



February 4, 2019

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THE CASE FOR MEDICARE-FOR-ALL

Acknowledgments

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Introduction

These facts are not in dispute: The United States spends the most per person in the world for health care while leaving a much greater share of its population uninsured and experiencing the worst health outcomes of any wealthy country.

“On almost every measure of life expectancy, the United States ranks at or near the bottom compared to other high-income countries,” the National Academy of Sciences wrote in 2014. “Each year, other high-income countries are improving their health at a much faster rate than the United States, and the United States currently ranks lowest on a variety of health measures.”¹

There is nothing inherent to the United States that consigns us to having poor health outcomes and high care costs. As recently as 1980, our health care spending was close to that of other wealthy countries and our life expectancy was about average. Since then, we have fallen to the bottom in life expectancy of these countries, while our spending has soared far beyond that of any other comparable country.²

The authors of the Affordable Care Act (ACA), otherwise known as Obamacare, sought to improve our dismal state of affairs while retaining the fundamental structure of our health care system. Although the law has achieved important progress, such as significantly decreasing the number of people who lack health insurance, it has not provided access to affordable care akin to what other wealthy countries provide to their residents.

Meanwhile, opponents of the ACA have perpetually sought to overturn the law or, short of that, to sabotage it at every opportunity. They have ended a requirement, initially proposed by conservatives and sought by insurance companies, that all Americans carry some form of health insurance or face a financial penalty. Because a federal judge in Texas used the end of that requirement to strike down the Affordable Care Act entirely, including the universally popular prohibition against insurance companies discriminating against people with preexisting conditions, health care for millions of Americans remains under threat as we wait for the case to be heard by the Supreme Court.³

Rising out of the ashes of this bleak landscape are increasingly optimistic prospects to improve and expand our most popular health care program—Medicare—to cover all Americans. This proposal, often referred to as Medicare-for-All, has long been recognized by most policy experts as a method to provide access to affordable health care to all Americans while reaping tremendous savings by streamlining our fragmented system.

Despite its allure on policy grounds, many policy makers have previously shied away from pursuing Medicare-for-All legislation for fear of challenging the many powerful special interests that profit from our current health care system. But the ongoing challenges of our health care system along with attacks on the ACA, Medicare, and Medicaid have helped garner mainstream support for reform. A recent

¹STEVEN H. WOOLF AND LAUDAN ARON, EDs., NATIONAL ACADEMY OF SCIENCES, POORER HEALTH: PANEL ON UNDERSTANDING CROSS-NATIONAL HEALTH DIFFERENCES AMONG HIGH-INCOME COUNTRIES, at 91 (January 2013), <https://bit.ly/2C6b8pj>.

²Austin Frakt, *Medical Mystery: Something Happened to U.S. Health Spending After 1980*, THE NEW YORK TIMES (May 14, 2018), <https://nyti.ms/2Gb6gOB>.

³Ariane de Vogue and Tami Luhby, *Federal Judge in Texas Strikes Down Affordable Care Act*, CNN (December 15, 2018), <https://cnn.it/2OZ7rKe>.

Reuters/Ipsos poll found that 70 percent of Americans supported Medicare-for-All, including, 52 percent of Republicans [Figure 1].⁴ Moreover, most of the Democratic members of the U.S. Senate who are potential candidates for president in 2020 have co-sponsored Medicare-for-All legislation.

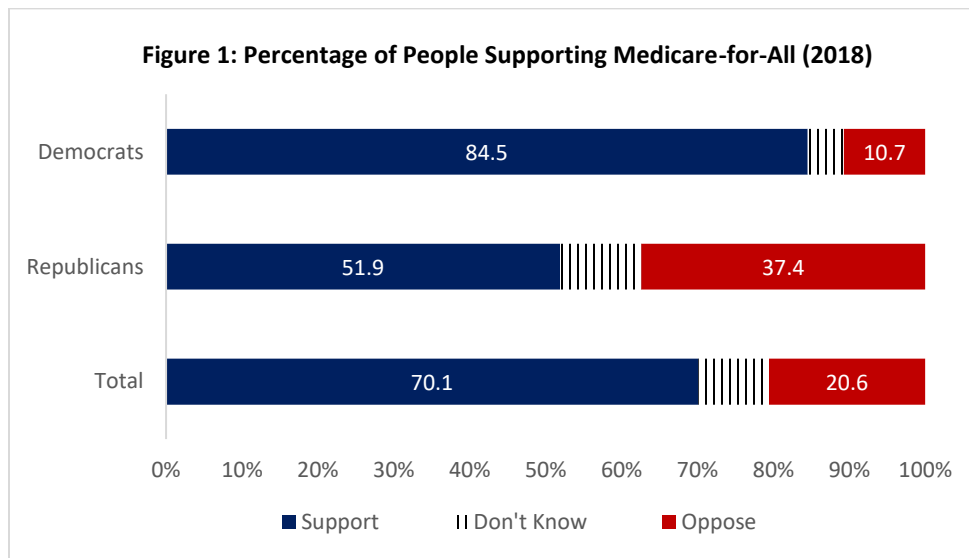


Figure note: Results are based on a Reuters/Ipsos survey of a random sample of nearly 3,000 American adults between June and July 2018.⁵

There remains some flexibility about how Medicare-for-All would work in practice. In the broadest sense, as its name suggests, it refers to improving and expanding the Medicare program, which primarily serves people 65 years of age or older, to everyone in the United States. Advocates have put forward proposals that differ on certain details, including on whether patients should be subject to any out-of-pocket costs and on the scope of health care services that should be included in the plan.

Public Citizen advocates for the broadest and most-inclusive plan possible. There should be no premiums, deductibles, or co-pays for necessary medical services or prescription drugs. Moreover, the plan we advocate for would expand Medicare to include vision and dental care, and vastly improve access to mental health care. The private insurance plans administered by Medicare, named Medicare Advantage, should be eliminated because they squander resources on overhead and private profits that would much more wisely be applied to providing actual health care.

An abundance of supporting research reveals that such a program would accrue tremendous savings, because of its scale and simplicity. A particularly vivid example of this—and a metaphor for the inefficiency that ails our system—would be ridding ourselves of the byzantine billing system that sometimes requires multiple people to handle remittances for a single doctor.

⁴Megan Keller, *Seventy Percent of Americans Support 'Medicare for All' in New Poll*, THE HILL (August 23, 2018), <https://bit.ly/2xCbVLU>.

⁵Leticia Stein, Susan Corwell, and Joseph Tanfani, *Inside the Progressive Movement Roiling the Democratic Party*, REUTERS (August 23, 2018), <https://reut.rs/2wjNxxu>.

Meanwhile, ensuring that everyone in the United States has access to affordable care through all stages of their lives would prevent many debilitating health conditions. In addition to improving quality of life, it would reduce uncompensated care, a significant source of increased costs for both the public and for health care providers, under the current system.

Numerous studies have concluded that Medicare-for-All would yield significant cost savings. But there is also a very simple exhibit to turn to: Medicare, itself. Although Medicare's costs have increased over time in real dollars, they have risen much more slowly than the cost of care for Americans covered by private health insurance. Since 2009, Medicare's costs (adjusted for inflation) have actually fallen [Figure 2].⁶

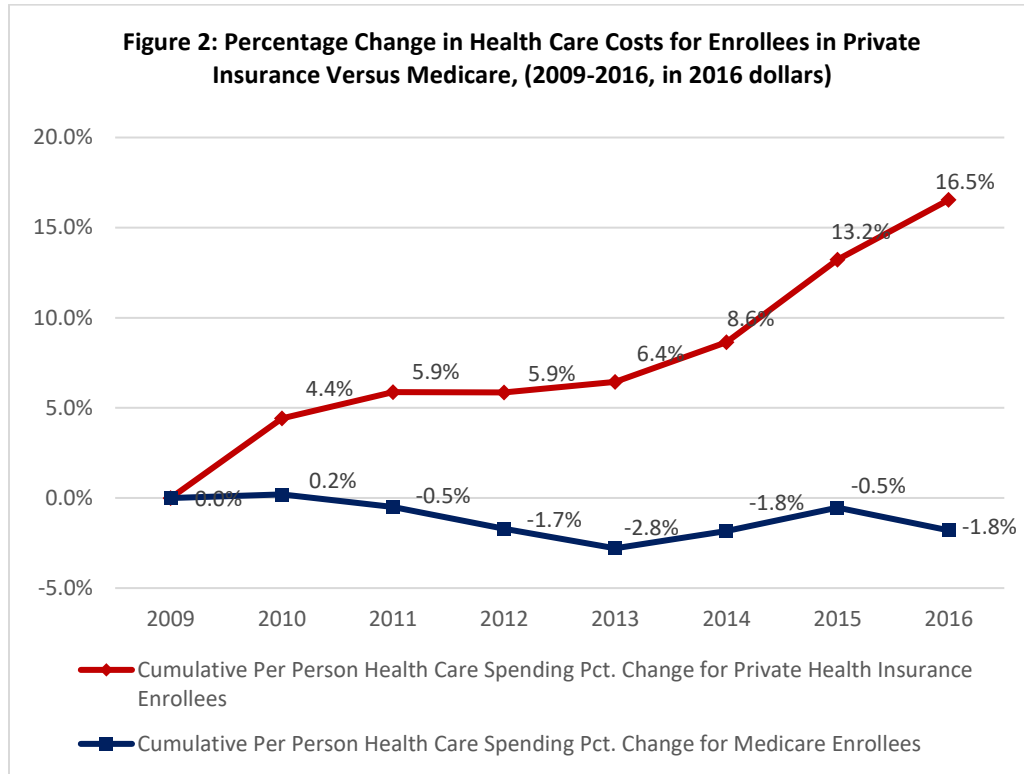


Figure note: Data are based on the National Health Expenditure Data from 2009-2016, adjusted for inflation using the Consumer Price Index of the Bureau of Labor Statistics.⁷

This accomplishment is all the more remarkable because Medicare primarily treats elderly patients with more chronic and complicated health conditions than the population as a whole. Medicare coverage in its current state is not as generous as the plan we envision but represents a strong foundation on which Medicare-for-All would be built.

⁶National Health Expenditure Data – Historical, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://go.cms.gov/1UFHHer> (viewed September 20, 2018).

Consumer Price Index – Databases, Bureau of Labor Statistics, <https://bit.ly/2Iazj6f> (viewed September 20, 2018).

⁷National Health Expenditure Data – Historical, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://go.cms.gov/1UFHHer> (viewed September 20, 2018).

Consumer Price Index – Databases, Bureau of Labor Statistics, <https://bit.ly/2Iazj6f> (viewed September 20, 2018).

As we seek to build a Medicare-for-All system, it is important to learn from countries that already provide universal health care. While studies comparing different countries' health care systems and outcomes invariably find the United States suffers numerous dubious distinctions, other countries' systems have faults, as well. For instance, many countries' health care systems have gaps in the types of services they cover and, because of out-of-pocket costs, some percentage of residents of every country in the world report going without necessary care because they cannot afford it. By understanding both best practices and areas for improvement, we can build a uniquely American health care system that guarantees access to care.

We are at a rare moment in time, in the window of what might be a once-in-a-century opportunity to boldly reshape our health care system to expand and improve access to care such that we could potentially leap-frog the countries that currently outperform us in health outcomes. Such a clear surge in support for Medicare-for-All that our nation is experiencing holds the promise of taking us from worst-to-first when it comes to providing guaranteed access to health care. In this report, we highlight research from a variety of scholars and researchers to answer the key questions about Medicare-for-All and lay out a path for finally achieving health care coverage for everyone in the United States.

Question: Would Medicare-for-All cause a huge increase in the nation's health care costs?**Answer: No. Medicare-for-All would improve efficiency and bring down the cost of care so much that overall health care costs would likely hold steady or decline even as the amount of care provided would significantly increase.**

In the United States, we already spend \$3.5 trillion, or more than \$10,000 per person, on health care annually—a staggering sum—a great deal of which is wasted or unnecessary.⁸ A well-designed Medicare-for-All system would create enough savings that even a significant increase in the amount of care rendered would be more than offset.⁹ This would be achieved by reducing administrative waste, harnessing the federal government's negotiating power to bring down the price of care, setting global budgets for institutions that would reduce the incentive for providers to administer unnecessary expensive treatments, and increasing access to more affordable long-term care.

As a country, we spend far more on health care than other comparably wealthy nations. Despite our excessive spending, the United States has the worst health outcomes of comparable countries. This illustrates that we clearly are not getting what we pay for.¹⁰ It hasn't always been this way, it wasn't so long ago that our health care spending was much more similar to comparably wealthy nations [Figure 3].¹¹ In the 1980s our spending was much more in line with cohort countries, before rapidly rising over the last few decades.

⁸CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURES 2016 HIGHLIGHTS, at 1 (January 2018), <https://go.cms.gov/1V5YDcl>.

⁹ROBERT POLLIN, ET AL, POLITICAL ECONOMY RESEARCH INSTITUTE, ECONOMIC ANALYSIS OF MEDICARE FOR ALL, at 2 (November 2018), <https://bit.ly/2E6AhCw>.

¹⁰Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1024 (2018).

¹¹OECD.Stat – *Health Expenditure and Financing*, ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, <https://bit.ly/2sNaLux> (viewed on January 27, 2019).

