from individuals, most of which would come from high-income earners.

An overlooked source of savings is the decreased utilization of more expensive services when less expensive services are covered. Many patients cannot afford coinsurance for outpatient visits and end up in emergency rooms or hospitals much sicker than they would have been if they had received earlier care. Patients also spend many days in the hospital waiting for nursing home beds and many days in nursing homes when they could have been better treated at home but couldn't afford it. We assumed many of these savings in some of the models below, but estimated a gradual 12% decrease in utilization of hospital services solely on the basis of increased availability of newly covered services under *Medicare for All*. We estimate savings of up to $123 billion (see Appendix, Table XX).

With *Medicare for All*, excess administrative costs will be directly decreased. Medicare's Annual Report shows administrative expenses of only 1% of the total health care costs of beneficiaries ($8 billion). This is likely an underestimate of total administrative costs of the program. The CDC's National Center for Health Statistics shows expenses for Medicare for administration and net cost of insurance of $46.8 billion, representing 7.0% of medical expenditures. However, most of that cost is related to the cost of private insurance plans in Part C (Medicare Advantage) and Part D (prescription drug plans), together accounting for $36.2 billion. Only $0.5 billion of that is for Part D plans. Federal expenditures for administration of standard Medicare (Parts A and B) would then be only $10.1 billion out of $366 billion of the expenditures reported by CMS for those parts (2.7%). With elimination of Part D and reduced attractiveness of Part C, likely leading to its disappearing, all medical expenses under *Medicare for All* will be the

same as standard Medicare. Allowing for some additional expense for drug administration, we assume administrative expenses of 3%. This is much lower than the administrative costs of private insurance (11.5% for employer-sponsored insurance and 33% for Part C Advantage Plans). Eliminating the increased administrative cost of private plans will therefore result in $102 billion in savings when *Medicare for All* is fully implemented; these savings are incorporated in the cost calculations for new enrollees (see Appendix, Table VII a). Incidentally, Medicaid administrative costs are also higher than Medicare's (10.9%), emphasizing the benefit of ending this program (another $46 billion in savings).

The administrative cost for providers is also much lower for Medicare than for private insurers (especially Health Maintenance Organizations) and for Medicaid as well. The complexity of the current system requires providers to spend enormous time, energy and money on billing that could be better spent on caring for patients. The Institute of Medicine report of wasted medical expenses identified $256 billion in excess administrative costs (in 2016 dollars). Capturing even 30% of that from reduced billing costs due to the single-payer system under *Medicare for All* would save $77 billion a year. Adjusting for 6% increase in utilization would increase that to $81 billion. Calculating another way, reducing total national physician and clinical expenditures by 10%, adjusted for 6% increase in utilization, would save $70 billion. We conservatively estimate savings of $75 billion at the end of the first year of implementation (see Appendix, Table XV).

Some of the most promising methods for reducing cost with *Medicare for All* will come from more effective use of tools currently being used. By increasing Medicare's administrative budget while eliminating Medicaid's complicated and inefficient billing system and providing a much larger group of beneficiaries to work with, *Medicare for All* will be able to reduce unnecessary services and fraud through improved claims monitoring. The simplest process is to audit claims on the basis of utilization that is outside of normal patterns of use. Medicare is currently doing this, but it is not well enough staffed for proper implementation. Use of more sophisticated algorithms can also improve results. Medicare also currently relies on the linking of procedure codes with an approved diagnosis to make sure the procedure is necessary. This is a very low level of scrutiny that allows for many unnecessary procedures to go undetected. With increased resources, Medicare will be able to develop additional linkages, such as sequences of procedures, supplemental codes, or claims reviews for certain procedures. We recommend increasing the administrative budget for Medicare during transition, as discussed above, to allow effective use of these tools.

Equally promising is the result of the addition of another layer on the low-complexity healthcare system: the single-platform. We propose the development of a clinical-only electronic medical record (EMR) repository into which all providers would submit every patient encounter. Development of a universal EMR has been slowed by commercial interests each seeking part of the profits and concerns about patient privacy.

Commercial interests can be circumvented by developing not a single EMR, but a simple required dataset and universal interface with which all EMRs would be required to comply. This would no different from application developers having to comply with the requirements of a particular operating system (such as Windows®). As for privacy concerns, they are completely unfounded. Despite the fact that whenever a patient sees a provider with access to records with other providers using the same EMR, no specific permission is either required or requested, all external systems designed to collect patient information from different sources have consistently built in a requirement for patient consent. This has dramatically weakened the usability of the systems by decreasing their universality. There is no need for such consent since consent for the exchange of information between healthcare providers is implicitly provided whenever a patient consents to treatment. All that is required is to ensure that access to the information is limited to healthcare providers who require the information for patient care. The interface should be open-source—it will not be proprietary or involve any fees. The interface should be available for use by all providers, just like the Internet itself. A leadership team from the most important stakeholders should be brought together to develop this universal EMR interface. This will be an engine that could drive dramatic reduction in the $1 trillion in medical waste identified by the Institute of Medicine. The information in this system could be accessed securely by individual providers for patient care needs, or patient-specific information can be removed from data that is gathered for important analysis of provider and diagnosis groups for healthcare research.

With increasing specialization, clinicians must coordinate patient care with multiple other providers. Medicare patients now see an average of seven physicians, including five specialists, split among four different practices. A typical primary care physician coordinates with an average of 229 other physicians in 117 different practices just for Medicare patients. This excessive fragmentation results in unnecessary costs and confusion for the patient and provider alike. One survey found that 75% of hospital patients were unable to identify the clinician in charge of their care. This complexity often affects healthcare quality and outcomes. Recent studies have reported that as many as one-third of hospitalized patients may experience harm or an adverse event, often from preventable errors. The advances in connectivity provided by this universal EMR interface have the potential to improve health care by expanding the reach of knowledge, increasing access to clinical information when and where needed, and assisting patients and providers in managing chronic diseases. Studies also have found that using effective electronic systems can improve safety—one study reported a 41 percent reduction in potential adverse drug events following the implementation of a computerized patient management system.

With this single-platform system, Medicare will be able to more effectively utilize other tools that the medical community has been attempting to use to improve our healthcare system. These include the use of clinical guidelines, clinical pathways, quality initiatives and care coordination. Groups like the U.S. Preventive Health Services Task Force, the American Society of Clinical Oncology, the Centers for

Disease Control, the Agency for Healthcare Research and Quality are just some examples of organizations with programs that would be able to use these resources to improve their efforts. Providers could be given incentives to participate and the single-payer, single-platform system would allow monitoring to determine their effectiveness in quality and cost reduction. The expectation would not be for providers to follow guidelines slavishly, but to use them with clinical judgment. The usual paradigm is called the "80-20 rule." The expectation is that about 80% of patients will be treated according to guideline and 20% will not, for one reason or another. When a practitioner's pattern falls outside of these limits, an explanation is required. Further decrease in administrative costs with tools like computerized order entry, electronic prescribing, medication reconciliation and record retrieval are obvious and could reasonably be expected to save another 15% of administrative expenses.

Americans receive only about half of the preventive, acute, and chronic care recommended by current research and evidence-based guidelines. Sometimes this occurs because available evidence is not applied to clinical care, while in other cases evidence is not available. As a result, the quality of health care varies considerably among states, with serious health and economic consequences. If all states could provide care of the quality delivered by the highest-performing state, an estimated 75,000 fewer deaths would have occurred across the country in 2005. With the single-payer, single-platform of *Medicare for All*, this universally high level of quality care will be achievable.

The cost of current clinical research methods averages $15-20 million for larger studies—and much more for some. Given the increasing number of new medical treatments and technologies, the complexity of managing multiple chronic diseases, and the growing personalization of treatments and diagnostics, the challenge is to produce and deliver practical evidence that clinicians and patients can apply to clinical questions. Despite the accelerating pace of scientific discovery, current clinical research does not sufficiently address many pressing questions. The result is decisions by both patients and clinicians that are inadequately informed by evidence. The single-payer, single-platform structure of our *Medicare for All* plan provides improved capabilities for these research questions. For example, one study found that real-time analysis of clinical data from electronic health records could have identified the increased risk of heart attack associated with one diabetes drug within 18 months of its introduction, as opposed to the 7-8 years between the medication's introduction and the point at which concerns were raised publicly. The additional research funding that is part of our plan will help realize this goal.

Combining the effectiveness of the universal coverage provided by *Medicare for All* with the single-platform system the prospects for cost savings are significant. With the tools discussed, we conservatively estimate reducing costs from unnecessary services, inefficiently delivered services, missed prevention, decreased administrative expenses and fraud by as much as $205 billion. (See Appendix, Table X for detailed calculations.)

As a result of the universal coverage of *Medicare for All*, the waste due to excess prices will also be eliminated. These will no longer be allowed under *Medicare for All* because of the universal reimbursement schedule. In our current healthcare system, some providers can charge excessive prices that drive up the cost of insurance, especially in the directly purchased market. The Institute of Medicine identified this as a source of $140 billion in waste. We estimate savings of $134 billion to be conservative (90% of the total, adjusted for 6% increase in utilization; see Appendix, Table XVI).

Other sources of savings under *Medicare for All* include improved chronic disease management and patient care models. These may be combined with newer payment models. In 2000, 125 million people suffered from chronic conditions. by 2020, That number is projected to grow to an estimated 157 million by 2020. The importance of chronic diseases has changed as the demographics of the population have shifted. For example, the population has gotten older; In the past decade, the portion of the population over age 65 has increased at 1.5 times the rate of the rest of the population. Almost half of those over 65 receive treatment for at least one chronic disease, and more than 20% receive treatment for multiple chronic diseases. Over 75 million people in the United States have multiple chronic conditions. The additional medical problems associated with these conditions are increasing, making the clinical decision-making and economic challenges faced by patients and clinicians more challenging. We conservatively estimate cost savings progressively reaching $67 billion a year. (See Appendix, Table XI.)

