

Medicare for All: Leaving No One Behind

April xx, 2016

Presidential candidate Bernie Sanders has designed a replacement for the Affordable Care Act (ACA), called “Medicare for All: Leaving No One Behind.” The replacement, referred to in this report as the Plan, is a proposal for a single-payer health program that is managed by the federal government with the goal of universal coverage. This report details the findings of the Center for Health and Economy’s (H&E) Under-65 Microsimulation Model on the proposal’s impact on health insurance coverage, provider access, medical productivity, and the federal budget. While our estimates are associated with some degree of uncertainty, the summary of our findings is as follows:

KEY FINDINGS:

- Without the need to sign up for insurance H&E assumes universal coverage.
- Under the Plan, medical productivity is projected to decrease by 20 percent for the year 2026 relative to the current baseline due to the massive increase of patients into the health system.
- Provider access is projected to increase by 19 percent by 2026 as a result of the universal coverage along with the elimination of cost sharing.
- The health insurance coverage provisions proposed plan for the non-elderly are estimated to increase federal spending by \$34.67 trillion between 2017 and 2026. In an alternative scenario with a more generous benefit, H&E projects an estimated increase in federal spending of \$47.55 trillion between 2017 and 2026.
- We predict that the cost of Plan exceeds the proposed tax revenues. The H&E expected cost is \$2.47 trillion in spending for the year 2017. The tax revenues raised will only cover \$1.37 trillion that year leaving a deficit of \$1.1 trillion. In the alternative scenario described above, the deficit left after proposed tax revenues is \$2.11 trillion in 2017.

Microsimulation Analysis

This analysis utilizes a microsimulation model developed for use by H&E. The model employs micro-data available through the Medical Expenditure Panel Survey to analyze the effects of health policies on the health insurance plan choices of the under-65 population and interpret the resulting impact on national coverage, average insurance premiums, the federal budget, and the accessibility and efficiency of the health care sector.

Medicare for All, which is scored in this report as taking effect in 2017, is a proposal to introduce a national single-payer health care system. The Plan is meant to fully cover the entire population. All health care costs would be covered by the federal government. Premiums, deductibles, copays and any other out-of-pocket costs would be completely paid for through federal funds. The Plan proposes to eliminate all other federal health

programs, including the private marketplace and to expand the Medicare program to include the entire population.

Since H&E's Under-65 Microsimulation Model is a plan-choice model that does not account for the over-65 population, certain assumptions and adjustments had to be made in order to simulate the effects the Medicare-for-all policy would have. The assumptions made are as follows:

- **Limited Plan Choice:** A single payer system would eliminate all consumer choice relative to how insurance is currently administered. H&E eliminated all possible plan choices outside of an actuarial value range that is comparable to the current actuarial value of Medicare.
- **Administrative Savings:** One of the perceived benefits of a single-payer system is a decrease in administrative costs. To account for this decrease, H&E uses national health expenditure data to make an estimate of those savings.
- **Similar Actuarial Value:** Current Medicare beneficiaries receive insurance with an actuarial value in the 70 to 80 percent range. Therefore, plan choices in the individual and employer market were limited to PPO's that are comparable to the current individual market's health insurance plans with Gold metal levels.
- **Total Government Spending:** Since the Plan argues for a single-payer system in which all costs to the consumer are eliminated (not including new taxes levied), H&E adjusts by converting all health insurance-related costs into federal spending.
- **Revenue:** Since the Under-65 Microsimulation Model only takes into account factors directly related to the health insurance market, and many of the pay-fors in the Plan are not related, H&E uses the estimates for revenue found in the text of the Plan.
- **Alternate Benefit Scenario:** Since the Gold plan does not cover all costs to the consumer, H&E offers an alternate scenario at the end of the paper scoring the cost of covering the entire population with a Platinum-level plan.

Coverage Impact

Table 1. Health Insurance Coverage (millions)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Non-Elderly Population	273	274	275	277	278	280	281	282	284	285
Total Insured¹	273	274	275	277	278	280	281	282	284	285
Uninsured¹	0	0	0	0	0	0	0	0	0	0

¹ All insurance coverage estimates refer only to the under-65 population.

True to any single-payer health plan, H&E projects there will be full coverage of the population. Since there is no need to sign up for a plan or a program, and anyone can access health care in this plan, complete coverage would be expected. Because of the change, distinctions between Medicare and Medicaid and other public insurance would no longer exist. Table 2 describes a change in coverage by different types of insurance coverage including the five status quo categories of Individual Market, Employer Sponsored Insurance, Medicaid, Other Public Insurance and Uninsured.