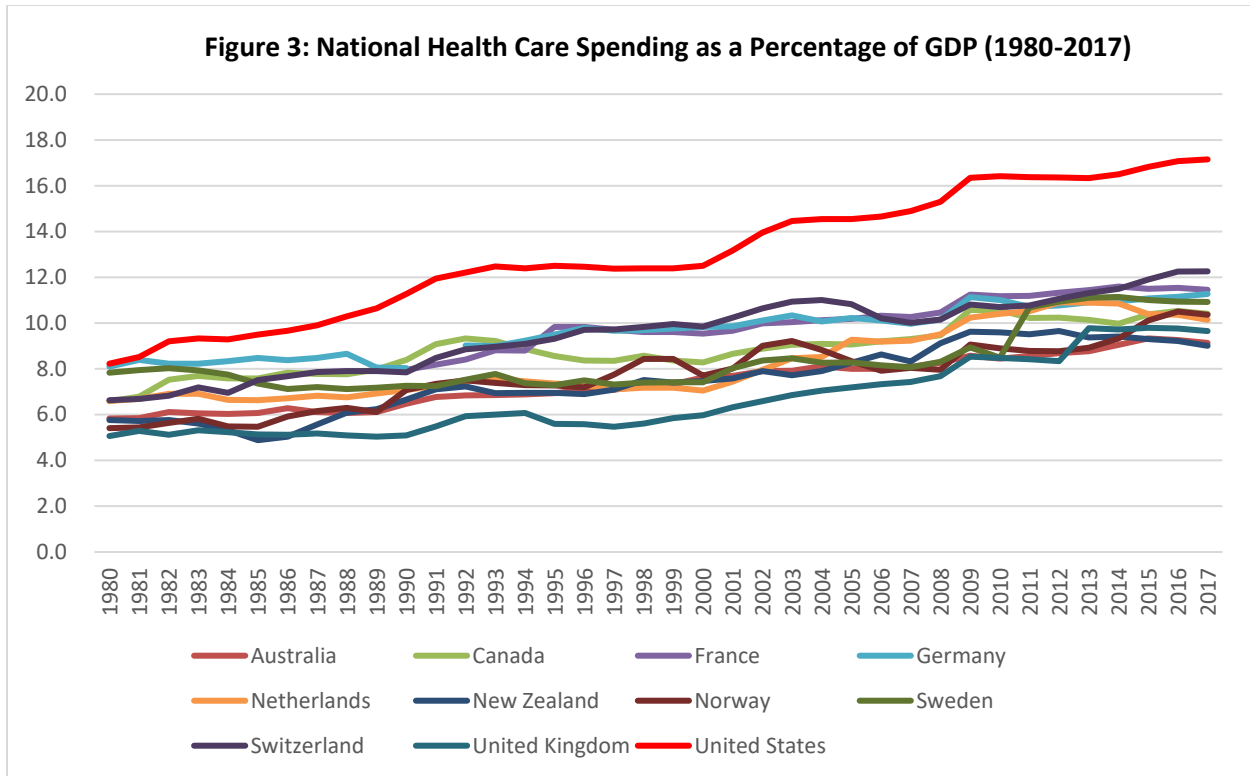


Figure note: Data are based on information collected by the OECD, EUROSTAT, and WHO Health Accounts.¹²

Similarly, U.S. life expectancy was about average in 1980, but we have been losing ground with comparable countries since that time [Figure 4]. Together these findings highlight that our excessive spending is not leading to better health outcomes.¹³

¹²*Id.*

¹³*Id.*

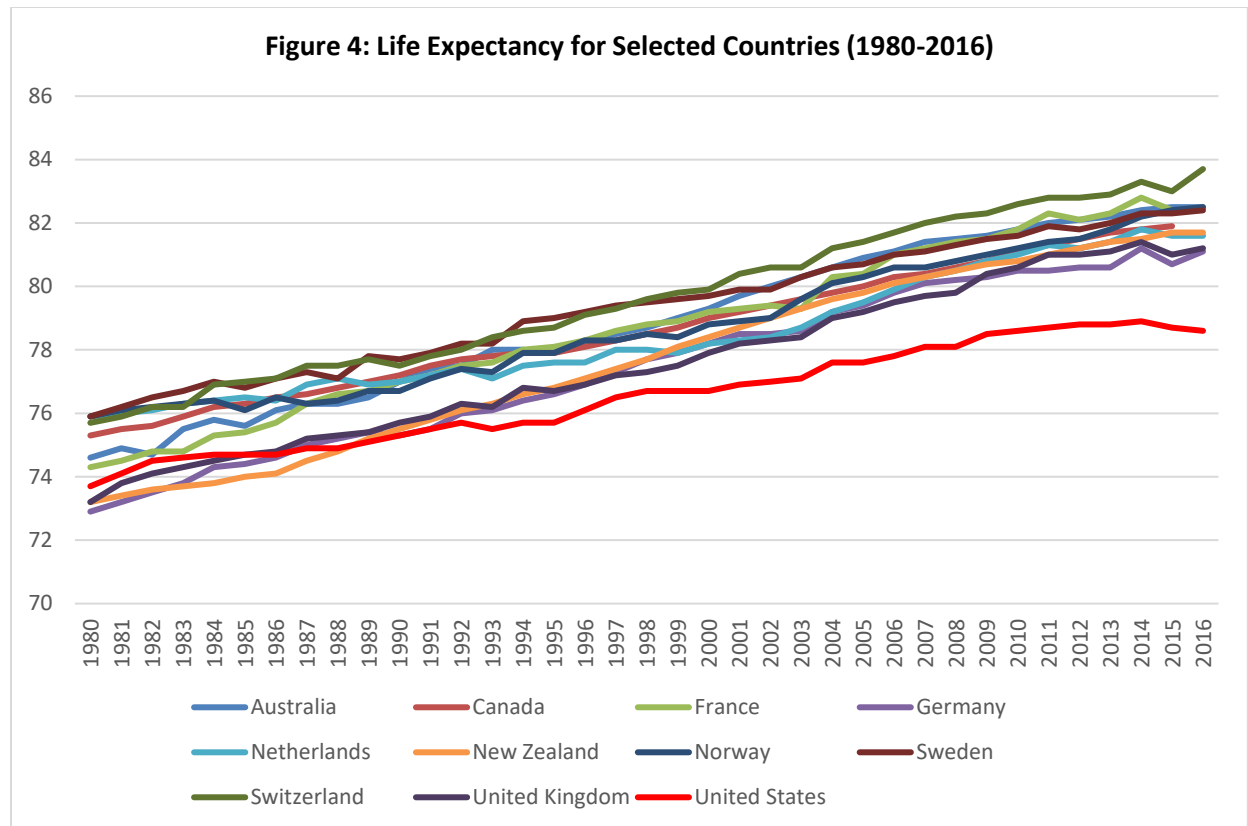


Figure note: Data are based on information collected by the OECD, EUROSTAT, WHO Health Accounts, the Australian Bureau of Statistics, Statistics Canada, Statistics New Zealand, and U.S. Department of Health and Human Services.¹⁴

Numerous studies have analyzed the prospective effectiveness of single-payer plans nationally and at the state level, as well as other universal coverage approaches.¹⁵ Most of these studies found savings, to varying degrees. These findings are supported by the experiences of countries that already have universal health care and provide care more efficiently than the United States.¹⁶ A recent study by the Political Economy Research Institute at the University of Massachusetts-Amherst found that Medicare-for-All could save nearly 20 percent versus our current system, with the largest sources of savings being increased administrative efficiency and significantly lower pharmaceutical prices.¹⁷ Even a recent study by a researcher at the Koch Brothers-funded Mercatus Center, reached conclusions on overall health spending that would result in \$2 trillion in lower health care spending over a ten-year period starting in

¹⁴*Id.*

¹⁵See e.g., *Listing of Single Payer Studies*, HEALTHCARE-NOW, <https://bit.ly/2ypjxwr> (viewed October 10, 2018).

¹⁶Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1024 (2018).

¹⁷ROBERT POLLIN, ET AL, POLITICAL ECONOMY RESEARCH INSTITUTE, ECONOMIC ANALYSIS OF MEDICARE FOR ALL, at 66 (November 2018), <https://bit.ly/2E6AhCw>.

2022.¹⁸ However, previous studies have found even higher savings from administrative efficiency than were cited in that study.¹⁹

Reasons Why Medicare-for-All Would Not Cause a Huge Increase in Health Care Costs:

1. Medicare-for-All Would Reap Huge Savings by Reducing Administrative Waste

Around one-third of U.S. health care dollars are spent on administrative functions, including insurance company overhead; administrative costs of hospitals, practitioners, nursing homes and other providers; and costs incurred by employers in managing their workers' benefits.²⁰ Studies have routinely found that the United States has the highest rate of administrative health care costs among wealthy countries.²¹ Excessive administrative spending is wasteful because it doesn't do anything to treat patients or improve public health. Through simplified administration under Medicare-for-All, some researchers have estimated that we would save more than \$500 billion a year.²²

Increased administrative costs are one of the key reasons that health care costs have risen sharply over the past 40 years. Costs relating to managing health insurance are a major component of these rising administrative costs. Private insurers spend around 12 percent of their annual budgets on administration.²³ Traditional Medicare is much more efficient, spending only around two percent on administrative costs.²⁴

In a seminal study published in the *New England Journal of Medicine* in 2003, researchers concluded that administrative functions consumed 31 percent of U.S. health care costs, compared to just 16.7 percent in Canada.²⁵ A breakdown of those costs, as measured on a per capita basis, is below [Figure 5].

¹⁸The chief conclusion of the study itself was that much of the cost currently borne by the private sector would instead be borne by the federal government, around \$32 trillion dollars. The study likely underestimates potential savings the country would experience under Medicare-for-All.

CHARLES BLAHOUS, MERCATUS CENTER, THE COSTS OF A NATIONAL SINGLE-PAYER HEALTHCARE SYSTEM, at 4 (July 2018), <https://bit.ly/2Ovq5FN>.

¹⁹Steffie Woolhandler, David U. Himmelstein and Adam Gaffney, *Single Payer is Actually a Huge Bargain*, THE NATION (August 10, 2018), <https://bit.ly/2vws2d2>.

²⁰Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENGLAND JOURNAL OF MEDICINE 768-775, 772 (2003).

Alexis Pozen and David M. Cutler, *Medical Spending Differences in the United States and Canada: The Role of Prices, Procedures, and Administrative Expenses*, 47 INQUIRY 124-134, (2010).

²¹ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (OECD), TACKLING WASTEFUL SPENDING ON HEALTH, at 232 (January 2017), <https://bit.ly/2yVVRhT>.

²²Steffie Woolhandler and David U. Himmelstein, *Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs*, 166 ANNALS OF INTERNAL MEDICINE 587-588, 588 (2017).

²³CONGRESSIONAL BUDGET OFFICE, PRIVATE HEALTH INSURANCE PREMIUMS AND FEDERAL POLICY, at 27 (February 2016) <https://bit.ly/1Qw9D0s>.

²⁴Nick Buffie, *Overhead Costs for Private Health Insurance Keep Rising, Even as Costs Fall for Other Types of Insurance*, CENTER FOR ECONOMIC AND POLICY RESEARCH (CEPR) BLOG (February 6, 2017), <https://bit.ly/2l6XVB0>.

²⁵Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENGLAND JOURNAL OF MEDICINE 768-775, 772 (2003).

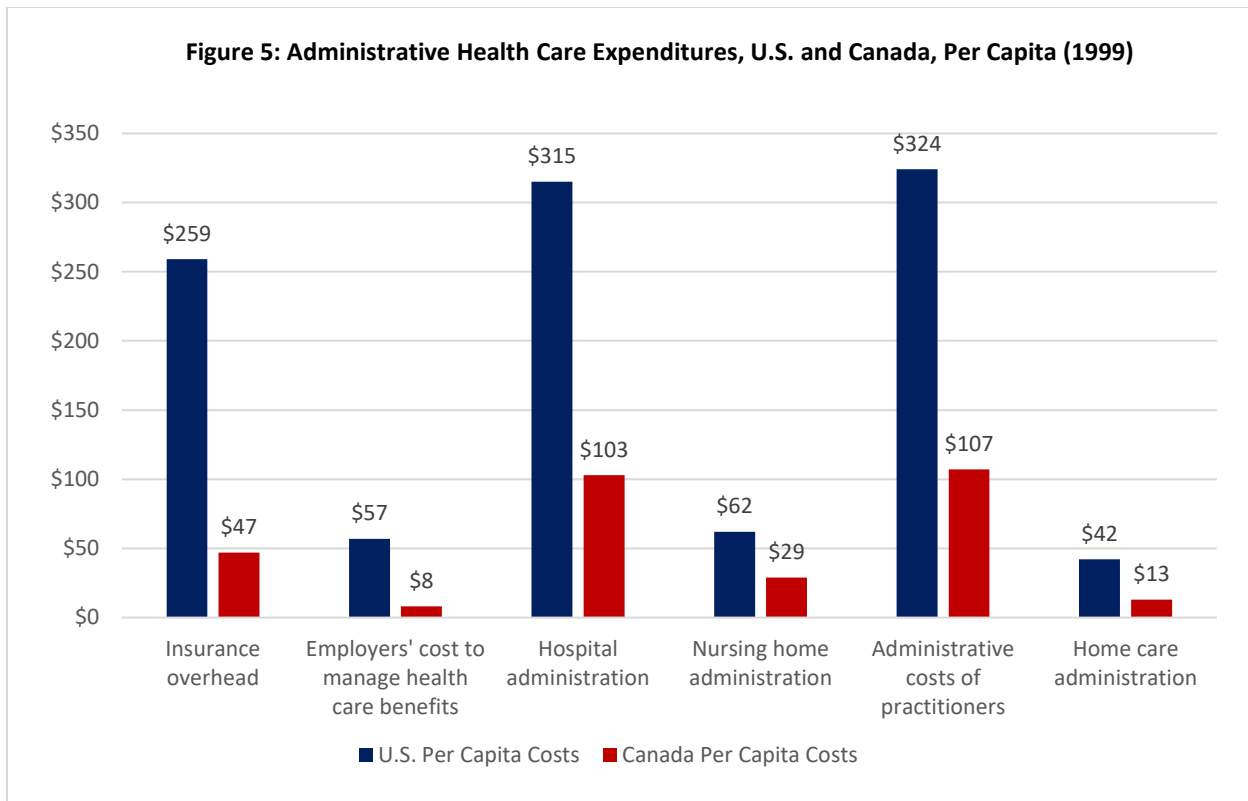


Figure note: Costs are reported in U.S. dollars. Study analyzed 1999 data on the administrative costs of health insurance, employer health benefit programs, hospitals and other care settings. The authors excluded retail pharmacy sales and other categories for which administrative costs data were unavailable.²⁶

In 2014, two of the authors from that *New England Journal of Medicine* article published a follow-up study comparing the expenditures for administrative functions at hospitals in the United States, Canada and several western European countries. They concluded that administrative costs consumed around 25 percent of U.S. hospital spending, far above most comparable countries [Figure 6].²⁷ If hospital administrative spending were brought in line with more efficient countries, the U.S. could save more than \$150 billion each year on hospital spending alone, the researchers concluded.²⁸

²⁶Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 *NEW ENGLAND JOURNAL OF MEDICINE* 768-775, 772 (2003).

²⁷David U. Himmelstein, et al., *A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far*, 33 *HEALTH AFFAIRS* 1586-1594, 1589 (2014).

²⁸*Id.* at 1593.