New care models (which may be coupled with new payment models) are another potential source of savings. An example of an innovative care model includes programs that use professionals trained to help individuals with memory problems and to work as a team with Alzheimer's disease patients. These programs have been shown to reduce hospitalizations with dramatic cost savings. With better training and support, caregivers are better able to keep patients safely managed in their homes and care facilities. Another example is a collaborative care model involving multidisciplinary teams trained in the management of individuals with memory problems were able to coordinate care throughout the healthcare system and reduce costs by an average of almost $4,000 per person compared to individuals cared for by a primary care provider alone. More than half the cost saving was due to lower inpatient hospital costs. The average annual cost of the program was about $700 per person—a return on investment of nearly 6 to 1. With the single-payer, single-platform model, this kind of progress, so difficult to achieve in the past, will be much easier. We estimate savings of up to $158 billion from these new models (see Appendix, Table XII). We believe these new care models hold much more promise for cost control than new payment models designed to replace the current fee-for-service system. Such models have not been shown to reduce costs nor to improve care. They also unfairly shift the burden of risk for unusually sick patients to providers instead of payers and give incentives to provide less care to patients. Unless new payment models can be devised that

are embraced by providers and avoid these problems, we think they are best deferred.

Another cost saving initiative, independent of the single-platform model but essential for long-term cost control is elimination of the current restriction that prevents Medicare from negotiating with drug companies directly on prices. Although there is a limit to how much savings this will accomplish, it would prevent uncontrolled increases. It is estimated that almost $450 billion was spent on prescription drugs in 2016, a 5.8% increase over 2015. According to Medicare, one of the biggest drivers of prescription drug costs were new and specialty drugs to treat serious conditions. In 2015, only 1 to 2% of Americans used specialty drugs, but they accounted for almost 38% of total drug expenses. There are many potential strategies for structuring negotiations on drug prices, but we favor the model used successfully in Germany.

Under the German model, any new drug approved by the Food and Drug Administration (FDA) would be immediately available to physicians for prescription at a price set by the manufacturer for the first year. During the first year, a Price-Setting Agency (PSA) governed by national associations of providers, insurers and patient advocates does a comparative analysis of the drug. PSA looks at the value to patients and any incremental benefit compared to other treatments. It then negotiates a price with the drug company. Once the price is negotiated, Medicare pays the price and may not interfere with physician prescribing with prior authorization or with patient access with additional cost sharing. Physicians are free to prescribe any EMA-approved drug without prior approval or other restrictions. PSA provides guidance to physicians on high-cost drugs, including FDA indications, the PSA's assessment and the cost of the drug compared to alternatives. Medical associations may also provide guidelines for prescribing percentages of brand name vs. generic drugs. Drug companies may not raise prices in future years unless PSA conducts a new comparative effectiveness analysis followed by a new round of negotiations. Negotiations are very structured: drug companies have the right to four confidential sessions with a fifth allowed under certain conditions. Failure to agree on a price after these sessions results in referral to independent arbitration board. The arbitration board makes its own assessment and independently chooses a price. Drugs assessed by the FDA as offering no incremental benefit must be negotiated at a price under a ceiling set by the price of the comparator treatment.

We recommend another strategy that Medicare previously used for years. The Sustainable Growth Rate was used to keep reimbursements to providers within a spending growth limit each year. A formula was calculated, adjusted for inflation, and if the amount spent by Medicare was above that limit, professional fees were decreased by an amount necessary to bring the next year's projected spending within the prescribed limits. However, the cost of services that most doctors order is four times as much as the value of services they perform. If doctors are made aware of the costs of the services they order, including drugs, there is a much better chance to contain costs than if they are simply responsible for the cost of their own

services. Applying a formula similar to the Sustainable Growth Rate to services in addition to pharmaceuticals would be a sensible way to ensure that other prices remain within reasonable ranges.

We therefore propose a Sustainable Health Index Fund Target (SHIFT) which the Secretary will use to measure the average cost of services ordered by providers exclusive of their own fees, including imaging, laboratory, drugs and medical devices. The information will be collected into quarterly reports and forwarded to providers with comparisons to their peers for feedback. Significant outliers, adjusted for patient mix, may be considered for targeted chart review by CMS, which may result in suggested changes in practice and/or further follow-up. In addition, reports may be forwarded to appropriate medical specialty societies to assist with their own educational programs on value-based medical care. Unlike our current situation, the doctor will have the tools to judge the relative value of the services drugs, devices and procedures they order for patients, and assist the patient into choosing wisely those that are most or least appropriate. They and their medical societies will be enlisted in educational opportunities that were not available due to the inability to access cost information. Their ability to leverage costs will be much greater and when they reduce costs, they will be able to reduce costs impartially. To ensure this outcome, it will be important to strengthen the Stark Law prohibitions against self-referral (see below) which will increase providers' confidence that cost reduction can be achieved with good stewardship. Improved enforcement of regulations and guidelines are also important for this goal, as is removing Congress from the process of setting reimbursement formulas. The current Merit Based Incentive Payment System (MIPS) will no longer be required and there will be no need for any national budget restraints to control costs.

Pharmaceutical companies, under this system, would now have incentives to make sure they set prices that are reasonable for the value of the drugs being marketed, that prices are not increased without merit, that development of multiple high-cost drugs with similar action and minimal distinction be limited unless they bring value to the market and to consumers, and that competition, including competition by generic companies, is not unfairly limited. We estimate savings of $108 billion a year from drugs and $6 billion a year from medical devices from these measures (see Appendix, Tables XIII and XIV).

Another issue is the undue influence of the healthcare industry on politicians. The pharmaceutical industry, for example, spent about $250 million on lobbying in 2016. We recommend a "Medical Products and Services Sunshine Act" that would require provider organizations, hospitals, health insurance companies, pharmaceutical and medical device companies and their lobbyists to report expenditures made that relate to any federally elected official to the Federal Election Commission, which would be required to report such contributions annually to the Secretary. This information would become part of the information considered when the Secretary updates Medicare reimbursement rates.

Eliminating loopholes in the Stark Law that allow for self-referral of patients to provider-owned healthcare facilities will reduce excess utilization. We estimate gradually increasing cost savings from $14 billion a year to $68 billion a year. (See Appendix, Table XVII.)

We have recommended incentives for deployment of advanced practice clinicians to permit them to take the place in the healthcare system that is appropriate and necessary for them. We estimate that gradually increasing advanced practice clinicians to 25% of the provider workforce would generate $42 billion in savings. (See Appendix, Table XVIII)

Altogether, savings from all these initiatives amount to $139 billion in the first year, increasing to $801 billion in the fourth year. After transition, savings under *Medicare for All* would total $1,066 billion a year. With removal of the special tax treatment for private health insurance premiums, another $131 billion can be diverted from general revenues to be used to pay for *Medicare for All* (the Congressional Budget Office estimates the current cost of subsidies to be $260 billion, but we have discounted the amount no longer recoverable due to the Tax Cut Act of 2017 plus the amount of employer contributions that will continue to be exempt from taxes; see Appendix, Table XX, Note 12 for details).

An additional factor to be considered is the money currently spent by the federal government on other programs. This includes the $410 billion federal share for Medicaid and CHIP (adjusted for increased utilization and Medicaid expansion) and $40 billion for ACA subsidies. After implementation of *Medicare for All*, funds will no longer be allocated to Medicaid and CHIP since it will no longer be separate programs, and subsidies will be used for *Medicare for All* instead of the ACA. The chart below lists the savings during transition and after implementation of *Medicare for All*, relative to maintaining our current system, assuming no other changes over time (the reduced cost of administration of insurance is not included under savings as it was included in the discounted cost of new enrollees, above).

	Year	1	2	3	4	After trans.
Health expenditure savings (billions)						
Uncompensated care		$26	$51	$51	$51	$59
Improved use of current tools		$29	$99	$168	$239	$239
Chronic disease management		$0	$6	$12	$18	$59
New payment and care models		$0	$66	$133	$201	$201
Decrease cost of drugs		$54	$81	$97	$108	$108
Decrease cost of devices		$1	$2	$3	$4	$6
Decrease provider admininstration						$75
Elimination of excessive pricing		$28	$59	$70	$85	$133
Close Stark Law loopholes		$14	$27	$41	$54	$68
Promote use of advance practice clinicians		$0	$8	$17	$25	$42
Decrease in hospitalizations		$12	$18	$39	$63	$123
Total health expenditure savings		**$163**	**$417**	**$630**	**$848**	**$1,113**
Funds reallocated from Medicaid/ACA		$20	$40	$40	$40	$450
Decrease insurance subsidy		$27	$48	$62	$80	$131
Total cost reductions		$210	$505	$732	$967	**$1,694**

We have carefully estimated the portion of savings we could allocate during the transition period to Medicare, Medicaid and private health insurance. We assumed a gradual 10% decrease in hospitalization costs associated with increased access to care, including the increased access to long-term care. We also included a 61% increase in cost of comprehensive short- and long-term care services and 6% increase in other services. With affordable premiums from individuals and businesses totaling $659 billion, the results are dramatic. With surpluses to general revenues, all of the additional services and programs can be funded through all four years of transition. By the end of the first year of implementation of *Medicare for All* we estimate cumulative savings of $587 billion. By the end of the 5th year of *Medicare for All,* (the tenth year from enactment) cumulative savings to general revenues will be $633 billion, with additional savings of $24 billion each year over current expenses. This includes the additional spending on support for advance practice clinicians, medical research, graduate medical education, 10 years of job training and a new Home Health Corps program to ensure the expansion of this important job market. Benefits of the program include reduction of state and local government costs of $295 billion for private insurance, Medicaid and CHIP,[*] savings by private employers of $243 billion ($136 billion going to small businesses), and savings to individuals of $563 billion. Since this is a static analysis, assuming no other changes over time, including population changes or healthcare technology, these numbers merely give a general sense of the magnitude of savings to be expected from a well-designed *Medicare for All* plan—actual savings are likely to be somewhat different. (See appendix Table XXIV.)