Table 2. Change in Coverage Estimates (millions)

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Individual Market	237	241	243	246	249	252	253	255	257	258
Health Insurance Marketplace	-17	-16	-15	-14	-13	-13	-12	-12	-12	-12
Non-Group Market	254	258	259	262	263	265	266	267	269	270
Employer Sponsored Insurance	-145	-145	-145	-145	-145	-145	-145	-145	-145	-144
Medicaid	-51	-51	-51	-52	-52	-52	-52	-53	-53	-53
Other Public Insurance	-10	-11	-12	-12	-13	-13	-14	-14	-15	-16
Uninsured	-32	-34	-36	-37	-39	-41	-42	-43	-45	-46
Feb 2016 Total Insured¹	241	240	240	239	239	239	239	239	239	240
Medicare for All Total Insured¹	273	274	275	277	278	280	281	282	284	285

¹ All insurance coverage estimates refer only to the under-65 population.

Productivity and Access

In an attempt to evaluate access and productivity in the health care system, H&E estimates the Medical Productivity Index (MPI) and the Provider Access Index (PAI). Health insurance plan designs are associated with varying degrees of access to desired physicians and facilities, as well as incentives that promote or discourage efficient use of resources. H&E estimates each index by attributing productivity and access scores to the

range of plan designs available and exploiting changing plan choices to project the evolution of health care quality.

H&E expects medical productivity to decrease under Medicare for All. The influx of the previously uninsured into the market along with the dissolution of the network structure leads to a decrease in efficiency. Also, a market-based system typically leads to more efficiency as individual market plans require cost-sharing, which encourages price-conscious decision making among patients. The elimination of a health insurance marketplace—and therefore any price-conscious decisions due to cost-sharing—also contributed to the decrease in productivity.

Table 3. Medical Productivity Index¹

	2017	2018	2019	2020	2021	2026
Total Insured	2.0	2.0	2.0	2.0	2.0	2.0

Change in Medical Productivity¹

	2017	2018	2019	2020	2021	2026
Total Insured	-15%	-14%	-15%	-17%	-18%	-22%

¹Productivity and access estimates refer only to the under-65, non-disabled population

H&E also projects an increase in average provider access for the total insured population. This, again, is a result of number of people projected to be insured relative to our current health care infrastructure.

Table 4. Provider Access Index¹

	2017	2018	2019	2020	2021	2026
Total Insured	3.4	3.4	3.4	3.4	3.4	3.4

Change in Provider Access¹

	2017	2018	2019	2020	2021	2026
Total Insured	11%	12%	13%	14%	15%	19%

¹Productivity and access estimates refer only to the under-65, non-disabled population

Budget Impact

H&E projects that the insurance coverage expansion under the Plan will have a net budgetary impact of -\$31.19 trillion dollars over the next decade. The budget impact table is divided into two sections: Sources of Funds refers to changes in dollars raised by the federal government and Uses of Funds refers to changes in dollars spent by the federal government. Though H&E is unable to accurately predict the effect of many of the Plan’s taxes, savings from reduced administrative costs are listed as a source of revenue. Also, the Plan does not make tax credits available to individuals to purchase insurance, unlike current law, the cost of providing insurance to all in the individual market is expressed in the following tables through “Single-Payer Health Care Costs.”

Over the decade spanning between 2017 and 2026, H&E estimates that non-elderly coverage provisions under current law will cost \$34.67 trillion. The yearly cost is expected to begin at around \$2.7 trillion in 2017 and increase to \$4.28 trillion in 2026.

One of the appeals of a single-payer health care system promoted by the Plan is the decreased administrative costs that comes with such a system. According to data provided by the Centers for Medicare and Medicaid Service, the administrative costs for Medicare accounts for 4 percent of beneficiary cost sharing while administrative costs for private health insurance is around 13 percent of cost sharing. H&E expects this decrease in administrative costs to save \$275 billion in 2017. The combined health care costs of the entire population is expected to be \$2.47 trillion in 2017, accumulating to \$31.19 trillion over the 10-year budget window.

Table 5. Cost of the Plan Coverage Provisions without Taxes (billions)¹

	2017	2018	2019	2020	2021	2026	2017-2026
Sources of Funds²							
Administrative Savings	275	288	302	320	336	429	3,471
Uses of Funds³							
Single Payer Health Care Costs	2,743	2,878	3,021	3,197	3,357	4,280	34,666
Net Budgetary Impact⁴	-2,469	-2,590	-2,718	-2,877	-3,021	-3,851	-31,194

¹ Cost estimates refer only for the under-65 population.

² Positive values denote increases in revenue; negative values denote decreases in revenue.

³ Positive values denote increases in spending; negative values denote decreases in spending.

⁴ Positive values denote surplus; negative values denote deficit.