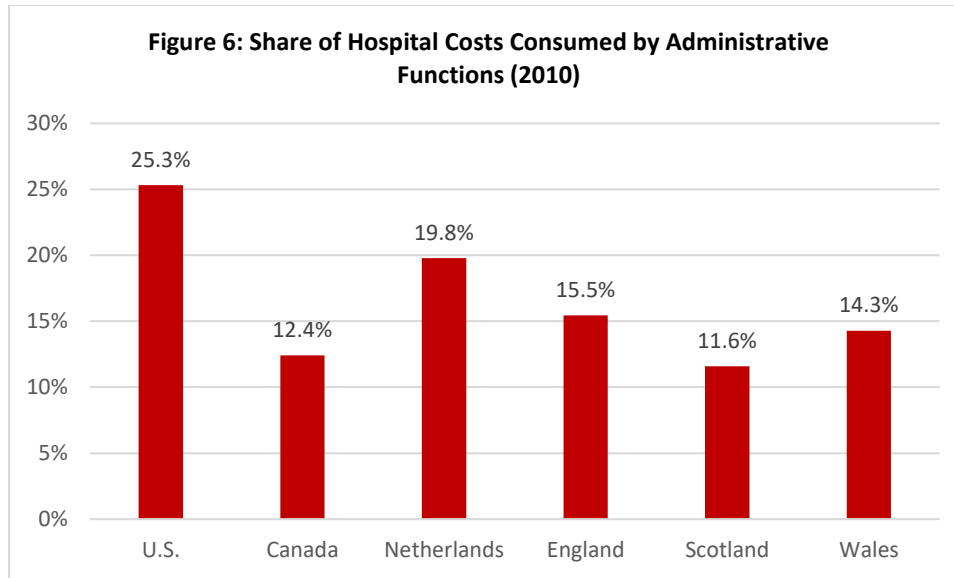
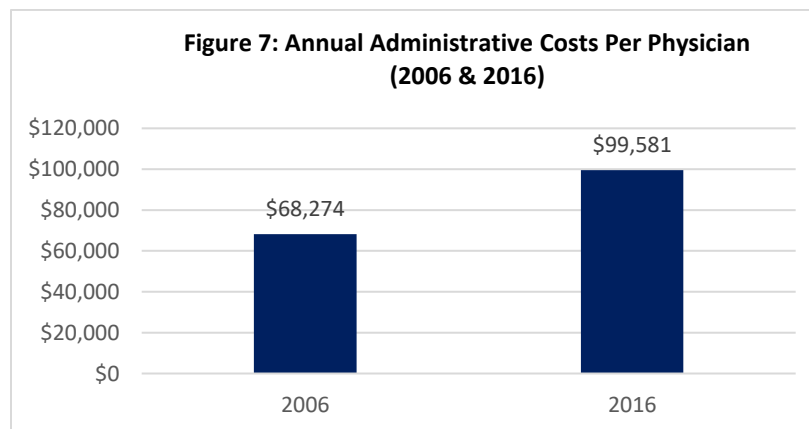


Figure note: The study analyzed data from the Organization for Economic Cooperation and Development, the National Health Service of Scotland, the Welsh Government and the UK National Health Service. Data for the United States and Canada were from 2010, data from England, Scotland and Wales are from 2010-2011, and data from the Netherlands were from 2011.

Other researchers have investigated the costs that administrative functions consume on a per physician basis for group medical practices. In a study published in *Health Affairs* in 2009, researchers surveyed physicians in practices of one to two, three to nine, and 10 and above. They concluded that administrative functions alone cost more than \$68,000 annually per physician, with fairly similar amounts paid by each category of practice size.²⁹ In a study published in *JAMA* in 2018, researchers concluded that administrative activities cost primary care practices an average of almost \$100,000 per physician.³⁰ This figure is not only striking in its size of nearly \$100,000, but fairly consistent with the finding of practices devoting about \$68,000 to administrative functions about a decade earlier [Figure 7].



²⁹Lawrence P. Casalino, et al., *What Does It Cost Physician Practices To Interact With Health Insurance Plans?*, 28 HEALTH AFFAIRS w533-w543, w538 (2009).

³⁰Phillip Tseng, et al., *Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 691-697, 691 (2018).

Figure notes: The 2006 number is from a 2009 study that used a randomly selected sample of data from the American Medical Association. Selection of physicians for study was based on specialty type and practice setting. The 2016 number comes from a 2018 study of data from a large health care system in North Carolina, with calculations based on interviews with health system administrators and physicians regarding insurance claim and revenue management processes.

Another study found that American medical practices spent almost four times more than Canadian doctors on dealing with payment issues: \$82,000 per physician annually compared to \$20,000 [Figure 8].³¹ The same study found that nurses in the United States spend nearly 10 times as many hours interacting with payers as their Canadian counterparts [Figure 9]. Most of the discrepancy in hours spent was due to nurses spending time obtaining prior authorizations from insurance companies.

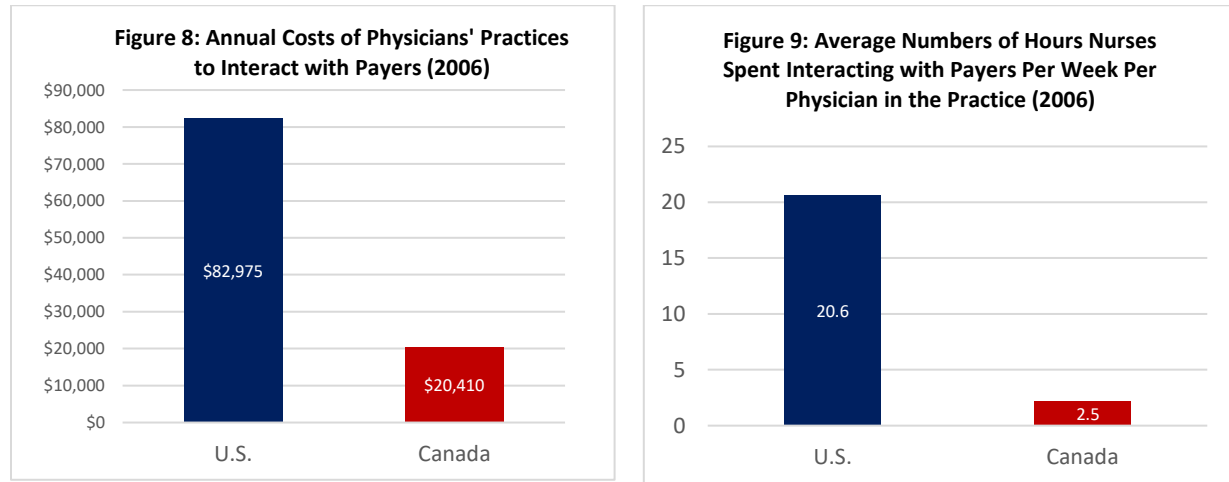


Figure notes: U.S. data are based on a random sample of 2006 data from the American Medical Association. Physicians were selected based on practice size and type care provided. Canadian data, also from 2006, were selected through a survey of Canadian physicians that were randomly selected through use of a Canadian database of physicians and large group practices. Average hours nurses spent per week were per physician in the practice.³²

A study published in *Health Affairs* in 2005, based on an analysis of data from a variety of western United States medical practices, found that billing costs, including both processing bills and collecting unpaid bills, accounted for approximately 50 to 60 percent of a medical practice's administrative costs. Such billing costs were slightly higher in single-specialty surgical settings than in other settings [Figure 10].³³ Those researchers concluded that administrative costs for physicians' offices accounted for 27 percent of their spending and 21 percent for hospitals.

³¹Dante Morra, et al., *US Physician Practices Versus Canadians: Spending Nearly Four Times as Much Money Interacting with Payers*, 30 *HEALTH AFFAIRS* 1443-1450, 1445 (2011).

³²*Id.*

³³James G. Kahn, et al., *The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals*, 24 *HEALTH AFFAIRS* 1629-1639, 1633 & 1634 (2005).

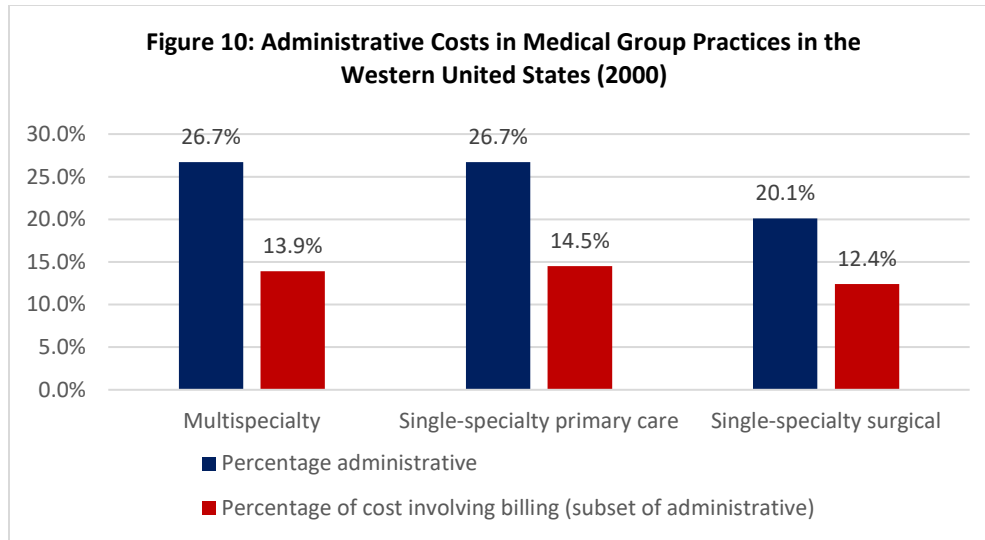
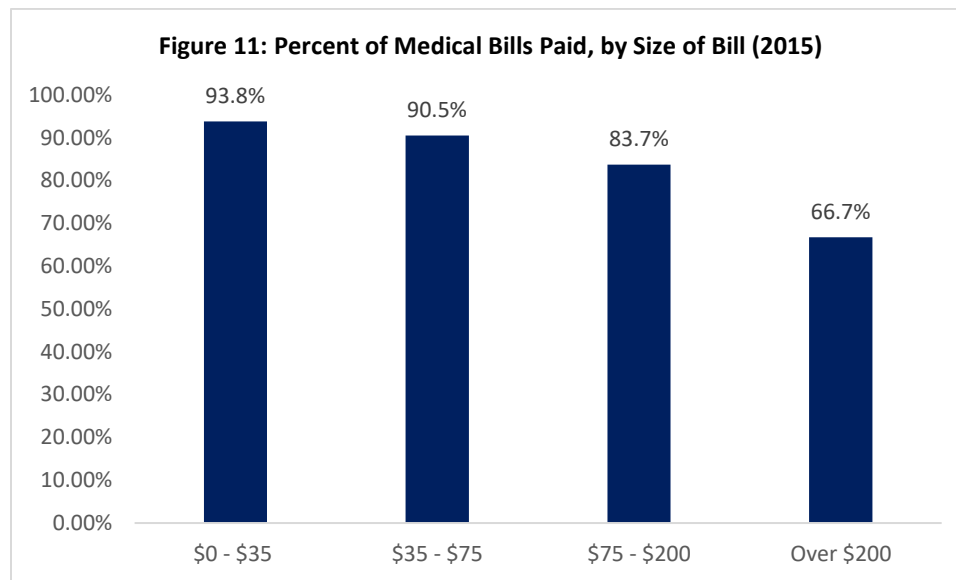


Figure note: Study used data from the 2000 Medical Group Management Association annual survey of its member physician group practices from the entire U.S. Western region.³⁴

Another aspect of health care providers' billing costs is collection of past-due medical bills. Using data from Athenahealth, Harvard health economist Michael Chernew computed the proportion of doctors' bills that were paid by patients. For relatively small bills, those under \$75, more than 90 percent were paid within a year. For larger ones, more than \$200, that rate fell to less than 67 percent [Figure 11].³⁵



³⁴James G. Kahn, et al., *The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals*, 24 HEALTH AFFAIRS 1629-1639, 1633 & 1634 (2005).

³⁵Michael E. Chernew and Jonathan Bush, *As Patients Take On More Costs, Will Providers Shoulder the Burden?*, HEALTH AFFAIRS BLOG (May 4, 2017), <https://bit.ly/2POOmH4>.

Figure note: Authors analyzed 2015 insurance claims data from athenahealth, a national network of 88,000 providers. Ambulatory services delivered in hospitals were excluded from their analysis.³⁶

Supporting this finding on medical bills going unpaid, a survey by the Consumer Financial Protection Bureau found that medical debt was the most common reason for debt collection calls in the United States.³⁷ Nearly 60 percent of consumers who were contacted about debt collection were contacted due to outstanding medical debt [Figure 12].

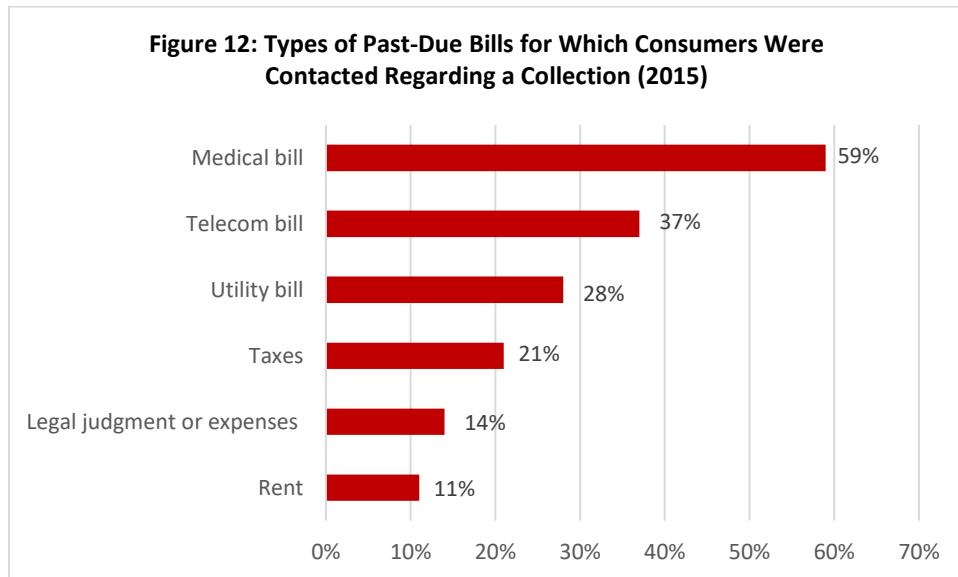


Figure note: The survey randomly sampled consumers from the Consumer Financial Protection Bureau's Consumer Credit Panel. More than 2,000 consumers responded to the survey. Sum of the percentages exceeds 100 percent because respondents could report being contacted for multiple types of debt.³⁸

Health care debt like this is unconscionable for a nation that could drastically reduce costs by eliminating the administrative waste baked into our health care status quo.