[*] The federal costs for Medicaid and CHIP are included in the calculations of new enrollees. They are therefore not calculated as savings but instead deducted from the cost of expanding Medicaid as shown in the cash flow analysis below.

Cash flow evaluation (in billions)					
Additional basic costs (to general revenues)	**1**	**2**	**3**	**4**	**After trans.**
Expand Medicaid	$7	$14	$14	$14	incl*
Cost (savings) of *Medicare for All*	($50)	($74)	($211)	($334)	$12
Increase in CMS budget	$5	$10	$15	$20	$20
Additional research budget	$5	$10	$15	$15	$15
Advanced practitioner training	$5	$5	$10	$15	$15
Graduate medical training	$5	$5	$10	$15	$15
Additional professional and dental support	$5	$5	$10	$15	$15
Total	**($23)**	**($30)**	**($147)**	**($255)**	**$92**
Supplemental program costs (years 1-5)					
Job training	$10	$10	$15	$15	$15
Home Health Corps	$10	$10	$10	$15	$15
Total supplemental programs (years 1-5)	$20	$20	$25	$30	$30
Total costs including supplemental programs	**($3)**	**($10)**	**($122)**	**($225)**	**$122**
Additional revenues (to general revenues)	**1**	**2**	**3**	**4**	**After trans.**
Decrease in private insurance subsidy	$27	$48	$62	$80	$131
Total revenues	**$27**	**$48**	**$62**	**$80**	**$131**
Annual net revenues (costs)	$29	$59	$184	$305	**$9**
Cumulative net revenues (costs)	$29	$88	$272	$578	$587
Cumulative net revenues (costs), years 6-10	**$46**				
Cumulative surplus (cost) at implementation	**$587**				
Cumulative surplus (cost) 5th year after implementation	**$633**				
Annual net revenues (costs) after year 10	**$24**				
Cumulative surplus (cost) 10th year after implementation	**$754**				
*the cost of expanding Medicaid is included in the costs of the *Medicare for All* program after implementation					

SUMMARY

The current U.S. healthcare system is facing rising costs that are unsustainable. Bowing to severe pressures to contain these costs, both public and private payers are reducing covered services, decreasing reimbursements and increasing premiums and coinsurance. Simultaneously, the same pressures are driving an increasing number of hospital mergers and acquisitions resulting in patients having to pay more and more while affording them reduced choice. Despite this, costs keep rising and more and more people opt not to get needed care because they cannot afford it. This has been worsening healthcare outcomes and extending and intensifying the healthcare crisis in America. These problems are insurmountable if we maintain the current system of financing healthcare in the U.S. healthcare market. The components of our *Medicare for All* program involve the use of tools that are demonstrated to work in our current system applied in a rational manner. *Medicare for All* takes full advantage of a single-payer, single-platform system to leverage these tools to decrease wasteful spending and increase the cost savings that have been impossible to achieve in our current system.

Our estimates for costs are reasonable and our estimates for savings are conservative. There are likely to be significant additional savings from decreased

utilization of more expensive services due to expanded coverage of less expensive coverage, decreased severity of illness due to improved access to preventive services and better coordination of care for chronic diseases, and overall decreased healthcare expenses due to improved health from expanded coverage for patient education. We have not attributed cost savings to these likely outcomes. We have analyzed only relative costs and savings compared to continuing our current system and have not considered the additional savings related to increasing healthcare inflation and increased costs due to an expanding and aging population under our current system.

Reduced financial burdens are also likely to reduce stress and improve overall well-being, factors that are known to improve a number of disease processes. We have also not attributed cost savings to these. We have allowed time for some savings to accrue and have assumed that savings will be incomplete. We assume *Medicare for All* may only be efficient enough to recover 75% of the $1 trillion in medical waste identified by the Institute of Medicine (adjusted to 2016 expenditures). We estimated a 6% increase in utilization of most other services in our cost and savings analyses (10% increase for uninsured, Medicaid-eligible enrollees). Increases of this size (especially physician visits and drugs) have been seen after the implementation of the ACA. Most of that increase has been attributed to additional Medicaid patients and there is some evidence it may be temporary due to accumulated needs that had not been addressed. To be conservative, we estimated a 61% increase in long-term care and home care costs. On the other hand, we assumed only a 12% decrease in hospitalization costs due to access to less expensive sources of care. We expect that our estimates for costs may be higher than those actually seen. However, with 17% of patients citing cost as a reason for medication non-adherence and medication non-adherence responsible for more than 30% of hospitalizations at a cost of $337 billion a year, we think our estimates for savings are likely to be conservative. Additional benefits to productivity and other effects on the economy have not been included in our calculations. Such benefits have been well-documented effects of the expanded access to care that resulted from the ACA.

We show how properly designed, *Medicare for All* can achieve affordable healthcare without increasing costs for anyone. All of the costs have been carefully evaluated and matched to estimated savings. The money required to establish *Medicare for All* is readily available in our healthcare system once we eliminate the waste and inefficiency that are inherent in the way it has developed. We show how *Medicare for All* can be accomplished without new administrative systems or bureaucracy. By eliminating the most inefficient parts of our healthcare system, the most negative impact on patients will be eliminated. Freedom of choice for patients and providers will be improved. A four-year transition, strengthened by the methods we propose to encourage enrollment in Medicare during this time, will allow for improved planning and decreased disruption of the economy. By addressing some of the issues that have plagued the ACA, *Medicare for All* will be able to avoid a similarly contentious fate.

Medicare for All will provide healthcare coverage for everyone that is affordable and remove financial and other barriers to care. It will expand the services covered to include nursing home care, home care, personal care, patient education by nurses and other professionals as well as basic dental care, vision and hearing. The quality of healthcare will be advanced. With the elimination of Medicaid and CHIP as separate entities, the costs of healthcare to the states will be reduced allowing for significant reductions in state and local taxes. The burden of medical care currently carried by employers and municipal governments will be drastically reduced. The well-being of the people will be enriched, productivity will improve, more money will be available for consumer spending and the economy will improve.

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APPENDIX: DETAILED COST AND SAVINGS CALCULATIONS

I. a. Cost of Medicaid expansion

Number eligible for Medicaid	2.4	million
Cost per new enrollee	$5,980	
Adjustment for increased utilization	$6,578	
Adjustment for federal cost sharing	$5,920	
Cost during transition	$14.2	billion
Cost after transition	$14.5	billion

Note 1: Data from CMS
Note 2: Utilization is assumed to increase 10% for this population.
Note 3: Federal cost sharing is 90% during transition.
Note 4: Cost during transition= number eligible times average cost of new enrollee, adjusted for increased utilization.
Note 5: Cost after transition= number eligible times average cost of new enrollee, adjusted for increased utilization and decreased administrative cost. Administrative cost of Medicaid is 10.9% compared to Medicare fee-for-service of 2.7%. A Medicare cost of 3% under Medicare for All is assumed (see text). The cost is adjusted by multiplying by .895 (1-0.105) and dividing by .97 (1-0.03).

I. b. Cost of expanding Medicare to those on private insurance

Number on private insurance and uninsured	201	million	Note 1
Average cost of individual policy	$6,690		Note 2
Adjust for decreased administrative cost	$6,104		Note 3
Cost of policies privately insured	$1,067	billion	Note 4
Adjust for increased utilization	$1091	6%	Note 5
Low-income subsidies	$73	billion	Note 6
Low-income subsidies from ACA	$40	billion	Note 7
Total cost	$1124	billion	Note 8

Note 1: From National Center for Health Statistics.
Note 2: From Kaiser Family Foundation.
Note 3: An adjustment is made by multiplying by the administrative cost of private insurance (0.885) and dividing by that of Medicare (0.97). Data are from the National Center for Health Statistics.
Note 4: The cost of policies is obtained by multiplying the number needed to insure by the adjusted cost of an individual policy, multiplied by a constant to adjust for the decreased cost of children's policies and the number of children in the population (.87) (Note 5 to Appendix Table XX, below).
Note 5: The adjustment for increased access to care is calculated by assuming a 6% increase in non-hospital utilization, as per the RAND study, multiplied by the average non-hospital costs (36%) National Center for Health Statistics) for a total increase of 2.2% .
Note 6: Low-income subsidies are calculated based on income and population data. See Note 11 to Appendix Table XX and Appendix Table XXI, below.
Note 7: Low-income subsidies from ACA are as reported by the Congressional Budget Office.
Note 8: Total cost = cost adjusted for increased access plus low-income subsidies minus low-income subsidies from ACA.