Table 6 illustrates the budgetary impacts that the Plan would have relative to the current H&E baseline once all ACA provisions are eliminated and replaced. As a result of eliminating the ESI and individual markets, revenue from the employer and individual

mandates would cease, and while savings from administration costs is not technically revenue, it counts as a net plus relative to the current baseline. H&E expects an increase of \$264 billion in revenue and savings in 2017.

Table 6. Change in Budgetary Impact Estimates (billions)¹

	2017	2018	2019	2020	2021	2026	2017 - 2026
Change in Sources of Funds Baseline Estimates²							
Tax on Employer Sponsored Health Insurance	0	0	0	-19	-20	-16	-132
Individual and Employer Mandate Taxes	-11	-13	-15	-17	-19	-37	-219
Administrative Savings	275	288	302	320	336	429	3,471
Subtotal	264	275	283	284	297	376	3,120
Change in Uses of Funds Baseline Estimates³							
Cost Sharing Benefits	-15	-14	-14	-13	-12	-5	-105
Premium Tax Credits	-57	-68	-68	-65	-63	-54	-835
Medicaid	-202	-208	-214	-219	-226	-269	-2,320
Medicare	-76	-89	-93	-97	-100	-117	-1,015
Single-Payer Health Care Costs	2,743	2,878	3,021	3,197	3,357	4,280	34,666
Subtotal	2,393	2,499	2,632	2,803	2,956	3,835	30,391
March 2016 H&E Baseline Net Budgetary Impact⁴	-360	-377	-386	-376	-382	-431	-3,920
The Plan's Net Budgetary Impact⁴	-2,469	-2,590	-2,718	-2,877	-3,021	-3,851	-31,194

¹ Cost estimates refer only for the under-65 population.

² Positive values denote increases in revenue; negative values denote decreases in revenue.

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Also with the elimination of the ACA and the subsequent launch the Plan, uses of funds for the under-65 population would be set to change. For this population, costs for Medicare, Medicaid, Cost Sharing Benefits and Premium Tax credits would be fundamentally changed. The costs for the single-payer system instituted by the plan are all rolled into the “Single-Payer Health Care Costs” line. In the year 2017, H&E expects extra spending caused by the plan to total \$2.39 trillion—adding up to \$30.39 trillion over the 10-year budget window.

In its analysis of a proposal's impact on the federal budget, H&E looks only at provisions directly related to health insurance coverage. For proposals that repeal the ACA—such as the Plan—there are a number of tax policy changes that are not directly related to health insurance coverage and are thus not included in our budget impact analysis above.

UNCERTAINTY IN THE PROJECTIONS

The Center for Health and Economy uses a peer-reviewed micro-simulation model of the health insurance market to analyze various aspects of the health care system.¹ As with all economic forecasting, H&E estimates are associated with substantial uncertainty. While the estimates provide good indication on the nation's health care outlook, there are a wide range of possible scenarios that can result from policy changes, and current assumptions are unlikely to remain accurate over the course of the next ten years. For instance, the uncertainty surrounding the implementation of the Affordable Care Act and similar obstacles facing the implementation of new health care overhauls affect the accuracy of short-term coverage estimates. Importantly, this uncertainty does not lead to biased results. H&E attempts to depict an unbiased, middle-ground representation of the future should the policy and economic environment remain constant. While the goal is to project the most likely scenario, actual events may differ significantly from published predictions.

With a proposal that puts forward substantial changes there are bound to be a myriad of uncertainties when projecting different scenarios. There are a handful of these that will be brought up in the discussion: the magnitude of health care usage in such a system and the complications that may bring and certain cost effects that may arise from the Plan, certain proposals that the model is unable to score, the effects of the pay-fors that are included in the Plan, and an alternate cost for a more generous benefit structure.

Medicare for All proposes a drastically different system that leads to many different assumptions for a plan choice model like H&E's Under-65 Microsimulation Model. Among those assumptions are the usage of insurance. Since the Plan proposes to eliminate premiums and all cost sharing, it is highly likely that health care usage will go up—which is confirmed by the decrease in provider access above. However, the magnitude of the increase at which people access health care is up for debate. This has multiple implications especially for the cost of universal health care to the federal government. To prevent any bias, H&E assumed that all underlying patient-choice assumptions remained the same with the exception of the patients' ability to choose plans that do not comply with the current range of actuarial values that Medicare plans currently offer.

Next, the Plan has a few policies that H&E is simply unable to account for; first among them is drug-price negotiations. The Under-65 Model lacks a drug pricing component that would allow H&E to score this part of the Plan in good faith.