2. The Federal Government's Bargaining Power Would Drive Down the Cost of Health Services and Reduce Profiteering

Basic health care prices for the same procedure vary wildly between health care providers, which reveals inefficiencies and overpriced services. For example, a recent analysis found that the cost of a colonoscopy ranged across the country from less than \$2,000 to more than \$8,500 [Figure 13].³⁹

³⁶*Id.*

³⁷CONSUMER FINANCIAL PROTECTION BUREAU (CFPB), CONSUMER EXPERIENCES WITH DEBT COLLECTION: FINDINGS FROM THE CFPB'S SURVEY OF CONSUMER VIEWS ON DEBT, at 21 (January 2017), <https://bit.ly/2ODJkk5>.

³⁸*Id.*

³⁹Elisabeth Rosenthal, *The \$2.7 Trillion Medical Bill*, THE NEW YORK TIMES (June 1, 2013), <https://nyti.ms/2yW7Gef>.

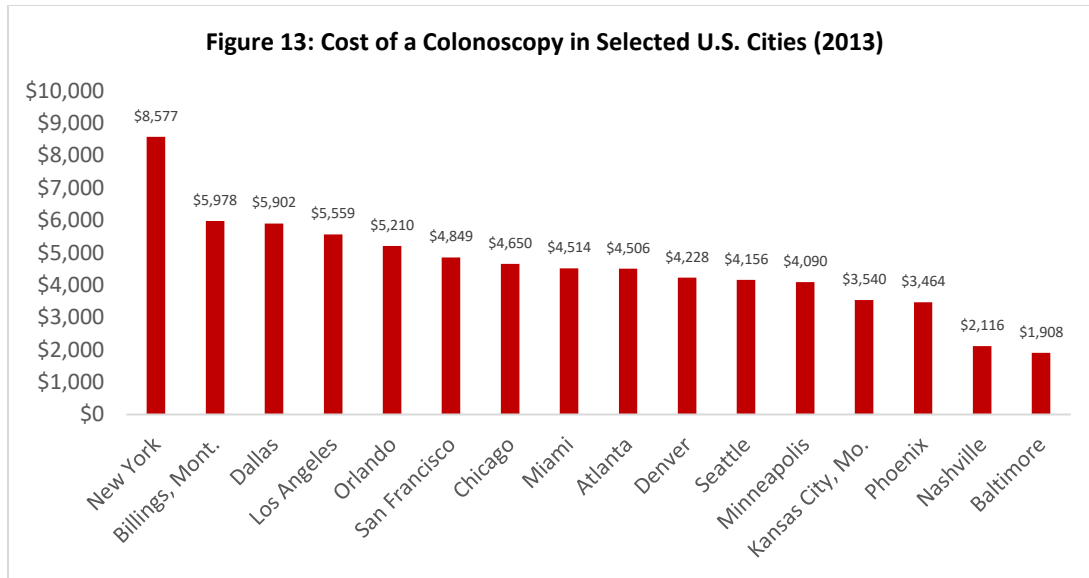


Figure note: Data are based on a 2013 Healthcare Blue Book analysis of the highest amount paid for a colonoscopy in selected metropolitan areas.⁴⁰

One reason for the price fluctuation is that providers and insurers currently negotiate prices behind closed doors and refuse to disclose their negotiated prices, citing trade secrets. Allowing the federal government to use its full negotiating power would make health care pricing more rational and wring out the massive amount of abusive overcharging. Under Medicare-for-All, the U.S. government would be able to negotiate reasonable prices for services, improving upon Medicare's current approach for setting prices. A rationally negotiated, transparent pricing system would prevent providers from charging vastly different prices for the same services.

The implications of our lack of rational pricing is reflected in just how much more expensive even common procedures, such as appendectomies, hip replacements, and angioplasties, can be in the U.S. than in other comparably wealth countries [Figure 14].⁴¹

⁴⁰*Id.*

⁴¹INTERNATIONAL FEDERATION OF HEALTH PLANS, 2015 COMPARATIVE PRICE REPORT: VARIATION IN MEDICAL AND HOSPITAL PRICES BY COUNTRY, at 17, 22, & 24 (September 2016), <https://bit.ly/2RS7R6K>.

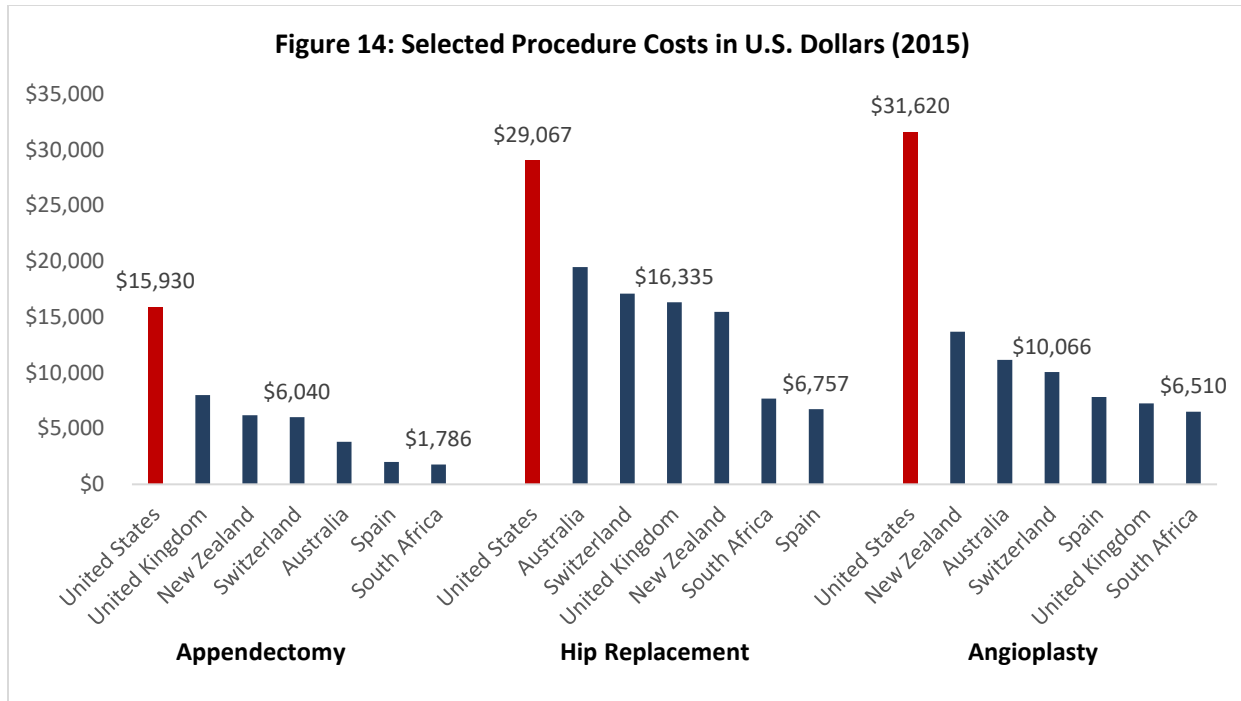


Figure note: Prices for each country are based on plans submitted by members of the International Federation of Health Plans in each country.⁴²

Historical trends on the growth of Medicare costs versus private insurance health care costs illustrate the potential for savings under Medicare-for-All. Traditional Medicare spending has grown much more slowly than private health insurance, even though private insurers generally serve a younger and healthier population.⁴³ Over the past 20 years, the cumulative change in health care costs for enrollees in private health insurance was nearly double that of Medicare beneficiaries [Figure 15].⁴⁴

⁴²*Id.*

⁴³Drew Altman, *Public vs. Private Health Insurance on Controlling Spending*, THE WALL STREET JOURNAL (April 16, 2015), <https://on.wsj.com/2ED1X2R>.

⁴⁴*National Health Expenditure Data – Historical*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://go.cms.gov/1UFHHer> (viewed September 20, 2018).

Consumer Price Index – Databases, Bureau of Labor Statistics, <https://bit.ly/2Iazi6f> (viewed September 20, 2018).

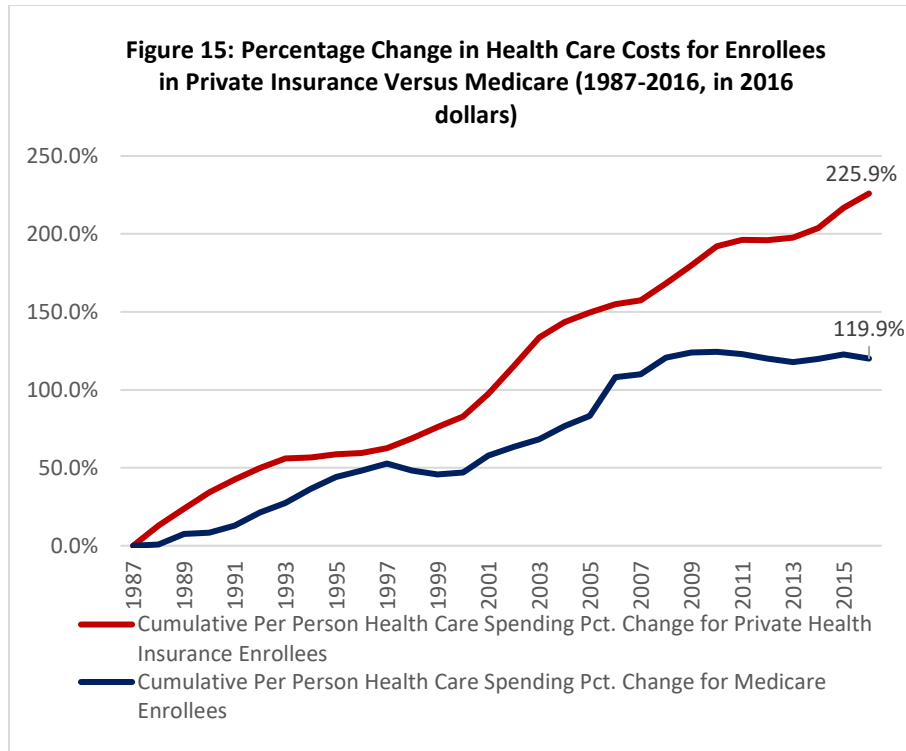


Figure note: Data are based on the National Health Expenditure Data from 1987-2016, adjusted for inflation using the Consumer Price Index of the Bureau of Labor Statistics.⁴⁵

Trends in recent years have been even more favorable for Medicare versus private health insurance. From 2009 through 2016, Medicare's cumulative costs have declined by nearly two percent while the cumulative costs of private insurance have grown by more than 16 percent [Figure 16].⁴⁶

⁴⁵National Health Expenditure Data – Historical, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://go.cms.gov/1UFHHer> (viewed September 20, 2018).

Consumer Price Index – Databases, Bureau of Labor Statistics, <https://bit.ly/2Iazj6f> (viewed September 20, 2018).

⁴⁶National Health Expenditure Data – Historical, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://go.cms.gov/1UFHHer> (viewed September 20, 2018).

Consumer Price Index – Databases, Bureau of Labor Statistics, <https://bit.ly/2Iazj6f> (viewed September 20, 2018).

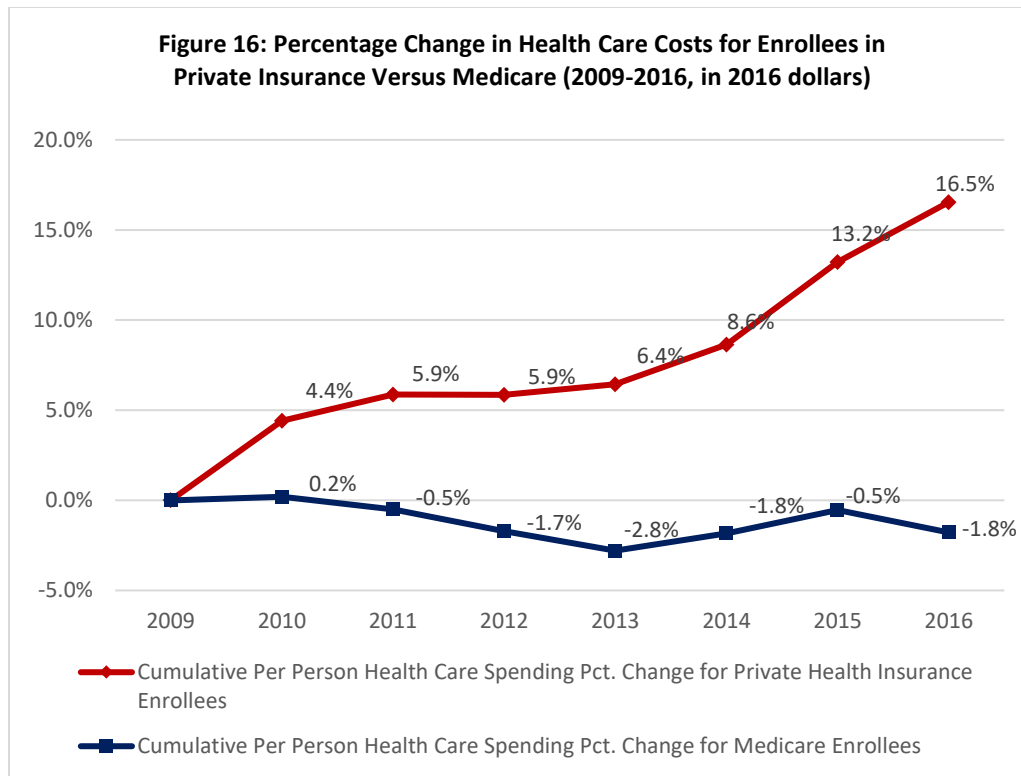


Figure note: Data are based on the National Health Expenditure Data from 2009-2016, adjusted for inflation using the Consumer Price Index of the Bureau of Labor Statistics.⁴⁷

When looking specifically at the cost per inpatient hospital stay, Medicare kept costs even the past 20 years, while private insurance has seen an increase of more than 65 percent [Figure 17].⁴⁸

⁴⁷National Health Expenditure Data – Historical, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://go.cms.gov/1UFHHer> (viewed September 20, 2018).

Consumer Price Index – Databases, Bureau of Labor Statistics, <https://bit.ly/2Iazj6f> (viewed September 20, 2018).