Table I. c. <u>Equalize benefits for Medicaid/CHIP and Medicare (in billions)</u>

	Physican fees	Nursing Home
Medicaid 2016	$73	$179
Medicare Equivalent	$101	$239
Difference	$28	$60
Total additional cost	$118	

Notes: Data for Medicaid and CHIP costs from CDC, National Center for Health Statistics, 2016. Data for Medicare equivalent rates from Kaiser Family Foundation. The average physician reimbursement rate for Medicaid is 72% of Medicare reimbursement. Data for nursing homes is much more difficult to estimate; in some cases it is higher, and in some cases lower. We have conservatively estimated 75% of Medicare reimbursement. Other fees, primarily inpatient services are also difficult to estimate but are probably similar to Medicare reimbursement. The total additional cost is calculated assuming 10% increase in utilization of physician services and 45% increase in nursing home use.

II.

Savings from decrease in uncompensated care		
Health expenditures full year uninsured per person, 2013	$2,443	Note 1
% paid by others	79%	Note 1
Uncompensated care, 2013	$1,930	Note 2
Per capita health expenditures 2013	$7,720	Note 3
Per capita health expenditures 2016	$8,788	Note 3
Increase in health expenditures, 2013 to 2016	114%	Note 4
Cost of uncompensated care per person, 2016	$2,197	Note 5
Number of uninsured 2016	28.2	Note 6
Total cost of uncompensated care	$61,954	Note 7
Increased utilization due to improved access	$65,672	Note 8
Expected savings	$64,358	Note 9
Total savings from decreased uncompensated care = $64 billion		
Note 1: Data from Kaiser Family Foundation.		
Note 2: Per capita uncompensated care= per capita health expenditures of		
Note 3: Data from CDC, National Center for Health Statistics, 2016.		
Note 4: Increase in helath expenditures 2013 to 2016= per capita health expenditures 2016 divided by per capita health expenditures 2013.		
Note 5: Cost of uncompensated care per person 2016= cost of uncompensated care per person 2013 time increase n helath expenditures 2013 to 2016.		
Note 6: In millions, data from CDC, National Center for Health Statistics, 2016.		
Note 7: Total cost of uncompensated care= cost of uncompensated care per person 2016 times number of uninsured 2016.		
Note 8: Cost adjusted for 6% increase in utilization as per RAND study.		
Note 9: Expected savings based on 98% recovery of uncompensated care costs. The costs paid for by federal, state and local government are 62% of total uncompensated costs, or $39,902 million. The proportion of savings to federal, state and other sources is accounted for in our model (see premium calculations).		

III. **Cost of nursing and other professional education visits**

Total cost of physician and clinical services: $881 billion (CDC, National Center for Health Statistics, 2016). Adjusted for 6% increase in utilization total costs would be $934 billion.

Estimated cost for nursing and other professional visits: $18.7 billion (2% of physician and clinical services)

IV. **Cost of dental services**

Dental care, National Health Expenditures: $124,373 (in millions, from CDC, National Center for Health Statistics, 2016)

Adjusted for 10% increase in utilization: estimated cost of prophylaxis, fillings, extractions: $14 billion (10%). (Assumes higher increase in utilization due to higher proportion of lower income individuals not previously covered for these services).

V. **Cost of vision services**

Total cost for refractive errors: $16.1 billion, 2013 (Preventblindness.org)

Adjustment for medical inflation, 2016: $20.9 billion (=16.1 times 1.3, CDC, National Center for Health Statistics, 2016). Adjusting for increased utilization of 6% (RAND Corporation) the total cost becomes $24.2 billion.

VI. **Cost of hearing services**

Current cost of one pair of basic hearing aids: $1,200 (estimate)
Cost of audiologist services: $800 (estimate)
Number of adults who could benefit from hearing aids: 28.8 million (CDC, National Institute on Deafness and other Communication Diseases)
Benefit requirement: up to one pair of hearing aids with audiology visits every 5 years.
Total cost: $11.5 billion

VII. **Cost of long-term care**

NHPC	Total NHE 2016	CAID/CHIP	CARE	Costs to cover	Inc utilization	
Nursing facilities	$162,685	$50,005	$37,477	$75,203	$109,044	45%
Home health care	$92,364	$34,043	$37,376	$20,945	$36,654	75%
Oth nurs & Personal care	$173,486	$99,777	$4,944	$68,765	$120,339	75%
Total	$428,535	$183,825	$79,797	$164,913	$266,037	61%

Note 1: NHE= National health expenditures. All data from CDC, National Center for Health Statistics, 2016, in millions. CAID= Medicaid, CHIP= Children's Health Insurance Program, CARE= Medicare
Note 2: Costs to cover= Total national health expenditures minus the sum of Medicaid/CHIP and Medicare expenditures.
A gradual 61% increase in utilization is included in our model (average increase in cost due to 75% increase in home health care and 45% increase in nursing facility utilization, conservatively based on analyses by the RAND Corporation suggesting 40-42% increase in nursing home use with comprehensive coverage).

VIIa. Savings from decreased cost of insurance

(in millions)	
(Based on data from National Center for Health Statistics)	
NHE private insurance 2016	$1,123,772
Administrative costs private insurance	$129,605
Percent admin costs private ins	11.5%
NHE Medicare 2016	$672,093
NHE Medicare Parts C & D 2016	$277,300
Administrative costs Medicare	$46,814
Adjusted adm costs (without Parts C & D)	$10,614
Percent admin costs without Parts C & D)	2.7%
Adjusted Medicare administrative costs (see text)	3.0%
Administrative savings private insurance	$95,892
Adjusted for 6% increase utilization	$101,645
NHE Medicaid/CHIP 2016	$582,433
Administrative costs Medicaid/CHIP	$63,250
Percent administrative costs Medicaid	10.9%
Administrative savings from Medicaid	$45,777
Adjusted for 6% increase in utilization	$48,524
Total administrative savings	$150,169

VIII.

Cost to reduce coinsurance (deductibles and copayments)		
Out-of-pocket expenses 2016 (millions)	$362,587	Note 1
Services added under *Medicare for All*		
Dental	$5,492	Note 1
Home healthcare	$9,260	Note 1
Nursing facilities	$50,345	Note 1
Oth nursing & personal care	$7,257	Note 1
Total expenses from added services	$72,353	Note 2
Total expenditures of new Medicaid	$7,893	Note 1
Out-of-pocket expenses of uninsured	34%	Note 1
Expenses from new Medicaid	$2,934	Note 3
Total expenditures of enrolled uninsured	$121,486	Note 4
Uninsured out-of-pocket differential	18%	Note 5
Uninsured expenditures	$23,386	Note 6
Total expenditures accounted for	$98,674	
Non-covered dental services	$44,936	Note 7
Other non-covered	$42,797	Note 8
Total expenditures to be covered	$176,180	Note 9
Cost of decutibles (estimate)	$8,000	Note 10
Total cost of copayments	$168,180	Note 11
Note 1: Data from CDC, National Center for Health Statistics, 2016. Long-term care costs are increased 15% and others 10% for increased utillizaton. The amount for dental represents is based on the estimate that *Medicare for All* will cover 10% of all dental expenditures.		
Note 2: Sum of out-of-pocket expenses for all services added under *Medicare for All.*		
Note 3: Out-of-pocket expenses for new Medicaid enrollees = one-half total expenditures of Medicaid enrollees times percent out-of-pocket expenses of uninsured (increased 10% for increased utilization). The uninsured have about half the expenditures of the insured population (see Kaiser Family Foundation).		
Note 4: Expenditures of enrolled uninsured = number of uninsured (28.2 million) times average cost of insured ($4,308 per person).		
Note 5: Out-of-pocket differential for uninsured = difference between average out-of-pocket costs of uninsured (33.8%) and average cost of insured (16.3%).		
Note 6: Uninsured expenditures = uninsured expenditures times uninsured out-of-pocket cost differential (adjusted for 10% increase in utilization).		
Note 7: Non-covered dental services = total out-of-pocket dental services minus dental services added under *Medicare for All.* Data from CDC, National Center for Health Statistics, 2016.		
Note 8: Other non-covered services estimated as 20% of other out-of-pocket expenses.		
Note 9: Total out-of-pocket expenditures to be covered = total out-of-pocket expenses minus total expenditures accounted for minus non-covered dental and other services.		
Note 10: We are unable to find data for the total cost of deductibles. We estimate the cost to be approximately $8 billion based on the relationship between the use of deductibles and copayments as components of cost-sharing.		
Note 11: Total cost of copayments = cost of total expenditures to be covered (copayments plus deductibles) minus cost of deductibles.		

IX.

Savings from decrease in uncompensated care		
Health expenditures full year uninsured per person, 2013	$2,443	Note 1
% paid by others	79%	Note 1
Uncompensated care, 2013	$1,930	Note 2
Per capita health expenditures 2013	$7,720	Note 3
Per capita health expenditures 2016	$8,788	Note 3
Increase in health expenditures, 2013 to 2016	114%	Note 4
Cost of uncompensated care per person, 2016	$2,197	Note 5
Number of uninsured 2016	28.2	Note 6
Total cost of uncompensated care	$61,954	Note 7
Increased utilization due to improved access	$65,672	Note 8
Expected savings	$64,358	Note 9
Total savings from decreased uncompensated care = $64 billion		
Note 1: Data from Kaiser Family Foundation.		
Note 2: Per capita uncompensated care= per capita health expenditures of uncompensated care		
Note 3: Data from CDC, National Center for Health Statistics, 2016.		
Note 4: Increase in helath expenditures 2013 to 2016= per capita health expenditures 2016 divided by per capita health expenditures 2013.		
Note 5: Cost of uncompensated care per person 2016= cost of uncompensated care per person 2013 time increase n helath expenditures 2013 to 2016.		
Note 6: In millions, data from CDC, National Center for Health Statistics, 2016.		
Note 7: Total cost of uncompensated care= cost of uncompensated care per person 2016 times number of uninsured 2016.		
Note 8: Cost adjusted for 6% increase in utilization as per RAND study.		
Note 9: Expected savings based on 98% recovery of uncompensated care costs. The costs paid for by federal, state and local government are 62% of total uncompensated costs, or $39,902 million. The proportion of savings to federal, state and other sources is accounted for in our model (see premium calculations).		