Along with drug negotiations, the Under-65 Model is unable to score proposals at the macro level. Funds raised by progressive income tax rates, taxing capital gains and dividends, and estate tax, among others, currently fall outside the realm of H&E's ability.

While H&E has the ability to score things like the individual income-based premium, to avoid confusion, it was left out of the budget impact tables 5 and 6. In order to provide a glance at what the budgetary impacts of these taxes might be, see table 7. H&E used the numbers provided in the text of Medicare for All and applied them to the budget for the year 2017 in order to see how these pay-fors might measure up.ⁱⁱ

Table 7. Budgetary Impact for 2017 with Funds from The Plan (billions)

	2017
Change in Sources of Funds Baseline Estimates ¹	275
Change in Uses of Funds Baseline Estimates ²	2,743
Subtotal	-2,469
Change in Sources of Funds (The Plan) ¹	
Employer Income Tax	630
Household Income Tax	210
Progressive Income Tax	110
Capital Gains and Dividend Taxes	92
Limited Tax Deductions for Rich	15
Health Expenditure Savings	310
Subtotal	1,367
Net Budgetary Impact³	-1,102

¹ Positive values denote increases in revenue; negative values denote decreases in revenue.

² Positive values denote increases in spending; negative values denote decreases in spending.

³ Positive values denote surplus; negative values denote deficit.

As seen from the table, after the revenues that the writers of the Plan calculated are added to the baseline for 2017, the net budget shortfall remains about \$1.38 trillion dollars. Though this is merely a rough picture of what 2017 might look like with the Plan's projected revenues, the net budgetary impact is a substantial amount to overcome. Outside of the healthcare budget, the impact of seeking to break even through increased taxes would be challenging on the economy at large.

While the current actuarial value of the insurance covered by Medicare is in the 70 to 80 percent range, or roughly a Gold metal level plan, the goal of Medicare for all is to cover all costs. In the Under-65 model, the plans that have the highest actuarial value are Platinum-level plans at 90 percent. Questions still remain about patient access and choices under a single-payer system, how those metrics might compare with those of Platinum plans today, and how it all might translate to costs, but it is fitting to score such a scenario given the goals of the Plan. To score this scenario, H&E moved the population in a Platinum level plan and did not change any other assumptions. Table 8 and Table 9 show an alternate set of budgetary effects for this scenario.

Table 8. Alternate Cost of the Plan Coverage Provisions without Taxes (billions)¹

	2017	2018	2019	2020	2021	2026	2017-2026
Sources of Funds ²							
Administrative Savings	275	288	302	320	336	429	3,471
Uses of Funds ³							
Single Payer Health Care Costs	3,748	3,936	4,134	4,370	4,593	5,909	47,548
Net Budgetary Impact⁴	-3,473	-3,648	-3,832	-4,050	-4,257	-5,480	-44,077

¹ Cost estimates refer only for the under-65 population.

² Positive values denote increases in revenue; negative values denote decreases in revenue.

³ Positive values denote increases in spending; negative values denote decreases in spending.

⁴ Positive values denote surplus; negative values denote deficit.

In the scenario where the actuarial value for the single-payer insurance in Medicare for All is comparable to a Platinum level plan, H&E expects federal costs to increase to \$3.75 trillion in 2017. Over the course of the next ten years, those costs are expected to accumulate to around \$47.5 trillion, offset partially by administrative savings. In Table 9, when the taxes that Medicare for All seeks to implement are put into effect, H&E expects that the net budgetary impact of such a benefit would be a deficit of about \$2.1 trillion in 2017.

Table 9. Alternate Budgetary Impact for 2017 with Funds from The Plan (billions)

	2017
Change in Sources of Funds Baseline Estimates ¹	275

Change in Uses of Funds Baseline Estimates ²	3,748
Subtotal	-3,473
Change in Sources of Funds (The Plan) ¹	
Employer Income Tax	630
Household Income Tax	210
Progressive Income Tax	110
Capital Gains and Dividend Taxes	92
Limited Tax Deductions for Rich	15
Health Expenditure Savings	310
Subtotal	1,367
Net Budgetary Impact³	-2,106

¹ Positive values denote increases in revenue; negative values denote decreases in revenue.

² Positive values denote increases in spending; negative values denote decreases in spending.

³ Positive values denote surplus; negative values denote deficit.

ⁱ Parente, S.T., Feldman, R. "Micro-simulation of Private Health Insurance and Medicaid Take-up Following the U.S. Supreme Court Decision Upholding the Affordable Care Act." Health Services Research. 2013 Apr; 48(2 Pt 2):826-49.

ⁱⁱ "Medicare for All: Leaving No One Behind." Retrieved from, <https://berniesanders.com/issues/medicare-for-all/>