⁴⁸Austin Frakt, *Private Vs. Public Prices*, ACADEMY HEALTH BLOG (January 13, 2017), <https://bit.ly/2Pe4BQL>.

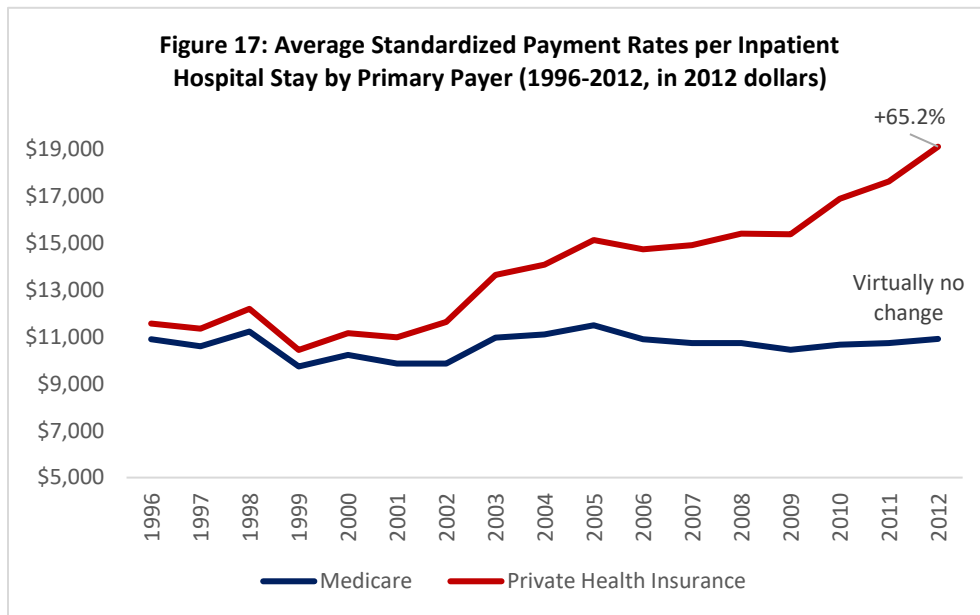


Figure note: Data are from the 1996-2012 Medical Expenditure Panel Survey. The authors of the study calculated rates based on the payment rates in Medicare versus private health insurance. The authors standardized payment rates in terms of patient age, sex, race/ethnicity, household income, and location. They also standardized payments in terms of medical conditions, health care charges, length-of-stay, and whether as surgical procedure was performed or not.⁴⁹

3. Negotiating Better Prices for Pharmaceuticals Would Save Billions and Improve Access

Spending on prescription drugs in the United States totaled more than \$480 billion in 2016, almost 15 percent of the \$3.3 trillion total spent on health care that year.⁵⁰ Instituting a Medicare-for-All system would finally allow the government to negotiate the price of prescription drugs on behalf of all Americans. Under its prescription drug benefit, known as Medicare Part D, Medicare is currently prohibited from negotiating drug prices.⁵¹ In contrast, the Veterans Health Administration (VHA) does negotiate the price of drugs for the veterans it serves. As a result, the VHA pays much lower drug prices than the general public. A researcher from Carleton University and the founder of Public Citizen's Health Research Group, Sidney Wolfe, concluded in a study published in 2015 that Medicare Part D would save around \$16 billion a year if the agency were able to negotiate similar prices to those negotiated by the VHA on the same brand-name drugs.⁵²

Given that Medicare-for-All would mean the government would have negotiating power on behalf of a much larger population—all Americans—drug prices would be even lower under Medicare-for-All than

⁴⁹Thomas M. Selden, et al., *The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care*, 34 HEALTH AFFAIRS 2147-2150, 2147 (2015).

⁵⁰Nancy L. Yu, Preston Atteberry, and Peter B. Bach, *Spending on Prescription Drugs in The US: Where Does All the Money Go?*, HEALTH AFFAIRS BLOG, (July 31, 2018) <https://bit.ly/2LjPRbm>.

⁵¹JULIETTE CUBANSKI AND TRICIA NEUMAN, KAISER FAMILY FOUNDATION, *SEARCHING FOR SAVINGS IN MEDICARE DRUG PRICE NEGOTIATIONS*, at 1 (April 2018), <https://bit.ly/2i1ffYI>.

⁵²MARC-ANDRÉ GAGNON AND SIDNEY WOLFE, *MIRROR, MIRROR ON THE WALL: MEDICARE PART D PAYS NEEDLESSLY HIGH BRAND-NAME DRUG PRICES COMPARED WITH OTHER OECD COUNTRIES AND WITH U.S. GOVERNMENT PROGRAMS*, at 11 (July 2015), <https://bit.ly/2p8FRji>.

they are for the VHA. Various studies have also predicted potential savings. For example, one study estimated that Medicare-for-All could save nearly a third of total spending on outpatient prescription drugs. In a study published in the *Annals of Internal Medicine* in 2017, the authors estimated that a Medicare-for-All system would save nearly \$115 billion on drug costs that year.⁵³ Even the conservative, Koch-backed Mercatus Center analysis of Medicare-for-All legislation put forth by U.S. Sen. Bernie Sanders (I-Vt.) estimated maximum savings on prescription drug costs of \$846 billion over a 10-year period beginning in 2022.⁵⁴

One recent study compared our health care spending with 10 other wealthy nations and found that the United States spent around \$1,450 per capita on prescription drugs, the most of any wealthy country and more than double the roughly \$750 per capita average of all 11 countries [Figure 18].⁵⁵ In addition, the study looked at four common medications and found that the U.S. price was the highest for each. For three of the four drugs, the price in the United States was at least double the price of the drug in the next most expensive country.

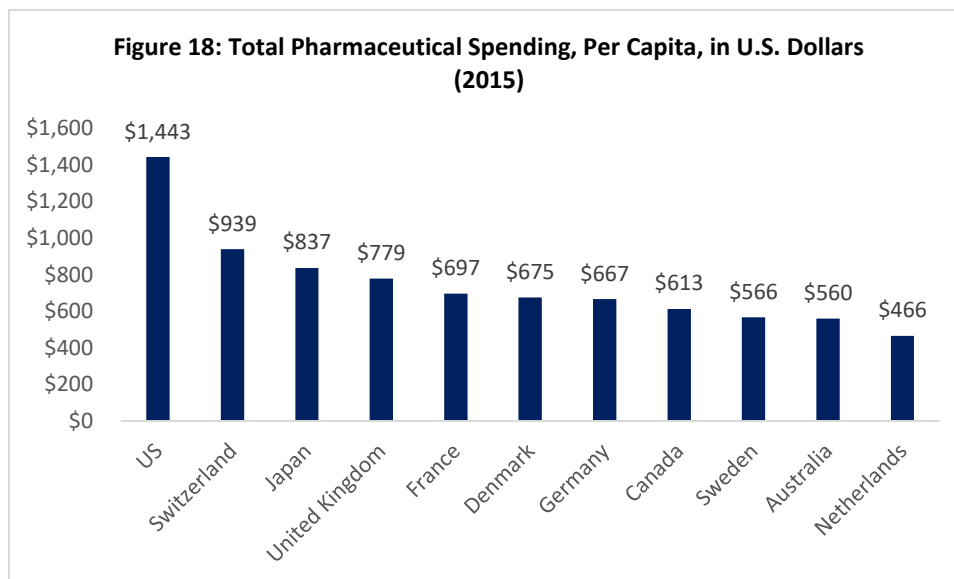


Figure note: Data are from the Intercontinental Marketing Services or the International Federation of Pharmaceutical Manufacturers and Associations.⁵⁶

An analysis by *The Wall Street Journal* compared U.S. prices across a number of drugs to prices in England, Norway, and Ontario, Canada. It found that U.S. drug prices were almost always higher, often significantly higher [Figure 19].⁵⁷

⁵³Steffie Woolhandler and David U. Himmelstein, *Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs*, 166 *ANNALS OF INTERNAL MEDICINE* 587-588, 588 (2017).

⁵⁴CHARLES BLAHOUS, MERCATUS CENTER, *THE COSTS OF A NATIONAL SINGLE-PAYER HEALTHCARE SYSTEM*, at 13 (July 2018), <https://bit.ly/2Ovq5FN>.

⁵⁵Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 1024-1039, 1035 (2018).

⁵⁶*Id.*

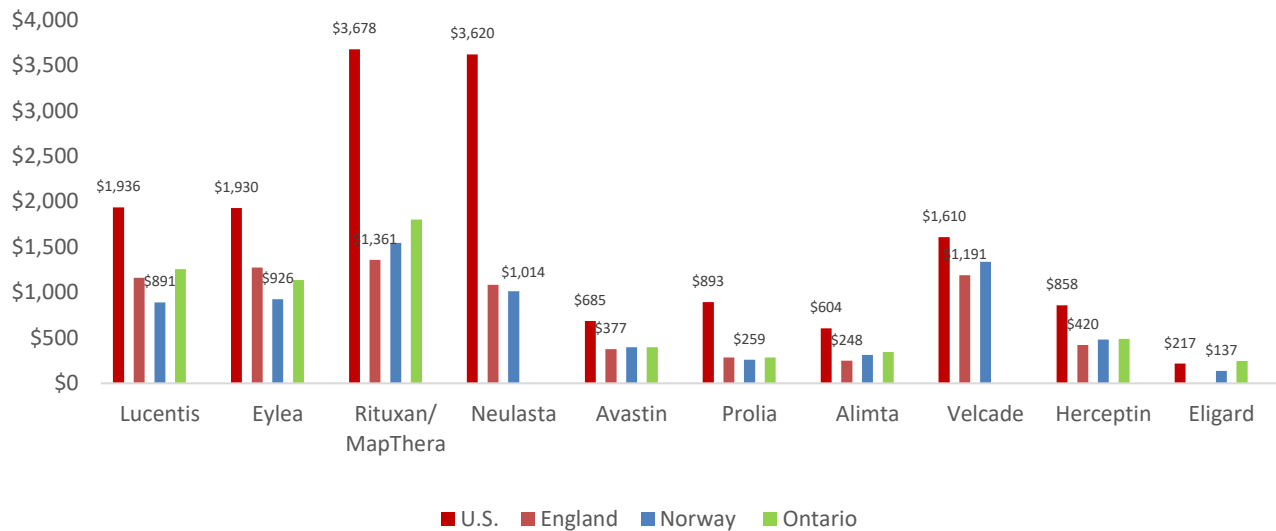
Figure 19: Price of Drugs in United States Versus England, Norway, and Ontario (2015)

Figure note: Wall Street Journal analysis of drug cost for selected drugs in the United States, England, Norway, and Ontario.⁵⁸

High drug prices produce huge profits for pharmaceutical companies. The average profit margin of pharmaceutical and biotechnology companies was 17.1 percent in 2015 and averaged 20.1 percent for the largest 25 drug companies; while the average profit margin for the largest 500 companies from other industries was 6.7 percent in 2015.⁵⁹ Pharmaceutical companies defend their enormous profits by emphasizing the importance of pharmaceutical innovation. But these companies spend often spend less than one in five dollars in revenue on research and development (R&D).⁶⁰ Further, much of their R&D is directed to products expected to maximize profits rather than meet priority health needs (so, for example, they invest heavily in drugs that compete with medicines already on the market, often referred to as “me-too” drugs, rather than novel therapies).⁶¹ Finally, most pharmaceutical breakthroughs come from publicly funded research, not that directed by Big Pharma.⁶²

And, of course, innovations in pharmaceuticals mean nothing if people can’t afford them. At the same time that pharmaceutical companies are reaping enormous profits, too many Americans cannot afford to take the medicines they need. Nearly one in five Americans report that they or a family member has not filled a prescription, cut pills in half, or skipped doses because of cost.⁶³ Medicare-for-All would ensure that Americans are able to access the prescription drugs they need while lowering drug costs for the entire health system.

⁵⁷Jeanne Whalen, *Why the U.S. Pays More Than Other Countries for Drugs*, THE WALL STREET JOURNAL (December 1, 2015), <https://on.wsj.com/2pe6SiS>.

⁵⁸*Id.*

⁵⁹U.S. GOVERNMENT ACCOUNTABILITY OFFICE, *DRUG INDUSTRY: PROFITS, RESEARCH AND DEVELOPMENT SPENDING, AND MERGER AND ACQUISITION DEALS*, at 17 (November 2017), <https://bit.ly/2DhdrV0>.

⁶⁰*Id.* at 32.

⁶¹*Id.* at 5.

⁶²*Id.* at 17.

⁶³KAISER FAMILY FOUNDATION, *KAISER HEALTH TRACKING POLL: HEALTH CARE PRIORITIES FOR 2017*, at 22 (December 2016) <https://bit.ly/2FTWdBA>.

Marketing is another source of wasteful spending that drives up the price of prescription drugs. This includes both direct-to-consumer advertising as well as a variety of promotion efforts aimed at health care providers. In 2017, pharmaceutical companies spent more than \$56 billion on marketing their drugs.⁶⁴ The majority of that spending, \$36.7 billion, was targeted at promoting drugs directly to health care providers [Table 1]. Companies also spent more than \$5 billion on providing drug samples and \$7 billion on sponsoring meetings. Finally, companies spent nearly \$6 billion on advertising directly to consumers in the U.S. alone.⁶⁵ Direct-to-consumer advertising continues to grow, with the number of drug advertisements on TV rising 65 percent just between 2012 and 2016.⁶⁶

Table 1: Pharmaceutical Industry Marketing Expenditures (2017)

Expenditure type	Cost (in billions)
Face-to-face sales and promotional activities	\$36.7
Samples (free medication provided to physicians)	\$5.1
Direct-to-consumer advertising	\$5.8
Promotional meetings and other events	\$7.0
Promotional mailings and other marketing	\$1.1
Total	\$56.1

Table note: Data are based on responses to the ChannelDynamics global survey of pharmaceutical companies.⁶⁷

Marketing provides little, if any, benefit to health care consumers and may hurt them because it pushes them and their doctors to choose products based on the persuasiveness of ads, instead of the appropriateness of a given product for a patient. Researchers at Yale found that, compared with top selling and top prescribed drugs, the most aggressively promoted drugs in the U.S. are less innovative and less valuable than existing treatments.⁶⁸ Such ads may also drive patients and their doctors to choose pricier brand name versions of drugs, instead of more affordable generic ones.⁶⁹

Articles in peer-reviewed journals and presentations at medical conferences are a far more appropriate way to disseminate information about prescription drugs than television commercials or pharmaceutical companies' representatives lobbying doctors with gifts and kickbacks. The government could encourage significant savings in this area by requiring pharmaceutical companies to refrain from certain types of marketing activities as a condition to be included in the formularies of government-funded programs. The net effect of doing so would be to save somewhere in the area of tens of billions of dollars a year with no downside for the public.