X.

Better use of current tools

Sources of medical waste identified		Note 1	
Unnecessary services	$270		IOM 1
Inefficient delivery	$174		IOM 2
Missed prevention	$73		IOM 3
Excessive prices	$140		IOM 4
Fraud	$100		IOM 5
Excess admin	$256		IOM 6
Total	$1,013		
Audits of outliers	$56	Note 2	15% of 1 & 5
Claims linking	$54	Note 3	20% of 1
Quality initiatives	$27	Note 4	10% of 1
Guidelines	$27	Note 4	10% of 1
EMR	$62	Note 5	25% of 2 & 3
Total savings	$225		
Adjusted for 6% increase in utilization	**$239**		
Total waste addressed	$654	Note 6	
% recovered	**34%**	Note 7	

Note 1: In billions, data from Institute of Medicine, 2010. All figures adjusted for growth in healthcare expenditures from 2009 to 2016.

Note 2: In billions, based on 15% of unnecessary services and fraud assuming increased administrative budget will allow improved audits.

Note 3: In billions, based on 20% of unnecessary services assuming increased administrative budget initially and single platform later will allow improved processes.

Note 4: In billions, based on 10% of unnecessary services assuming increased administrative budget and single platform later will allow improved processes.

Note 5: In billions, based on 25% of inefficient delivery of services and missed prevention assuming universal EMR will allow improved processes.

Note 6: In billions, sum of unnecessary services, inefficient delivery, missed prevention and fraud.

Note 7: Total savings divided by total waste addressed. This is a very conservative estimate.

XI. **Savings due to improved management of chronic disease**

Chronic disease management		
(in billions)		
Inefficient delivery	$174	Note 1
Missed prevention	$73	Note 1
Total	$247	
Amount from chronic disease	$173	Note 2
Recovered from tools	$62	Note 3
Potential still available	**$111**	
Savings due to improved management	$55	Note 4
Adjusted for 6% increase in utilization	**$59**	

Note 1: Data from Institute of Medicine, 2010, adjusted for growth in healthcare expenditures from 2009 to 2016 (CDC, National Center for Health Statistics, 2016).
Note 2: Assumes 70% of costs are due to chronic disease.
Note 3: Reduction for the 55% of unnecessary services and 25% of inefficient delivery recovered through better use of current tools (see separate appendix table). The potential still available is the amount from chronic disease minus this amount.
Note 4: The savings due to improved management is conservatively estimated at 60% of the potential amount available.

XII. **Savings from new payment and care models**

(in billions)		
Inefficient delivery	$174	Note 1
Missed prevention	$73	Note 1
Amount recovered from chronic disease	($59)	Note 2
Fraud	$100	Note 1
Unnecessary services	$270	Note 1
Recovered from better use of tools	($174)	Note 3
Potential still available	$379	Note 4
Savings due to new models	$189	Note 5
Adjusted for 6% increase in utilization	$201	

Note 1: Data from Institute of Medicine, 2010, adjusted for growth in healthcare expenditures from 2009 to 2016.
Note 2: See appendix table XI.
Note 3: See appendix table X.
Note 4: The sum of inefficient delivery, missed prevention, fraud, and unnecessary services less the sum of the amounts recovered from chronic disease and better use of tools.
Note 5: Based on 50% of potential still available, a conservative estimate.

XIII. **Decrease cost of drugs**

Country	Drug costs per capita	Population (millions)	Total (billions)
U.S.	$1,000	326.7	$326,700
Switzerland	$780	8.5	$6,630
Germany	$690	82.3	$56,787
Canada	$675	37.0	$24,975
France	$550	65.2	$35,860
U.K.	$500	66.6	$33,300
Australia	$410	24.8	$10,168
Netherlands	$405	17.1	$6,926
Norway	$400	8.4	$3,360
Sweden	$350	10.0	$3,500
		646.6	$508,206
Average per capita cost	$786		
Per capita cost under German model	$690		
% savings	31%		
Baseline drug costs	$328,588	(millions)	
Savings from negotiations	$101,862	(millions)	
Adjusted for 6% increase in utilization	$107,974		

Total savings from drug negotiations = $108 billion

Notes: International data from Organization for Economic Cooperation and Development, 2017.

% savings = current per capita cost Germany divided by per capita cost U.S.

Baseline drug costs from CDC, National Center for Health Statistics, 2016.

Savings from negotiations = baseline drug costs times % savings.

XIV. **Decrease cost of devices**

Total cost of devices: $62 billion (CDC, National Center for Health Statistics, 2016). Adjusted for 6% increase in utilization, cost= $66 billion.

Savings from price negotiation: $6.6 billion (10%, estimate). Savings assumed to accrue gradually throughout transition. Rounded down to $6 billion in calculations.

XV. **Savings from reduced provider administrative costs**

(in billions)

Two alternate calculations of reduced administrative waste.

Administrative waste	$256	IOM study
Estimate 30% recovery	$77	
Adjusted for 6% increase	$81	
Total physician expenses	$664	National Center for Health Statistics
Adjusted for 6% increase	$704	
Estimate 10% reduction	$70	

Average of estimates=$75 billion

XVI.

Savings from reduction of excessive prices

Total excess prices	$140	Note 1
Adjusted for 6% increase utilization	$148	
Savings	$134	Note 2

Note 1: In billions, data from Institute of Medicine, 2010, adjusted for growth in healthcare expenditures from 2009 to 2016.

Note 2: Medicare fee schedule should eliminate excessive prices, defined as above customary. We conservatively estimate 90% recovery of excessive prices.

XVII.

Enhance Stark Law

Unnecessary services	$270	Note 1
Fraud	$100	Note 1
Total	$370	
Recovered from better use of tools	$164	Note 2
Recovered from new models	$99	Note 3
Potential still available	$108	Note 4
Adjusted for 6% increase utilization	$103	
Savings	**$68**	Note 5

Note 1: In billions, data from Institute of Medicine, 2010, adjusted for growth in healthcare expenditures from 2009 to 2016.

Note 2: In billions, 55% of unnecessary services and 15% of fraud, see appendix, X

Note 3: In billions, 22.5% of unnecessary services and 42.5% of fraud, see appendix, XI

Note 4: In billions= total of unnecessary services plus fraud less amount already recovered from better use of tools and new models

Note 5: In billions, assumes 60% savings from improved regulations; savings are assumed to increase proportionately each year of transition until implementation

XVIII. **Savings from increased use of advanced practice clinicians**

National health expenditures MD visits	$664	Note 1
Average annual salary, MD	$208,800	Note 2
Average annual salary, nurse practitioner	$107,460	
Average annual salary, physician's assistant	$101,480	
Average annual salary, advanced practice clinician	$104,470	Note 3
Practice cost savings/visit	50%	Note 4
National health expenditure savings	25%	
MD visits adjusted for increased volume	$704	Note 5
10% increase in advanced practice clinicians	$17	Note 6
20% increase in advanced practice clinicians	$33	
25% increase in advanced practice clinicians	$42	

Note 1: In billions, data from CDC, National Center for Health Statistics, 2016.
Note 2: Annual salary data from U.S. Bureau of Labor Statistics, Healthcare Occupations (May 2016).
Note 3: The average annual salary of advanced practice clinicians is calculated as the average of the salaries of nurse practitioners and physician's assistants (assuming relatively equal distributions).
Note 4: The practice cost savings per visit = average annual salary advance practitioners divided by average annual salary MD. The national health expenditure savings are decreased by half to allow for half of the cost savings to remain with the practice.
Note 5: In billions. MD visit costs are increased 6% to adjust for increased volume of visits.
Note 6: In billions. The increase in advanced practice clinicians is assumed to occur gradually, 10% in the second year of transition, 20% in the third year and 25% in the fourth year and thereafter. Savings are calculated by multiplying the percent advanced practice clinicians by the 25% national health expenditure savings by the adjusted MD visit costs.

XIX.
Costs and savings related to utilization changes

We have assumed a gradual increase in long-term care utilization of 61% (see Table VII) over 4 years beginning with the second year of transition due to increased access to care except for new enrollees who were previously uninsured and Medicaid eligible, for whom we assumed a 10% increase in utilization. We also assume an immediate increase of 6% for non-hospital medical costs. Along with this, we have assumed a gradual 10% decrease in utilization of hospitalization due to both increased access to long-term care and to increased overall access to care.

