Funding Medicare for All

The campaign for single payer has hit a new high with the filing by Senator Bernie Sanders of a single-payer bill in the Senate with 16 cosponsors.[1] While this bill, and its house counterpart HR 676, has more support than any similar measure has ever had in Congress, it still faces serious opposition because of the cost, and the required new taxes.[2]

There is an alternative. Much of the revenue needed for a full single-payer program like that proposed by Senator Sanders is required for "Improved Medicare for All" (IMFA) or a national health insurance program providing full coverage to everyone. By contrast, the existing Medicare program, enacted in 1965, provides relatively skimpy coverage, comparable to a Bronze plan on the ACA Exchanges, and includes considerable built in revenues. As was once proposed by Senator Daniel Moynihan, simple Medicare for All (MFA) could be enacted by removing the age limits in the laws establishing Medicare, and it could be done with a fraction of the taxes required for IMFA.[3]

I estimate the revenue needed for MFA and report the results in an article in *The Conversation*. Below, I explain my calculations, summarized in Table 1. (I base my calculations on 2015, the last year for which we have data on all relevant values.)

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[1] Bernard Sanders, "A Bill to Establish a Medicare-for-All National Health Insurance Program," September 13, 2017, https://www.sanders.senate.gov/download/medicare-for-all-act?id=6CA2351C-6EAE-4A11-BBE4-CE07984813C8&download=1&inline=file.

[2] Dean Baker, "Can We Pay for Single Payer?," *Democracy Journal*, September 14, 2017, http://democracyjournal.org/arguments/can-we-pay-for-single-payer/; Gerald Friedman, "Friedman Analysis of HR 676: Medicare for All Would Save Billions - PNHP's Official Blog," 676, accessed January 24, 2014, http://pnhp.org/blog/2013/07/31/friedman-analysis-of-hr-676-medicare-for-all-would-save-billions/; Dylan Matthews, "Kenneth Thorpe's Analysis of Bernie Sanders's Single-Payer Proposal.," *Scribd*, accessed February 5, 2016, https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal; John Holahan et al., "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending" (Washington, D. C.: Urban Institute, Health Policy Center, May 2016), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/200785-The-Sanders-Single-Payer-Health-Care-Plan.pdf.

[3] Joseph J. Fins, "When Pat and Bob Nearly Saved Health Care Reform: A Lesson in Senatorial Bedside Manner," *The Conversation*, accessed July 29, 2017, http://theconversation.com/when-pat-and-bob-nearly-saved-health-care-reform-a-lesson-in-senatorial-bedside-manner-81649; James A. Morone and Lawrence R. Jacobs, eds., *Healthy, Wealthy, & Fair: Health Care and the Good Society* (Oxford ; New York: Oxford University Press, 2005).

Table 1. Funding Medicare for All, 2015 ($billions).

Coverage replacement	$	754.1
Covering uninsured	$	81.8
Total cost:	*$*	*835.8*
Savings:		
Provider administration	$	89.5
Insurance administration	$	75.4
Hospital monopoly pricing	$	53.1
Total savings:	*$*	*218.0*
Net cost:	***$***	***617.9***
Revenues:		
Tax expenditure savings:	$	141.9
Reduced ACA subsidies	$	19.2
Premiums:	$	210.3
subtotal, natural enhancements:	*$*	*371.5*
New revenue needed:	$	246.4
New revenue needs as share of payroll:		2.99%

Coverage replacement: Medicare currently covers 7% of the spending by the population under age 65. I assume that under MFA it would cover 52% of these costs.[4] The difference, 45% of spending for those under 65, comes to $656.8 billion in 2012. I bring this up to 2015 to match enrollment data; assuming the new coverage amount increases at the same rate as national health expenditures between 2012 and 2015, or by 1.1482; multiplying this by $656.8 gives $754.1 b. in 2015.[5]

Covering the uninsured: The population of uninsured in 2015 is 28,455,000. [6] Assuming that they spend 55% as much as do the insured, I estimate that their per capita spending without MFA is $3800.[7] With insurance, they would spend 80% as much as the insured, or an average of $5527. Multiplying the population by this per capita spending gives total spending of $137 billion. Assuming that MFA would cover 52% of this spending, this gives spending of $71 billion.

Total new spending is the sum of these or $835.8.

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[4] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Age-and-Gender.html

[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

[6] https://www.cdc.gov/nchs/hus/contents2016.htm#healthinsurance

[7] Jack Hadley and John Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending" (Kaiser Commission on Medicaid and the Uninsured, May 10, 2004), http://www.thesoutherninstitute.org/docs/publications/Policy%20Resources/KaiserReport.pdf.

Savings from provider administration: A full single payer plan would save about 10% of costs in provider offices.[8] MFA would shift a quarter of healthcare spending to the Centers for Medicare and Medicaid Services, and I assume it would save a quarter of these costs, or 2.5% of total spending.

Savings from insurance administration: Traditional fee-for-service Medicare operates at a Medical Loss Ratio of about 98% compared with 88% for private insurance.[9] This means that there is an administrative savings of 10% of the money shifted from private insurance to the MFA program, or $75.4 billion.

Hospital monopoly pricing: Medicare reimburses hospitals at about 22% less than private insurance. [10] Hospital spending comes to almost a third of total spending. The savings from lower hospital prices are estimated as .22*.32*754.1=$53.1 billion

Total savings are the sum of these three lines or $218 billion.

The net cost of the program is the difference between $835.8 billion in new costs and the $218.0 in savings, or, allowing for rounding error, $617.9 billion.

New revenues from savings on tax expenditures: Tax expenditures on employer provided health care are estimated by the Treasury as $235 billion, or 18% of spending on private health insurance.[11] Applying this to the $754 in reduced private health gives an increase in tax revenue of $141.9 billion.

New revenue from reduced ACA subsidies. ACA subsidies in 2015 were $28 billion.[12] If MFA replaces 68% of private health insurance spending, then I assume it will replace the same share of ACA subsidies.

New revenues from Medicare Part B premiums: I calculated the distribution of the population by income from the IRS Statistics of Income and applied to each income group the Medicare Part B premium for that income. For households eligible for ACA subsidies or Medicaid, I assumed premium payments would be no more than the ACA allows for private insurance premiums. I then calculated premium payments assuming that each tax return represents 2.13 persons.

Total revenue "natural enhancements" is new revenue that would come without any new legislation. It is the sum of revenue from these three sources, or $371.5 billion.

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[8] Friedman, "Friedman Analysis of HR 676."

[9] Diane Archer, "Medicare Is More Efficient Than Private Insurance," *Health Affairs*, accessed September 4, 2017, http://healthaffairs.org/blog/2011/09/20/medicare-is-more-efficient-than-private-insurance/.

[10] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (Washington, D. C.: Medicare Payment Advisory Commission, March 2017), http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf.

[11] Treasury of the United States, "Tax Expenditures FY2015" (Washington, D. C.: Executive Office of the President, January 2015), http://www.treasury.gov/resource-center/tax-policy/Documents/Tax-Expenditures-FY2015.pdf.

[12] Congressional Budget Office, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014" (Washington, D. C.: United States Congress, Congressional Budget Office, April 2014), https://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf.

After subtracting "natural enhancements" from the revenue needs, $246.4 in additional new revenue is needed. I divided this by the Bureau of Economic Analysis estimate of wage and salary income to get a payroll tax increase of just under 3.0%.