Pharmaceutical companies also spend an inordinate amount of money buying back their own stock in order to temporary boost share value. In just a year since the passage of the Tax Cuts and Jobs Act in

⁶⁴IQVIA, CHANNELDYNAMICS GLOBAL REFERENCE 2018, at 16 (October 2018), <https://bit.ly/2FRZmBY>.

⁶⁵*Id.*

⁶⁶Joanne Kaufman, *Think You're Seeing More Drug Ads on TV? You Are, and Here's Why*, THE NEW YORK TIMES (December 24, 2017), <https://nyti.ms/2whupDr>.

⁶⁷IQVIA, CHANNELDYNAMICS GLOBAL REFERENCE 2018, at 16 (October 2018), <https://bit.ly/2FRZmBY>.

⁶⁸Tyler Greenway and Joseph S Ross, *U.S. Drug Marketing: How does Promotion Correspond with Health Value*, 357 BRITISH MEDICAL JOURNAL j1855, j1855 (2017).

⁶⁹David Lazarus, *Direct-to-Consumer Drug Ads: A Bad Idea That's About to Get Worse*, LOS ANGELES TIMES (February 15, 2017), <https://lat.ms/2lM8qym>.

December 2017, pharmaceutical companies spent nearly \$75 billion dollars on stock buybacks.⁷⁰ A recent study found that the 18 drug companies in the S&P 500 spent a totally of \$261 billion on stock buybacks between 2006 and 2015.⁷¹ They found that this was equal to about 56 percent of the companies' combined R&D spending. When companies use stock buybacks to boost their stock prices, they earn hefty bonuses for their executives.⁷² Imagine if those companies used that money to bring down the cost of the drugs or to invest in genuinely live-saving medicines versus the focusing on profit and enriching their executives.

Further reforms could be included in or advanced to supplement efforts to rein in exorbitant prescription drug prices through Medicare-for-All, such as remedies that prohibit price spikes and curb pharmaceutical corporations' monopoly abuses; but price negotiations under Medicare-for-All would have a profound impact on prescription drug prices and spending.

4. A Medicare-for-All System Would Enable the Government to Set Overall Budgets for Providers to Give Them an Incentive to Provide Efficient Care

By using global budgets—comprehensive budgets negotiated between the government and health care institutions (such as hospitals and nursing homes)—Medicare-for-All would control overall spending while ensuring access to medically necessary services.⁷³ Under global budgets, institutions provide care within prescribed ranges of annual costs, giving them incentives to control costs as they provide care. In contrast, our current system creates incentives for institutions to maximize revenue, for example by building expensive new hospital wings and then pressuring providers to refer patients for care, instead of furnishing the most sensible and necessary care.⁷⁴ Cost controls, including global budgets, would have the potential to align providers' incentives with their mission to provide medically necessary care to those who need it.

Some U.S. states and a number of countries have used global budgeting to help control their costs.⁷⁵ For example, in 1977 Maryland implemented an all payer system to regulate hospital payment rates. Under Maryland's system, a commission sets hospital rates for the entire state. This reform has allowed Maryland to significantly reduce hospital cost growth and has saved the state around \$45 billion since its inception.⁷⁶ Massachusetts set up a commission that is responsible for holding down growth in health care costs. The commission monitors the health care system and can take enforcement actions, including fines,

⁷⁰Press Release, Americans for Tax Fairness, *Blockbuster Merger, Stock Buybacks: How Big Pharma is Using its Trump-GOP Tax Cuts* (January 8, 2019), <https://bit.ly/2GgYYwr>.

⁷¹WILLIAM LAZONICK, ET AL., INSTITUTE FOR NEW ECONOMIC THINKING, U.S. PHARMA'S FINANCIALIZED BUSINESS MODEL, at 4 (July 2017), <https://bit.ly/2uvjIP0>.

⁷²*Id.* at 5.

⁷³STEPHEN H. LONG AND M. SUSAN MARQUIS, RAND CORPORATION, TOWARD A GLOBAL BUDGET FOR THE U.S. HEALTH SYSTEM: IMPLEMENTATION ISSUES AND INFORMATION NEEDS, at 1 (July 1994), <https://bit.ly/2O3v3YS>.

⁷⁴ROBERT A. BERENSON, ET AL., URBAN INSTITUTE, GLOBAL BUDGETS FOR HOSPITALS, at 2 (April 2016), <https://urban.is/202ExmU>
JOSHUA M. SHARFSTEIN, ET AL., THE COMMONWEALTH FUND, AN EMERGING APPROACH TO PAYMENT REFORM: ALL-PAYER GLOBAL BUDGETS FOR LARGE SAFETY-NET HOSPITAL SYSTEMS, at 3 (August 2016), <https://bit.ly/2Ra6awE>.

⁷⁵SARABETH ZEMEL AND TRISH RILEY, THE NATIONAL ACADEMY FOR STATE HEALTH POLICY, ADDRESSING AND REDUCING HEALTH CARE COSTS IN STATES: GLOBAL BUDGETING INITIATIVES IN MARYLAND, MASSACHUSETTS, AND VERMONT, at 1 (January 2016), <https://bit.ly/2ldDk0a>.

Bradley Chen and Victoria Y. Fran, *Global Budget Payment Proposing the CAP Framework*, 53 INQUIRY 1-6, 1 (2016).

⁷⁶SARABETH ZEMEL AND TRISH RILEY, THE NATIONAL ACADEMY FOR STATE HEALTH POLICY, ADDRESSING AND REDUCING HEALTH CARE COSTS IN STATES: GLOBAL BUDGETING INITIATIVES IN MARYLAND, MASSACHUSETTS, AND VERMONT, at 1 (January 2016), <https://bit.ly/2ldDk0a>.

against entities with excessive cost growth. In addition, a number of countries with universal health coverage also use some form of global budgeting.⁷⁷ Countries use a number of different approaches to implement global budgets, some with more success than others. Researchers found that the details of the type of global budgeting used must align closely with the goals of the health care system in order to achieve savings.⁷⁸

A key part of reducing the incentive for institutions to maximize revenue is to ensure rational spending on expensive renovations and on purchasing brand-new health care technology that can cost millions of dollars for a single machine. This can be done by creating a separate budget for capital expenditures, such as on medical equipment and expansions of facilities, from operating expenditures under global budgets. Such purchases impose upfront costs on providers. Once purchased, they create incentives to provide unnecessary care to recoup their investments.⁷⁹ By requiring separate budgets for the purchases of expensive medical equipment and other expansions, Medicare-for-All could ensure that such purchases are warranted by a community's needs and would thus reduce unnecessary spending, both on the capital expenses themselves as well as on spending for related services. Instead of having every hospital compete by purchasing complex new technology or building fancy new hospital wings, city and regional capacity would be considered to ensure access across the country.

5. Better Access to Care Would Reduce Expenditures to Treat Chronic and Catastrophic Conditions

Gaps in health insurance coverage are one of the biggest reasons that Americans go without needed medical treatment. A recent survey found that nearly half of Americans reported not going to the doctor when sick or injured in the past year, due to cost.⁸⁰ Further, the survey found that Americans reported being more afraid of paying the medical bills for getting seriously ill than they were about health consequences of getting seriously ill.⁸¹ This was particularly true for Americans who previously suffered financially due to health care costs.⁸² Another survey found that nearly half of uninsured working-age adults lacked a regular source of care, compared with approximately 10 percent of those who were insured, whether through public or private coverage [Figure 20].⁸³ Further, nearly one in four reported postponing care due to cost and one in five reported going without needed care or failing to adhere to their prescription medication due to cost.

⁷⁷Bradley Chen and Victoria Y. Fran, *Global Budget Payment Proposing the CAP Framework*, 53 INQUIRY 1-6, 1 (2016).

⁷⁸*Id.*

⁷⁹U.S. GOVERNMENT ACCOUNTABILITY OFFICE, *MEDICARE: HIGHER USE OF ADVANCED IMAGING SERVICES BY PROVIDERS WHO SELF-REFER COSTING MEDICARE MILLIONS*, at 16 (September 2012), <https://bit.ly/2CDgusT>.

Dan Munro, *Why Physician Self-Referrals Have to Stop Now*, FORBES (January 26, 2015), <https://bit.ly/2ArvYPd>.

⁸⁰NORC AT THE UNIVERSITY OF CHICAGO, *AMERICANS' VIEWS ON HEALTHCARE COSTS, COVERAGE AND POLICY*, at 3 (March 2018), <https://bit.ly/CuBUXo>.

⁸¹*Id.* at 4.

⁸²*Id.*

⁸³KAISER FAMILY FOUNDATION, *KEY FACTS ABOUT THE UNINSURED POPULATION*, at 5 (September 2017), <https://bit.ly/2q8AEU7>.

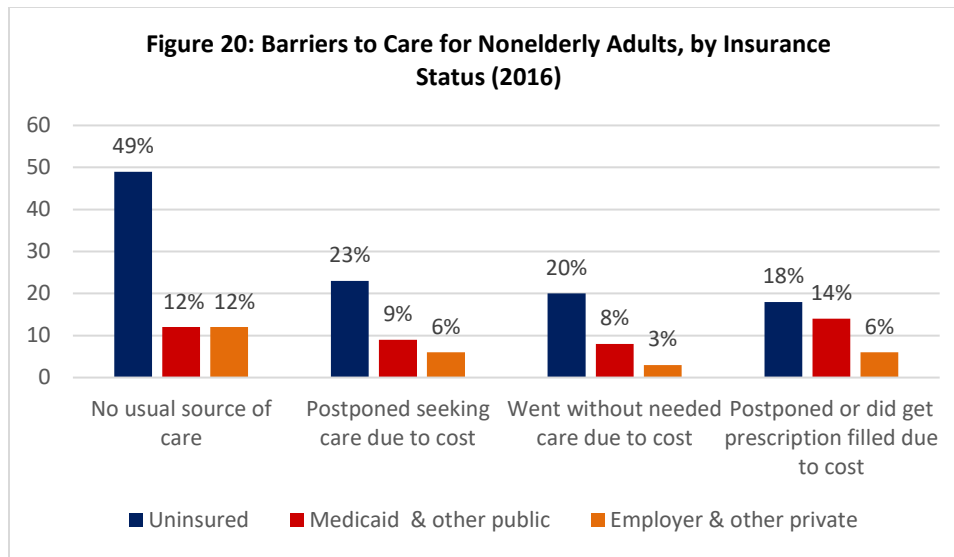


Figure note: Study authors analyzed data on adults ages 18-64 from the 2016 National Health Interview Survey. Barriers reported are those experienced in the prior 12 months. Respondents who reported that the emergency room was their usual source of care were included as not having a usual source of care.⁸⁴

One example of the dangers of going without care can be seen for Americans with diabetes, who face difficult and expensive complications, such as amputations and stroke, if they are unable to afford adequate medication and treatment.⁸⁵ Because of the rising price of life-sustaining insulin, some patients are forced to ration, which places diabetics at risk for complications.⁸⁶ Without adequate control of their disease, patients with diabetes also face an increased risk of complications, potentially requiring regular dialysis or a kidney transplant, or worse, death.⁸⁷ Complications created by the lack of access to care are one reason the United States ranks in the bottom fourth among OECD countries for most days lost due to disability.⁸⁸

Health care spending is highly concentrated among patients with significant acute and long-term health care needs. For example, the top one percent of spenders on health care account for around 20 percent of total health care spending and the top five percent of spenders account for nearly half of all health care spending [Figure 21].⁸⁹ Improved access to preventative care and improved care coordination could help patients better control chronic conditions like diabetes and high blood pressure and prevent unnecessary

⁸⁴*Id.*

⁸⁵CENTER FOR DISEASE CONTROL AND PREVENTION, NATIONAL DIABETES STATISTICS REPORT, 2017: ESTIMATES OF DIABETES AND ITS BURDEN IN THE UNITED STATES, at 10 (August 2017), <https://bit.ly/2tnbN35>.

⁸⁶Xinyang Hua, et al, *Expenditures and Prices of Antihyperglycemic Medications in the United States: 2002-2013*, 315 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1400-1402, 1400 (2016).

⁸⁷Edward W. Gregg, et al, *Changes in Diabetes-Related Complications in the United States, 1990-2010*, 370 NEW ENGLAND JOURNAL OF MEDICINE 1514-23, 1521 (2014).

CENTER FOR DISEASE CONTROL AND PREVENTION, NATIONAL DIABETES STATISTICS REPORT, 2017: ESTIMATES OF DIABETES AND ITS BURDEN IN THE UNITED STATES, at 10 (August 2017), <https://bit.ly/2tnbN35>.

⁸⁸ALBERTO PALLONI AND JAMES A. YONKER, CENTER FOR DEMOGRAPHY AND ECOLOGY, UNIVERSITY OF WISCONSIN-MADISON, HEALTH IN THE U.S. AT YOUNG AGES: PRELIMINARY FINDINGS, at 32 (December 2012) <https://bit.ly/2G3XIQY>.