XX. Calculation of costs, savings and premiums

Year		**1**	**2**	**3**	**4**	**After trans.**
	Baseline	Estimated MC enrollees (millions)				
Previously MC eligible (SMC)	53	53	53	53	53	53
Previously on CAID/CHIP	65	-	-	-	-	67
Previously on ACA	12	6	12	12	12	12
Uninsured	28	14	28	28	28	26
Previously on employer sponsored insurance	153	20	45	60	83	153
Previously on other private insurance	10	2	4	6	6	10
VA, military, other	5	-	-	-	-	-
New MC enrollees (EEM)	-	42	89	106	129	268
EEM from private insurance and uninsured		42	89	106	129	201
Total MC enrollees	53	95	142	159	182	321
Total all	326					
		16%	35%	45%	57%	100%
Additional cost new enrollee and new services (per capita)						
Total per capita medical expenditures	$6,238					
Per capita cost dental	$44	$44	$44	$44	$44	$44
Per capita cost nurse/prof visits	$58	$58	$58	$58	$58	$58
Per capita cost deductible	$25	$25	$25	$25	$25	$25
Per capita cost vision	$75	$75	$75	$75	$75	$75
Per capita cost LTC	$514		$618	$723	$827	$827
Per capita cost hearing	$36					$36
Per capita cost copays	$527		$132	$263	$395	$527
Total additional cost new enrollee and new services						
Total cost new enrollees		$235	$497	$589	$712	$1,583
Additional cost of new services		$19	$135	$189	$259	$511
Increased utilization by previous enrollees		$2	$3	$5	$7	$7
Additional cost dental/transp CAID						$16
Equalization of Medicaid/Medicare rates						$118
Total additional costs		$256	$636	$783	$977	$2,234
Savings						
Year		**1**	**2**	**3**	**4**	**After trans.**
Health expenditure savings (billions)						
Uncompensated care	20% CAID	$26	$51	$51	$51	$59
Improved use of current tools	100% MC	$29	$99	$168	$239	$239
Chronic disease management	MC, 20% CAID		$6	$12	$18	$59
New payment and care models	100% MC		$66	$133	$201	$201
Decrease cost of drugs	100% MC	$54	$81	$97	$108	$108
Decrease cost of devices	100% MC	$1	$2	$3	$4	$6
Decrease provider admininstration		$0	$0	$0	$0	$75
Elimination of excessive pricing	100% MC	$28	$59	$70	$85	$133
Close Stark Law loopholes	20% CAID	$14	$27	$41	$54	$68
Promote use of advance practice clinicians	MC, 20% CAID	$0	$8	$17	$25	$42
Decrease in hospitalizations		$12	$18	$39	$63	$123
Total health expenditure savings		$163	$417	$630	$848	$1,113
Funds reallocated from Medicaid/ACA		$20	$40	$40	$40	$450
Total cost reductions		$183	$457	$670	$888	$1,563
Net costs (savings)		$73	$179	$113	$90	$671
Calculation of monthly and annual premiums, (costs) or surplus to general revenues						
New premium for Part B (with drugs)		**$155**	**$156**	**$158**	**$163**	**$168**
Part B premium surplus (deficit)		$13	$13	$14	$18	($83)
Target monthly EEM premium		**$180**	**$185**	**$190**	**$195**	
Total premum for EEM, family		$414	$426	$437	$449	
Annual premium EEM, single		$2,160	$2,220	$2,280	$2,340	.
Annual premium EEM, family		$4,968	$5,106	$5,244	$5,382	
Annual EEM premiums collected		$79	$172	$210	$262	$343
% single employer-based premium		178%	183%	188%	193%	
% family employer-based premium		87%	89%	92%	94%	
EEM low income subsidies		($25)	($53)	($60)	($72)	
Decrease insurance subsidy		$27	$48	$62	$80	$131
Subtotal costs (surplus) to general revenues		**($21)**	**($2)**	**($114)**	**($197)**	**$279**
Unearned income contribution to Part E premiums		$4	$4	$4	$4	$4
Employer contribution to Part E premiums		$52	$116	$155	$213	$394
Total additonal revenues		$56	$120	$159	$217	$399
Total costs (surplus)		($76)	($123)	($273)	($414)	($119)
Costs (surplus) excluding insurance subsidy		($50)	($74)	($211)	($334)	$12

(notes on next page)

XX. Premium and cost to general revenue calculations (notes)

Note 1: All baseline population data are from 2016. Enrollment data for Medicare, Medicaid and CHIP from CMS. Data form ACA, uninsured and numbers insured at work and on private insurance from Kaiser Family Foundation. We have assumed: 50% enrollment of those previously on ACA in Medicare in the first year of transition, with remaining 50% enrolling in the second year; full enrollment of the uninsured, 50% in the first year and the remainder in the second year of transition; 50% of those insured at work enrolled during transition, with 25% of that total during each year of transition; and two-thirds of those with other private insurance enrolling during transition, half in the first year, and the remainder by the second year.

Note 2: The percent with private insurance enrolled on Medicare represents the total of the number of those enrolled who were previously on ACA insurance, insurance at work or other private insurance divided by the baseline total number of those with these insurance coverages in 2016.

Note 3: The additional costs are calculated by using the baseline per capita costs of medical expenditures for new enrollees (using data for private insurance) and the additional per capita costs of new services (using national health expenditure data) and then multiplying by the number of enrollees for each group.

Note 4: The total per capita cost of medical expenditures is calculated by taking the average premium for an individual for employer-sponsored health insurance in 2016 ($6,690, Kaiser Family Foundation), adjusted for increased non-hospital costs by 6% (The RAND Corporation estimates a maximum of 6% increase in medical costs and 3% for drugs and devices over 10 years. For simplicity we used a 6% increase) multiplied by average non-hospital utilization proportion of 36%=$6,834) and multiplying by 1 minus the average administrative cost of private insurance (1-11.5%=88.5%, based on data from CDC, National Center for Health Statistics, 2016) to obtain the average medical expenditures per capita. This is then divided by the same percentage for *Medicare for All* (97%, based on data from CDC, National Center for Health Statistics, 2016, see text for calculation of estimate, p. 63) to obtain the expected per capita cost per new enrollee ($6,238).

Note 5: To calculate total costs for new enrollees, an adjustment needs to be made for children. Since those to be covered under age 65 include children, an adjustment needs to be made for family coverage, since the baseline cost was calculated using data from premiums for employer-sponsored health insurance (the problem of more than one worker in a family being covered by separate policies would no longer be an issue under *Medicare for All)*. Since there were 73 million children in 2016, 28 million are in Medicaid/CHIP and virtually none of them are in Medicare, there are about 160 million adults and 45 million children to be covered (U.S. Census Bureau). With a premium for children that is 0.4 times the premium for an adult, by algebraic manipulation we can simply multiply EEM by the constant 0.87 to adjust for families including children during transition. After transition, all new enrollees are included in cost calculations, excluding only those on SMC and other government programs. Costs for the 2.4 million newly enrolled uninsured who were Medicaid-eligible are different. They have costs of $5,980 per enrollee (CMS). These are calculated separately. After transition, those previously on Medicaid/CHIP are also included in costs. They are also calculated separately with a cost of $7,560 per enrollee. An additional cost of $118 billion is added to adjust for the differential in cost between Medicaid and Medicare fees after transition.

Note 6: Additional costs of new services per capita are calculated by dividing total costs by total baseline population. Total costs (in billions) are as follows (and as detailed in the prior appendix tables): dental care $14 (estimated at 10% of total national health expenditures of $124 billion, CDC, National Center for Health Statistics, 2106, increased by 10% for utilization), nursing/other professional visits $18.7 billion, deductibles $8 billion, vision care $24.2 billion, comprehensive short- and long-term care $164.9 billion, hearing care $11.5 billion, copayments $168 billion, additional dental care and transportation reimbursement for Medicaid $16 billion. The cost of comprehensive short- and long-term care is assumed to increase gradually by 61% over the 3 years of transition due to increased access to care.

Note 7: Total additional costs of new services are calculated by multiplying the number of total Medicare enrollees (since all Medicare enrollees will benefit from the new services) by the sum of the per capita costs of new services. Since these calculations use total costs averaged over all individuals, no adjustment for children is required. An additional cost for increased utilization by previous enrollees is calculated by adding 6% of baseline costs. (The RAND Corporation estimates a maximum of 6% increase in medical costs and 3% for drugs and devices. We conservatively used a 6% increase for all costs.) The increase was phased in by 25% increments over implementation to account for the gradual increase in benefits. At implementation, an additional cost of $16 billion is added for the cost of additional dental services and transportation reimbursement for Medicaid-eligible enrollees (see above).

Note 8: Funds previously used to pay for ACA subsidies ($40 billion) are reallocated to decrease costs to general revenues. At implementation, funds previously allocated to the federal share of Medicaid and CHIP ($373 billion total Medicaid and CHIP expenditures in 2016 adjusted to $395 billion for 6% increase in utilization, plus $15 billion for Medicaid expansion=$410 billion) are also reallocated to decrease costs to general revenues. Total health expenditure savings are calculated by adding the sum of all savings for each category.

Note 9: The new premium for Part B is set to less than the current Part B premium ($136) plus the average current cost of Part D premium for drugs (about $40) for a total of less than $175 per month during transition. After transition, the premiums for Part B are included in the row for Part E premiums (see note 10).

Note 12: The Part B premium surplus (or deficit) is calculated by subtracting the sum of the current premiums collected for Part B and D (25% of Part B costs and 14% of Part D costs for a total of $86 billion) from the expected collections from the new Part B premium, obtained by multiplying by the new Part B premium by the number of SMC enrollees paying premiums multiplied by 12 months. This is divided by 1000 to obtain an amount in billions of dollars a year. After transition, the deficit represents the amount currently collected in Part B premiums since all premiums are calculated based on income, so Part B premiums are included in the row for Part E premiums (see note 10).

Note 10: The target monthly EEM premium, is set at a level that is competitive to the current average cost of an individual and family premiums in the group market when accounting for the services provided and low out-of-pocket costs (about 15% of individual policies are high-deductible policies, see Congressional Budget Office, "Private Health Insurance Premiums and Federal Policy," February 2016). The annual premium is, of course, 12 times this amount. The average cost of a family policy is obtained by multiplying the cost of an individual policy by the inverse of the ratio of the constant for the adjustment for children (see note 5), i.e., 1/0.85 = 1.17. Annual costs are equal to monthly costs multiplied times twelve. The Annual EEM premiums collected is equal to the annual premium for individuals multiplied by the number of new enrollees multiplied by the adjustment for children, 0.85 (see note 5). New enrollees from Medicaid and CHIP are excluded from the calculation of premiums collected (see note 5). Although the EEM premiums for single individuals are significantly higher than in the group market, they are much lower than in the non-group market or the ACA marketplace. This is due to the discount in the group market due to their average lower age and the inability for the group market to make any other risk adjustments (such as number of children). The rows for "Target monthly EEM premium" through "Annual premium EEM, family" as well as "% single employer-based premium" and "% family employer-based premium" are not applicable after transition, since the calculation is different. After transition, all premiums are calculated as 5% of household adjusted gross income after excluding the amount below 138% of the federal poverty level. This includes those on SM. Since those below 138% of the federal poverty level would qualify for Medicaid, who do not pay premiums, this automatically accounts for the Medicaid population. It also obviates the need to make a separate calculation for low-income subsidies, since it is based on a percentage of income above 138% of the federal poverty level. See Table XXIII for calculations.

Note 11: The EEM low-income subsidy is calculated by estimating the amount of the subsidies required for low-income individuals and families, based on the distribution of household size, income levels, number of children in households by number of parents, and the subsidy level according to income (see appendix table "Premium subsidies," following). An adjustment is made for those below 100% of the federal poverty level, assuming that the overwhelming majority will be covered under Medicaid and not newly enrolled in Medicare. This adjustment is reduced by half for the first year of implementation, assuming only 50% effectiveness of Medicaid expansion (see Note 1, above). New enrollees from Medicaid and CHIP are excluded from the calculation after transition, since they do not pay premiums (see note 5). This row is not applicable after transition since subsidies are replaced by income exclusion in calculation of premiums (see note 10).

Note 12: The decrease in insurance subsidy is calculated by reducing the current cost of tax subsidies for private insurance premiums ($260 billion, Congressional Budget Office) to account for the effect of the Tax Cut Act of 2017. Since part of that amount is accounted for by the employer contribution to premiums ($519 billion), previously exempted from corporate taxes of 30% ($156 billion), that portion of the subsidy would be reduced by $78 billion. We assume the remaining amount, $94 billion for tax-exempt employee premiums and $10 billion for deductions for other private insurance premiums would each be reduced 10% ($10 billion). However, since employers would still be contributing $274 billion to Part E premiums, which would be deductible from the (lower) corporate tax rate, premium subsidies of $41 billion would still be in effect. The total reduction at full implementation would therefore be $260 billion minus 78 minus 10 minus 41 for a total of $131 billion. The total for each year is obtained by multiplying the percentage decrease in the amount of subsidy for the transition year (10%, 25%, 50% and 75%, for years 1-4, respectively) by the proportion of enrollees remaining in employee-sponsored health insurance and other private insurance for those years and then by the amount of tax subsidies eligible for reduction for those groups ($85 billion and $9 billion, respectively) and adding to that the proportion of new Medicare enrollees from each group multiplied by the full amount of tax subsidy recoverable (for ESHI, $78 billion minus $41 billion for the employer portion plus $85 billion for the employee portion=$122 billion, and 9 billion for other private insurance).

Note 13: The overall costs (or surplus) to general revenues is calculated by adding the sum of the total Medicare costs (or surplus) to general revenue to the decrease in insurance subsidy. This represents the total program costs of additional enrollees and services that must be paid out of general revenues after accounting for all fund transfers, savings, premiums and subsidies.

Note 14: The unearned income contribution to Part E premiums is calculated by multiplying the contribution rate (5%) by 25% of the total amount of unearned income filed with the IRS ($355 billion in 2015, the latest complete data). The 25% is a conservative estimate since 15% of filers has income over $200,000 and it is likely that unearned income is more concentrated in high-income earners. Multiplying 355 x .05 x .25 = 3 for total payments of $4 billion. The 5% rate is chosen to approximate the equivalent of the average cost of a Part E premium as a percentage of a worker's premium.

Note 19: The Employer contribution to Part E premiums is calculated by multiplying the total U.S. payroll of $7.69 trillion by 4.5% ($346 billion) and subtracting half of 4.5% the 27% of the U.S. payroll of $1.7 trillion of businesses with fewer than 100 employees ($43 billion) = $303 billion.

XXI. Premium subsidies

Household size	Distribution	100%	133%	150%	200%	250%	300%	400%
1	28%	$11,770	$15,654	$17,655	$23,540	$29,425	$35,310	$47,080
		8%	4%	2%	6%	5%	3%	7%
2	34%	$15,930	$21,186	$23,895	$31,860	$39,825	$47,790	$63,720
		20%	7%	3%	10%	12%	8%	13%
3	15%	$20,090	$26,719	$30,135	$40,180	$50,225	$60,270	$80,360
		30%	7%	9%	11%	10%	8%	11%
4	13%	$24,250	$32,252	$36,375	$48,500	$60,625	$72,750	$97,000
		40%	15%	5%	13%	9%	7%	8%
Total	90%							
		Average subsidy cutoffs and subsidies						
	Poverty level	100%	138%	150%	200%	250%	300%	400%
	Premium	2.08%	2.08%	3.63%	5.35%	7.45%	9.11%	9.86%
1	$2,160	$245	$245	$568	$944	$1,754	$2,681	$3,482
	subsidy	$1,915	$1,915	$1,592	$1,216	$406	$0	$0
2	$4,320	$331	$331	$769	$1,277	$2,374	$3,628	$4,712
	subsidy	$3,989	$3,989	$3,551	$3,043	$1,946	$692	$0
3	$5,184	$418	$418	$970	$1,611	$2,993	$4,575	$5,943
	subsidy	$4,766	$4,766	$4,214	$3,573	$2,191	$609	$0
4	$6,048	$504	$504	$1,171	$1,944	$3,613	$5,523	$7,173
	subsidy	$5,544	$5,544	$4,877	$4,104	$2,435	$525	$0
	Percent eligible for subsidy							
	1 person family	$99						
	2 person family	$604						
	3 person family	$421						
	4 person family	$531						
	Total	$1,655	per enrollee	(unadjusted)				
	Medicaid eligible	$1,091	< 138% federal poverty level					
	Medicaid adj	$1,037						
	Year 1 adj	$1,064						
	Years 2-4 adj	$1,091						
	Adj subsidy 1st yr	$591						
	Adj subsidy yrs 2-4	$563						

Note 1: Distribution of income and household size is from the U.S. Census Bureau, 2016. The table of federal poverty levels shows the different federal poverty levels for each household size. The percentage for each income level is estimated from cumulative income distributions nearest the appropriate federal poverty level with appropriate interpolations, when necessary (see Table XXII).

Note 2: The subsidy cutoff levels are taken from the current ACA regulations and the guidelines from S.1804 for 100% federal poverty level.

Note 3: The premium for each household size is calculated by multiplying the individual premium by the average composition of each household of that size. For 1 and 2-person families this is the same as the household size. For 3-person and 4-person families an adjustment is made for children by multiplying by 0.4 for each child. We calculated only up to 4-person households for simplicity since this comprises 90% of households.

Note 4: The dollar value of the cutoff for each poverty level for each household size is calculated by multiplying the federal poverty level for that household by the percent of income that will trigger a subsidy (the subsidy cutoff level).

Note 5: The percent eligible for subsidy is calculated by multiplying each household size at each approximate federal poverty level (the data from the Census Bureau are not provided by poverty level except at or above 100%), where the subsidy cutoff level is less than the premium for that household size.

Note 7: The total subsidies per family are calculated by adding the subsidies for each household size, each of which is calculated by adding the difference between the premium and the subsidy cutoff level and then dividing in half. (Since the income levels are ranges, we estimate the subsidy required by essentially taking a midpoint of the income levels.)

Note 8: The Medicaid adjustment is calculated by adding the subsidies for all the households for 100% federal poverty level, assuming all of these families would be eligible for Medicaid.

Note 9: The year 1 transition adjustment for Medicaid is calculated by subtracting one-half the Medicaid adjustment from the total subsidies per person. The adjustments for years 2-4 are calculated by subtracting the entire Medicaid adjustment from the total subsidies per person.