⁸⁹EMILY M. MITCHELL AND STEVEN R. MACHLIN, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, CONCENTRATION OF HEALTH EXPENDITURES AND SELECTED CHARACTERISTICS OF HIGH SPENDERS, U.S. CIVILIAN NONINSTITUTIONALIZED POPULATION, 2015, at 4 (December 2017), <https://bit.ly/2HiEnKa>.

and expensive complications, enhancing quality of life while bringing down spending.⁹⁰ The challenges of uncontrolled chronic illnesses cost many Americans their wellbeing, both in terms of health and their finances.⁹¹

Figure 21: Percentage of Population Responsible for Percentage of U.S. Health Care Spending (2015)

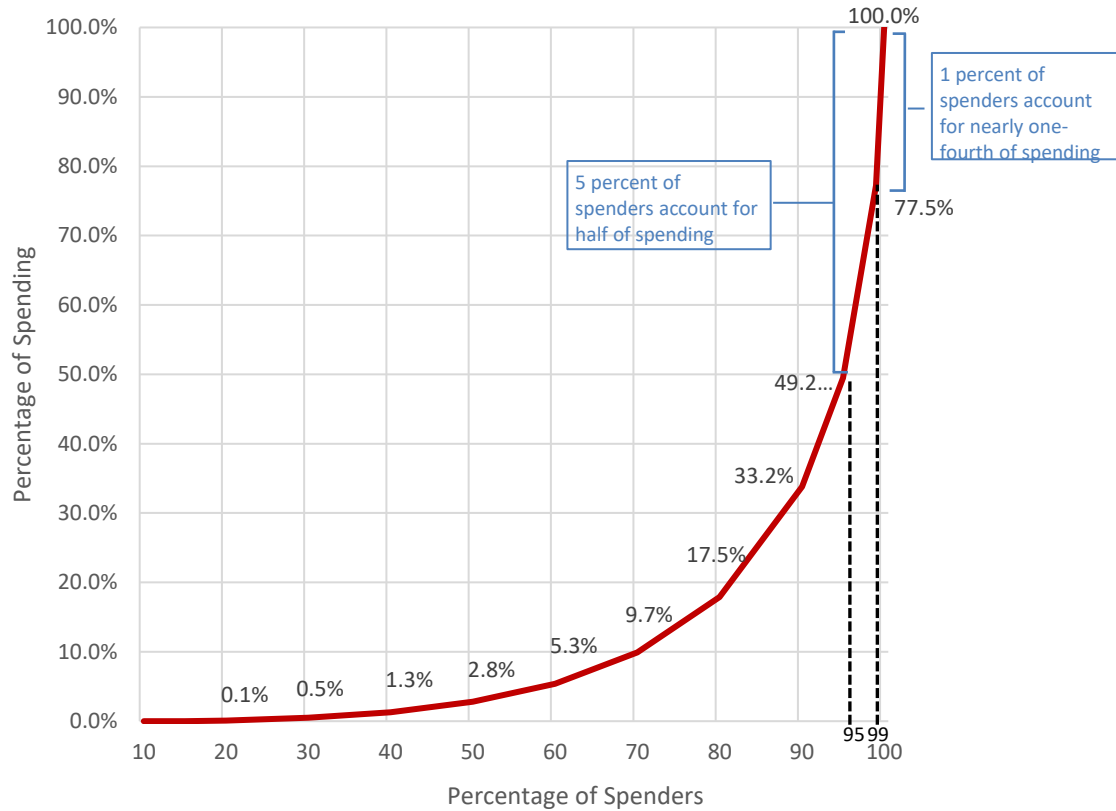


Figure note: Data are from the Household Component of the 2015 Medical Expenditure Panel Survey.⁹²

Medicare-for-All would finally allow everyone to access the care they need, when they need it. Having access to medically necessary care, including preventive services, would reduce the incidence of many preventable diseases and allow earlier treatment for a variety of illnesses. This, in turn, would reduce both personal and system-wide spending on treating preventable illnesses or treating illnesses at a stage when

⁹⁰Laura M. Keohane, et al, *Trends In Medicare Fee-For-Service Spending Growth For Dual-Eligible Beneficiaries, 2007–15*, 8 HEALTH AFFAIRS 1265-1273, 1265 (2018).

⁹¹AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, MULTIPLE CHRONIC CONDITIONS CHARTBOOK: 2010 MEDICAL EXPENDITURE PANEL SURVEY DATA, at 1 (April 2014), <https://bit.ly/2lgtgv0>.

⁹²EMILY M. MITCHELL AND STEVEN R. MACHLIN, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, CONCENTRATION OF HEALTH EXPENDITURES AND SELECTED CHARACTERISTICS OF HIGH SPENDERS, U.S. CIVILIAN NONINSTITUTIONALIZED POPULATION, 2015, at 4 (December 2017), <https://bit.ly/2HiEnKa>.

they are cheaper and easier to treat, preventing later complications and more expensive medical interventions.

6. Improving Access to Home and Community Based Long-Term Care Would Reduce Costs

Instituting a Medicare-for-All system would offer an excellent opportunity to improve our approach to providing long-term care. These reforms would improve the quality of life of patients that need long-term care while also bringing down the cost of care, both for consumers and for the country as a whole. Under our current system, Medicaid is the largest payer of long-term care, accounting for more than half of the approximately \$300 billion spent on long-term care each year.⁹³

The current system discourages providing home and community-based services, despite such services being less expensive to provide than nursing home care. The policies that guide Medicaid long-term care are biased in favor of patients ending up in nursing homes because state Medicaid programs are required to cover institutional services, like nursing homes, but home and community-based services are optional for states to provide. As such, the availability of home and community-based services varies widely by state. A number of states have expanded access to home and community-based services coverage through requesting waivers of certain federal Medicaid requirements.⁹⁴ However, even states with waiver programs often have waiting lists for their programs and face challenges ensuring access to services for all who need them.⁹⁵ And regardless of waivers, before someone can receive Medicaid long-term care, they must prove they are already in poverty or spend down their assets until they are in poverty.⁹⁶ These requirements can create significant hardship for many families, especially those who may face significant or unexpected expenses not covered by Medicaid after having spent down their assets.

The long-term care benefits available under Medicare-for-All should be designed to provide more comprehensive and sensible benefits than Medicaid, including ensuring that beneficiaries could be served in the setting of their choice. Medicare-for-All would also ensure access to services based on need. And by providing more care through long-term home and community-based services, Medicare-for-All could save money compared to institutional care, such as that provided in a nursing facility, given that a year of care in a nursing home costs more than twice as much as having a home health aide for a year and five times as much as a year of care through adult health day care [Figure 22].⁹⁷

⁹³ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), <https://bit.ly/2CAzEPY> & OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, AN OVERVIEW OF LONG-TERM SERVICES AND SUPPORTS AND MEDICAID: FINAL REPORT, at (May 2018), at 14 <https://bit.ly/2MAPVqf>.

⁹⁴ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), <https://bit.ly/2CAzEPY>.

⁹⁵MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, DATA DO NOT SUPPORT RELATIONSHIP BETWEEN MEDICAID EXPANSION AND HOME AND COMMUNITY-BASED SERVICES WAIVER WAITING LISTS, at 1 (March 2018), <https://bit.ly/2O25tTZ>.

⁹⁶ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), <https://bit.ly/2CAzEPY>.

Harold Pollack, *Health-Care Reform's Disability Blind Spot*, THE AMERICAN PROSPECT (January 9, 2018), <https://bit.ly/2yxmi4l>.

⁹⁷ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER, at 3 (December 2015), <https://bit.ly/2CAzEPY>.

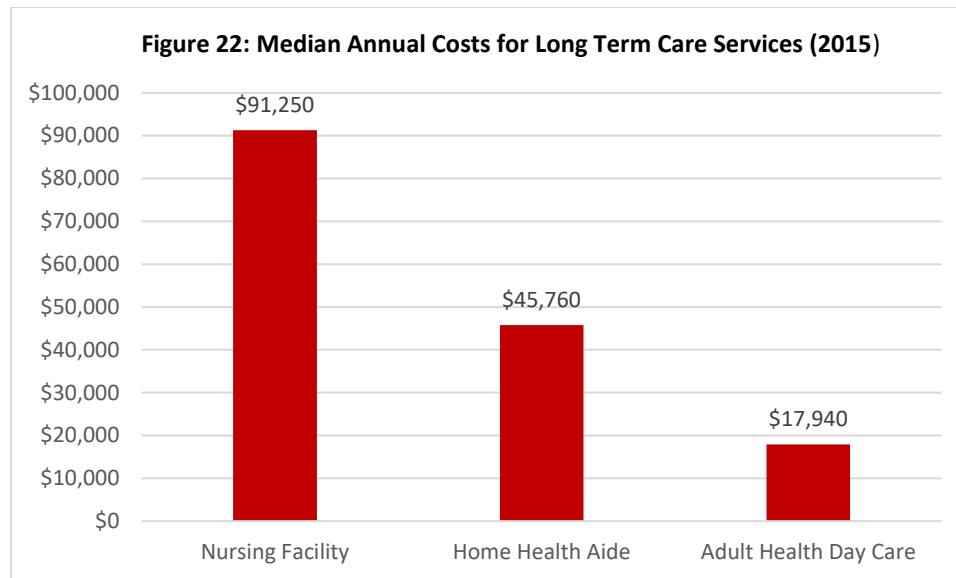


Figure note: Data are based on random selection of providers in four categories: home care, adult health day care, assisted living facilities, and nursing homes. In 2015, the survey collected data from more than 15,000 providers across these four categories. Data were generally based on daily, weekly, or monthly rates that were then extrapolated to annual rates, based on relevant circumstances.⁹⁸

Advocates have successfully pushed to improve access to home and community-based services in recent decades. As a result, home and community-based services recently overtook institutional coverage, in terms of overall Medicaid long-term care spending.⁹⁹ But availability of home- and community-based services still varies widely. The states with the highest percentage of home- and community-based services (HCBS) spending—Minnesota, New Mexico, and Oregon—devote more than 75 percent of their Medicaid long-term care spending to HCBS, while the states with the lowest spending—Mississippi, Florida and Indiana—all devoted only around a third of their spending toward home and community-based services.¹⁰⁰

However, legislative and budgetary threats to Medicaid, including long-term care, threaten access to health care for millions of Americans. Medicaid flexibility has also been used to limit coverage and to deny access to needed services, particularly under the Trump administration. With an administration hostile to health care, we are unfortunately seeing states rush to the bottom as well, in particular by using new Medicaid flexibility to constrain access to care through work requirements. For example, as of January 2019, seven states had been approved for waivers to implement work requirements for Medicaid and another eight had pending waivers.¹⁰¹ Though federal guidance has suggested that states make reasonable accommodations for people with disabilities, the elderly, and women who are pregnant,

⁹⁸ERICA L. REAVES AND MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, *MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER*, at 3 (December 2015), <https://bit.ly/2CAzEPY>.

⁹⁹STEVE EIKEN, ET AL, TRUVEN HEALTH ANALYTICS, *MEDICAID EXPENDITURES FOR LONG-TERM SERVICES AND SUPPORTS (LTSS) IN FY 2015*, at 10 (April 2017), <https://bit.ly/2PUZmm3>.

¹⁰⁰*Id.* at 11.

¹⁰¹KAISER FAMILY FOUNDATION, *MEDICAID WAIVER TRACKER: APPROVED AND PENDING SECTION 1115 WAIVERS BY STATE*, at 1 (January 2019), <https://bit.ly/2Dt0lud>.

implementing Medicaid work requirements threatens coverage for these vulnerable populations as well through unnecessary and excessive paperwork requirements.¹⁰²

Around 70 percent of people over 65 will require at least some long-term care in their lifetimes.¹⁰³ Given our changing demographics—by 2030 all baby boomers will be 65 or older and by 2035 Americans age 65 and older will outnumber the number of children under 18 for the first time in U.S. history—we must ensure that we are providing access to needed long-term care in the most humane and efficient way possible.¹⁰⁴ Medicare-for-All would meet both of these goals and begin the crucial transition from the institutional bias of our current long-term care system to a system that serves patients in the setting and community of their choice.

¹⁰²BRYANT STORM, WOLTERS KLUWER, HHS LETS STATES OPEN DOORS ON MEDICAID WAIVERS, at 1 (January 2018), <https://bit.ly/2PphQOU>.

¹⁰³Emily Gurnon, *The Staggering Prices of Long-Term Care 2017*, FORBES (September 26, 2017), <https://bit.ly/2W5hFZp>.

¹⁰⁴Press Release, U.S. Census Bureau, *Older People Projected to Outnumber Children for First Time in U.S. History* (Sep. 6, 2018), <https://bit.ly/2p8zoQY>.

Question: Would Medicare-for-All cause the U.S. deficit to soar?**Answer: No. The government already pays for two-thirds of health care and there are many options to take on the rest without adding to the deficit.**

Medicare-for-All would entail the federal government taking on the vast majority of the nation's health care costs, which has caused some concern that converting to this system would lead to soaring deficits. However, there are several reasons this will not happen. First, federal and state taxpayers already pay for nearly two-thirds of health care costs, so the change would not be as big as many people might think. Second, as discussed in the previous section, Medicare-for-All would likely reduce overall health care expenditures. Third, many options exist to provide dedicated funding sources to cover these costs without breaking the budget. Notably, by instituting progressive taxes, most families and businesses would actually experience comparable or reduced costs versus what they currently pay in health insurance premiums, out-of-pocket costs, and other health care related spending.

Reasons Why Medicare-for-All Would Not Cause the Deficit to Soar:**1. Taxpayers Already Pay for Nearly Two-Thirds of Health Care Costs**

Those who are worried about the federal government shouldering a greater share of health care costs might be surprised to learn that federal, state and local governments already pay for about 65 percent of health care costs through payments (such as through Medicare and Medicaid), direct care (such as through the Veterans Administration hospitals), insurance premiums paid on behalf of employees, and tax breaks to businesses that pay for their employees' health insurance.¹⁰⁵

Most of these expenses are borne by the federal government. Medicare and Medicaid made up more than half—approximately one-third and around one-quarter, respectively—of tax-financed spending.¹⁰⁶ Tax subsidies for employer-sponsored private health insurance accounted for around 16 percent and coverage for public employees accounted for 10 percent. The rest of the tax-financed spending, around 18 percent, included a number of other government health programs, including those run by the Department of Defense, the Department of Veterans Affairs, the Indian Health Service, the National Institutes of Health and a number of other smaller programs [Table 2].

¹⁰⁵Lower estimates exclude two large sources of taxpayer-funded care: health insurance for government employees and tax subsidies to employers to provide coverage.

David U. Himmelstein and Steffie Woolhandler, *The Current and Projected Taxpayer Shares of US Health Costs*, 106 AMERICAN JOURNAL OF PUBLIC HEALTH 449-452, 451 (2016).