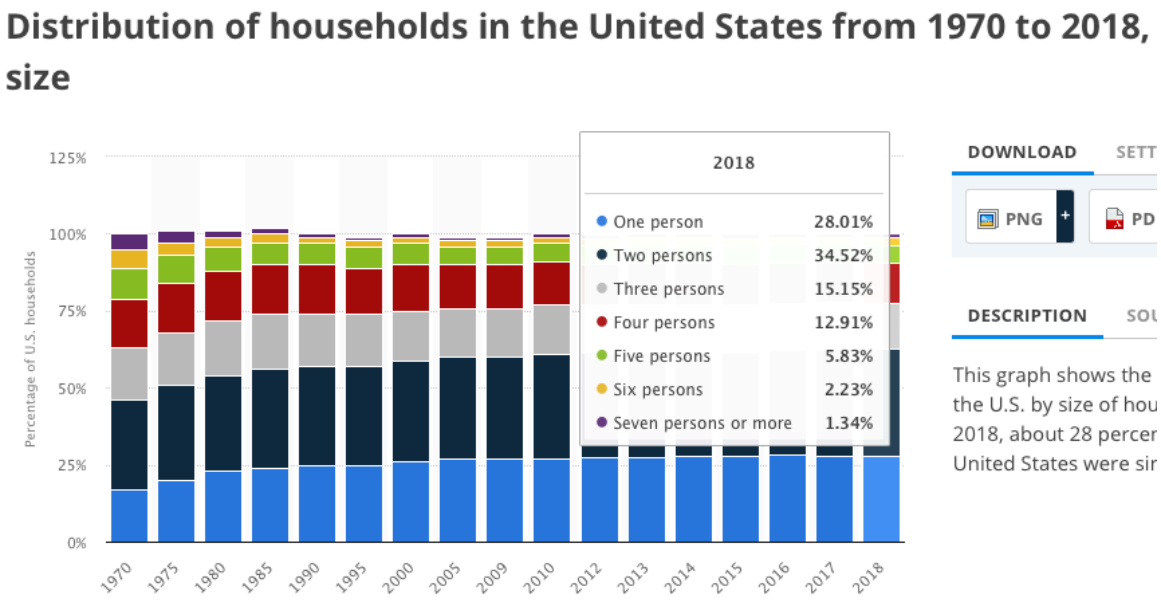
XXII. Distribution of income by household size and income level

	Thousands	Percent	Cumulative	% inc level	Inc level	% inc level	Inc level
Total	127,586	100.00%					
Under $5,000	4,218	3.31%	3.31%				
$5,000 to $9,999	3,497	2.74%	6.05%				
$10,000 to $14,999	5,875	4.60%	10.65%	8%	$12,500		
$15,000 to $19,999	6,091	4.77%	15.43%	4%	$16,250	2%	$18,750
$20,000 to $24,999	6,127	4.80%	20.23%	6%	$24,250		
$25,000 to $29,999	5,818	4.56%	24.79%	5%	$30,000		
$30,000 to $34,999	5,952	4.67%	29.45%	2%	$32,500		
$35,000 to $39,999	5,644	4.42%	33.88%	3%	$36,250		
$40,000 to $44,999	5,184	4.06%	37.94%				
$45,000 to $49,999	4,898	3.84%	41.78%	10%	$48,650		
$50,000 to $54,999	5,025	3.94%	45.72%	9%	$55,000		
$55,000 to $59,999	4,067	3.19%	48.91%	3%	$60,000		
$60,000 to $64,999	4,077	3.20%	52.10%	3%	$65,000		
$65,000 to $69,999	4,033	3.16%	55.26%				
$70,000 to $74,999	3,786	2.97%	58.23%	5%	$72,500		
$75,000 to $79,999	3,711	2.91%	61.14%				
$80,000 to $84,999	3,709	2.91%	64.04%				

$85,000 to $89,999	3,054	2.39%	66.44%				
$90,000 to $94,999	2,919	2.29%	68.73%	10%	$91,000		
$95,000 to $99,999	2,581	2.02%	70.75%	3%	$97,500		
$100,000 to $104,999	2,838	2.22%	72.97%				
$105,000 to $109,999	2,094	1.64%	74.61%	5%	$110,000		
$110,000 to $114,999	2,207	1.73%	76.34%				
$115,000 to $119,999	1,896	1.49%	77.83%				
$120,000 to $124,999	1,905	1.49%	79.32%	4%	$121,250		
$125,000 to $129,999	1,817	1.42%	80.75%	3%	$130,000		
$130,000 to $134,999	1,673	1.31%	82.06%				
$135,000 to $139,999	1,438	1.13%	83.19%				
$140,000 to $144,999	1,355	1.06%	84.25%	4%	$145,000		
$145,000 to $149,999	1,258	0.99%	85.23%				
$150,000 to $154,999	1,578	1.24%	86.47%				
$155,000 to $159,999	1,031	0.81%	87.28%				
$160,000 to $164,999	1,006	0.79%	88.07%				
$165,000 to $169,999	930	0.73%	88.80%				
$170,000 to $174,999	833	0.65%	89.45%				
$175,000 to $179,999	819	0.64%	90.09%				
$180,000 to $184,999	838	0.66%	90.75%				
$185,000 to $189,999	683	0.54%	91.28%				
$190,000 to $194,999	658	0.52%	91.80%	8%	$195,000		
$195,000 to $199,999	588	0.46%	92.26%				

$200,000 to $249,999	4,310	3.38%	95.64%	4%	$250,000		
$250,000 and over	5,564	4.36%	100.00%				

Note: Income levels are chosen to approximate appropriate cutoffs for subsidy calculations. Percentages for each income level are interpolated as necessary from the cumulative data.



Note: These data are used to calculate subsidies based on federal poverty level. It is assumed that household distribution is the same at each income level, in the absence of more precise data.

XXIII. Calculation of premiums after transition (note on next page).

Individual premium calculations							
Total AGI US	$9,578	billions					
Exclusions	(billions)			Household size distribution	133% Fed poverty level	% total AGI for income bracket	Total AGI for bracket (billions)
<$15,000 income	$70.3		<$15,000 income	100.0%		100%	$70.3
1 pers household	$10.1		1 pers household	28.0%	$16,971	40%	$90.5
2 pers household	$21.0		2 pers household	34.5%	$22,929	50%	$121.8
3 pers household	$9.1		3 pers household	15.2%	$28,888	40%	$150.0
4 pers household	$24.4		4 pers household	12.9%	$35,511	50%	$378.0
5 pers household	$2.5		5 pers household	5.8%	$40,804	10%	$435.6
Total FPL exclusions	$137.5						
Number of returns	150,272,157		Average excl	$24,001			
# excl returns	43,161,286						
Addl exclusions	$2,571	average exclusion times number of non-excluded returns, in billions					
Total income subj to prem	$6,870	total AGI US minus total FPL exclusions minus addl exclusions, in billions					
Premium	5.00%						
Total premiums	$343						

Note: The percent total AGI for income bracket is estimated based on the average income of the nearest income bracket reported by the IRS. The amount of income subject to exclusion is multiplied by this amount and summed for all households to obtain a total amount of excluded income (the sum of the amount of income below the federal poverty level for all low-income tax returns). After excluding these returns, the average amount of excluded income (based on household size distribution) is then multiplied by the remaining number of returns to obtain the additional amount of income subject to exclusion. The total AGI minus the excluded income is multiplied by the percent premium to obtain the total individual premiums.

Employer premium calculations after transition:

	Payroll (billions)	Employed (thousands)	Businesses	% Businesses	% Payroll	Avg payroll (millions)	Exclusion
500+	$3,702	65,148	19,464	0.3%	59.2%	$190.2	$0.6
100-499	$846	17,503	89,479	1.5%	13.5%	$9.5	$2.7
<100	$1,707	41,555	5,791,788	98.2%	27.3%	$0.3	$118.2
Subtotal	$6,253	124,086	5,900,731	100.0%	100.0%	$1.1	$121.4
Government	$2,046	36,340	10,000	0.2%			$5.0
Total	$8,299	160,426					$126.4

After transition	All	Private	Government
Total prem without excl	$498	$375	$123
Prem excluded	$126	$121	$5
Employer contrib	**$372**	**$254**	**$118**
Employee contrib	$343		
Total premiums	$715		
Employer share	52%		
Tax exemption	$56	15% corporate tax rate	
Adj employee share	48%		

Note: Total premiums without exclusions is calculated by multiplying the total payroll by the premium percentage, 6%. Since businesses with <100 employees have an average payroll of $300,000, the excluded amount is assumed to be 100% of payroll for 50% these 5,791,788 businesses and approximately 82% of payroll for the remaining businesses. For businesses with 100+ employees, we assume that virtually all will be able to exclude the first $500,000 in payroll. For government, we assume virtually all 10,000 employers have payrolls in excess of $500,000.

Table XXIV. Total cost comparisons.

(dollar values in billions)	Without Medicare for All	After transition	Difference		
Federal					
Costs					
Medicare	$670	n/a	n/a		
Medicaid/CHIP	$373	$0	($373)		
ACA subsidies	$40	$0	($40)		
Total	$1,083	$1,754	$671		
Additional budget items	$0	$80	$80		
Additional programs	$0	$30	$30		
Tax subsidies[2]	$172	$59	($113)		
Subtotal costs	$1,255	$1,923	$668		
Revenues					
Premiums	$86	$745	$659		
Payroll taxes	$263	$263	$0		
Other[3]	$40	$40	$0		
Total revenues	$389	$1,048	$659		
Total from general revenues	$866	$875	$9		
State & local					
Medicaid/CHIP	$230	$0			
Medicare	$13	$0			
Medicare payroll taxes	$15	$15			
Medicare premiums	$0	$118			
Private premiums	$169	$0			
Total	$427	$133	($295)		
Private employers					
Small	$142	$6	($136)		
Med-large	$377	$270	($107)		
Total	$519	$276	($243)		
Individuals					
Premiums[4]	$640	$351	($289)		
Payroll taxes	$124	$124	$0		
Other taxes and fees	$27	$27	$0		
Out-of-pocket	$352	$78	($274)		
Total	$1,143	$580	($563)		
Total costs[5]	$3,344	$2,912	($432)		

[1] These comparisons are based only on changes due to Medicare for All and do not consider changes in popluation, demographics or health characteristics over time.

[2] Adjusted for effects of Tax Cut Act of 2017

[3] Includes state payments, taxes on Social Security income interest on fund balances and fees and other income. Interest on income for Medicare for All is increased by 0.5% of total expenses to account for larger amounts in fund balances. State payments eliminted under Medicare for All.

[4] Baseline data from Bureau of Labor Statistics

[5] Does not include all healthcare costs. Includes loss to general revenues from tax exemptions for private insurance premiums.