¹⁰⁶*Id.*

Table 2: Tax-Financed Health Expenditures in the United States (2013)

Government Expenditures	Amount (in billions)
Medicare	\$586
Medicaid and Children's Health Insurance Program	\$463
Other health programs*	\$346
Public employee health benefits - federal	\$32
Public employee health benefits - state and local	\$156
Tax subsidies for private employer-paid health insurance - federal	\$249
Tax subsidies for private employer-paid health insurance - state and local	\$46
Total tax-financed health care expenditures	\$1,877
Total national health care expenditures	\$2,919
Percentage of national health care expenditures paid by taxpayers	64.3%

Table note: Other health programs include a number of government health programs, such as those run by the Department of Defense, the Department of Veterans Affairs, the Indian Health Service, the National Institutes of Health and a number of other smaller programs. The study's authors used data from the CMS Office of the Actuary to estimate direct government spending and from Office of Management and Budget, the Census Bureau, and the Internal Revenue Service to estimate health care-related tax subsidies.¹⁰⁷

Our public spending on health care, per capita, alone is higher than what nearly all other wealthy countries pay, per capita, for their *entire* health care systems. This is all the more remarkable because all of these countries, unlike the United States, provide nearly universal coverage to their residents. A study found that tax-funded spending in the U.S. was approximately \$6,000 per capita in 2013, higher than the total per capita spending for all but one of the nine other wealthy countries included in the study [Figure 23].¹⁰⁸

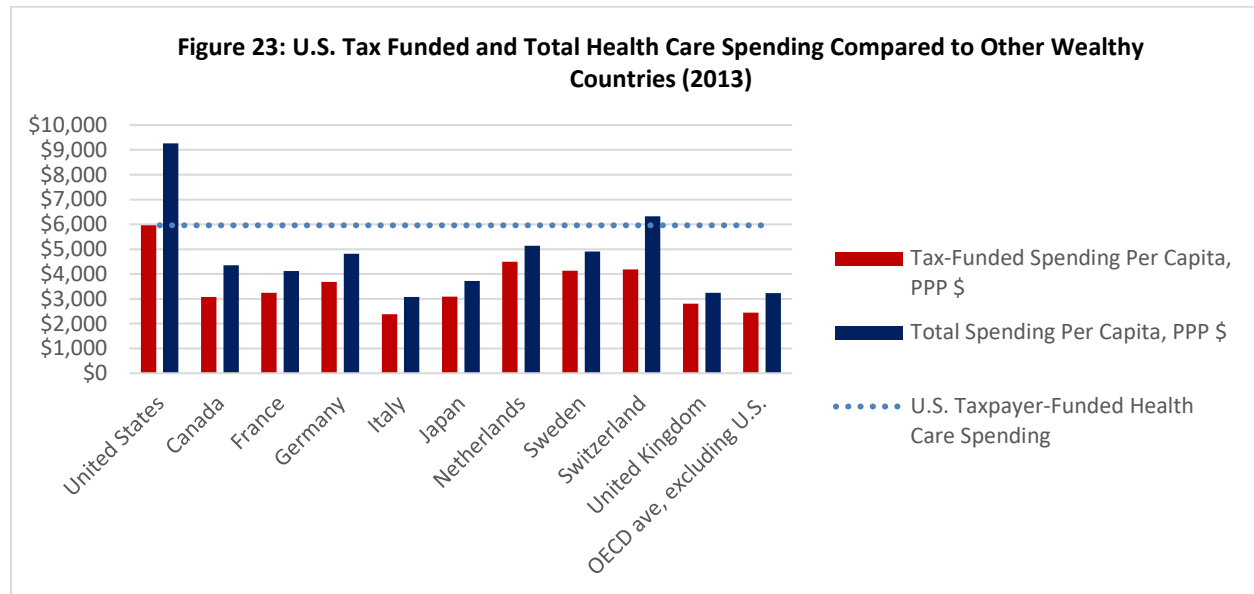


Figure note: To estimate U.S. spending, the study's authors used data from the CMS Office of the Actuary to estimate direct government spending and from Office of Management and Budget, the Census Bureau, and the Internal Revenue Service to

¹⁰⁷*Id.* 450.

¹⁰⁸*Id.*

estimate health care-related tax subsidies. Data for all other countries is from the Organization for Economic Cooperation and Development (OECD).¹⁰⁹

To put this finding in perspective, if our health care system were as efficient as those of other countries, we could provide universal care without adding a penny of public spending and we could improve access to mental health, dental, and vision care, even for Americans who already have coverage.

2. A Medicare-for-All System Would Rely on Dedicated Funding Sources

There are many options to fund a Medicare-for-All system. Among those that have been suggested are possibilities including payroll taxes, taxes on Wall Street trades, increasing taxes on high-income earners, and a tax on unearned income (including investments, interest, profits, and rents).¹¹⁰

These funding methods would likely include progressive formulas, such that higher-income earners would pay a greater percentage of their income than moderate or low-income earners. This would be an improvement over our current health care funding system, which is deeply regressive and essentially assesses the same level of costs to all, except for the very poor and those who are eligible for Medicare.

Most people and businesses would likely pay a comparable or reduced amount for health care. For instance, if a payroll tax were instituted, the businesses and/or employees that paid it would experience the savings of not paying insurance premiums. Two recent studies found significant potential savings from transitioning to a Medicare-for-All system. A study by the Political Economy Research Institute (PERI) found, due to more progressive funding mechanisms, middle-class Americans would see savings of up to 14 percent while high-income Americans would only see a small increase in their total health care spending [Figure 24].¹¹¹

¹⁰⁹*Id.*

¹¹⁰GERALD FRIEDMAN, FUNDING HR 676: THE EXPANDED AND IMPROVED MEDICARE FOR ALL ACT: HOW WE CAN AFFORD A NATIONAL SINGLE-PAYER HEALTH PLAN, at 5 (July 2013), <https://bit.ly/NPPQjb>.
OFFICE OF SENATOR BERNIE SANDERS, OPTIONS TO FINANCE MEDICARE FOR ALL, at 2 <https://bit.ly/2fhTNhh>.

Medicare for All: Leaving No One Behind, BERNIE SANDERS 2016, <https://bit.ly/1Or3Lr8> (viewed on October 24, 2018).

¹¹¹ROBERT POLLIN, ET AL, POLITICAL ECONOMY RESEARCH INSTITUTE, ECONOMIC ANALYSIS OF MEDICARE FOR ALL, at 143 (November 2018), <https://bit.ly/2E6AhCw>.

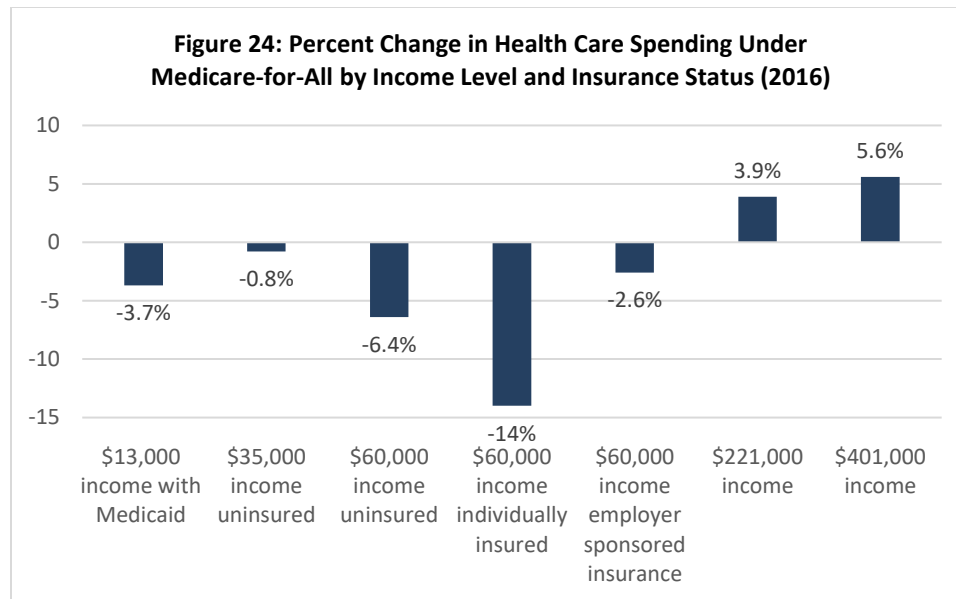


Figure note: Data for the estimates are from the 2016 American Community Survey, the Consumer Expenditure Survey, and a number of other sources.¹¹²

In addition, a recent RAND Corporation study of a single-payer proposal for New York State found that most families of four with incomes below \$275,000 a year would save money, when compared to the current health care system.¹¹³

3. Medicare-for-All Would Improve the Economy, Increasing Economic Growth and Generating Additional Federal Budget Revenue

By freeing Americans from their dependence on their employers to maintain access to health care, Medicare-for-All would encourage entrepreneurialism. Our health care system hampers individuals by tying access to health care to employment and putting employees at risk of no longer being able to afford health care if they leave their job and lose employer-sponsored health plans. This is a phenomenon known as “job lock.”

Workers who have employer-sponsored insurance are much less likely to start their own business than workers who receive health insurance through their spouse or those who are uninsured, according to a study by the RAND Institute for Civil Justice.¹¹⁴ The RAND researchers also found that individuals were more likely to start businesses once they were eligible to receive Medicare.¹¹⁵ A separate study found that a New Jersey law that guaranteed access to health insurance at a reasonable rate was associated with a 14-to-20 percent increase in self-employment.¹¹⁶ All of this is reflected in the fact that the United States has

¹¹²*Id.* at 2.

¹¹³JODI L. LIU, ET AL., RAND CORPORATION, AN ASSESSMENT OF THE NEW YORK HEALTH ACT: A SINGLE-PAYER OPTION FOR NEW YORK STATE, at 48 (August 2018), <https://bit.ly/2ywgE2s>.

¹¹⁴ROBERT W. FAIRLIE, KANIKA KAPUR, AND SUSAN M. GATES, RAND INSTITUTE FOR CIVIL JUSTICE, IS EMPLOYER-BASED HEALTH INSURANCE A BARRIER TO ENTREPRENEURSHIP?, at 45 (September 2010), <https://bit.ly/2CEZt1C>.

¹¹⁵*Id.* at 46.

¹¹⁶PHILIP DeCICCA, UPJOHN INSTITUTE WORKING PAPER, HEALTH INSURANCE AVAILABILITY AND ENTREPRENEURSHIP, at 19 (April 2010), <https://bit.ly/PYnsxd>.

the lowest self-employment rate of the 36 countries that make up the Organization for Economic Co-operation and Development (OECD) [Figure 25].¹¹⁷



Figure note: Data are from the Organization of Economic Cooperation and Development.¹¹⁸

By increasing the number of small businesses and allowing more Americans to self-employ, Medicare-for-All could help spur economic growth while reducing job lock.¹¹⁹

Medicare-for-All would also lift burdens from employers. Most employers are responsible for at least some portion of the premiums for their employees and their family members, which has been cited as a drag on U.S. competitiveness.¹²⁰ These costs have been growing rapidly—about 5 percent a year for the past 5 years—outpacing both inflation and wage growth.¹²¹ As a result it is no surprise that the cost of health insurance has remained the number one concern among small businesses for more than 30 years, according to a recurring survey of National Federation of Independent Business.¹²² Another survey found that many companies would invest more in their business if their health care costs were lower.¹²³ In

¹¹⁷*Self-Employment Rate*, ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (OECD), <https://bit.ly/2D2U8BX> (viewed October 24, 2018).

¹¹⁸*Id.*

¹¹⁹DEAN BAKER, AARP PUBLIC POLICY INSTITUTE, *JOB LOCK AND EMPLOYER-PROVIDED HEALTH INSURANCE: EVIDENCE FROM THE LITERATURE*, at 31 (March 2015), <https://bit.ly/2D5kCDd>.

¹²⁰TONI JOHNSON, COUNCIL ON FOREIGN RELATIONS, *HEALTHCARE COSTS AND U.S. COMPETITIVENESS*, at 1 (March 2012), <https://on.cfr.org/2SgO6SQ>.

Natalie Burg, *How Rising Healthcare Costs Make American Businesses Less Competitive*, FORBES (December 29, 2014), <https://bit.ly/201Vuy9>.

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, *THE EFFECT OF HEALTH CARE COST GROWTH ON THE U.S. ECONOMY*, at 48 (September 2007), <https://bit.ly/2PPWGX6>.

Sarah O'Brien, *Employers to Spend about \$10,000 on Health Care for Each Worker*, CNBC (August 9, 2018), <https://cnb.cx/2vR9INt>.

¹²¹Sarah O'Brien, *Employers to Spend about \$10,000 on Health Care for Each Worker*, CNBC (August 9, 2018), <https://cnb.cx/2vR9INt>.

¹²²HOLLY WADE, NATIONAL FEDERATION OF INDEPENDENT BUSINESS RESEARCH FOUNDATION, *SMALL BUSINESS PROBLEMS AND PRIORITIES*, at 7 (August 2016), <https://bit.ly/2R183ez>.

¹²³Press Release, Castlight Health, Inc., *New Poll: U.S. Business Leaders Would Increase Employee Wages and Technology Investments If They Could Lower Healthcare Costs* (June 9, 2014), <https://bit.ly/20QWaM8>.

addition, health care costs can be unpredictable. Some companies may face significant increases in their premiums, much higher than the 5 percent average annual increases cited previously.¹²⁴

Because of their size and the lack of economies of scale, small businesses are hit particularly hard by the employer-sponsored insurance system. They face a significant disadvantage when negotiating with insurers and end up paying higher prices than larger companies. Employers with fewer than 10 employees face premiums nearly 20 percent higher, for the same benefits, than those paid by large businesses, and employers with 10 to 25 employees can expect to pay around 10 percent more.¹²⁵

Many have suggested that a payroll tax could be one of the funding mechanisms for Medicare-for-All, potentially in combination with other funding mechanisms. If this were the case, what employers currently pay on health insurance could be transferred in whole or in part to a payroll tax. And, business owners would receive important certainty regarding the cost of premiums and would no longer see shocking annual increases.

A healthier country would lead to a healthier economy. Medicare-for-All would improve Americans' overall health, reducing sick days taken and increasing productivity. Illness-related losses in productivity cost U.S. employers more than \$500 billion a year.¹²⁶ At least in part, this is likely due to Americans not having sufficient access to affordable health care.¹²⁷ The lack of consistent access to needed care is illustrated in the fact that the United States has among the highest rate of deaths from noncommunicable diseases among wealthy countries [Figure 26].¹²⁸ A Medicare-for-All system would invariably lead to improved national health, improving economic productivity and expanding the tax base.

¹²⁴ Natalie Burg, *How Rising Healthcare Costs Make American Businesses Less Competitive*, FORBES (December 29, 2014), <https://bit.ly/201Vuy9>.

¹²⁵ Claire Martin, *In the Health Law, an Open Door for Entrepreneurs*, THE NEW YORK TIMES (November 23, 2013), <https://nyti.ms/2O463R5>.

¹²⁶ Press Release, Integrated Benefits Institute, *Poor Health Costs US Employers \$530 Billion and 1.4 Billion Work Days of Absence and Impaired Performance* (Nov. 15, 2018) <https://bit.ly/2EqWwmM>.

¹²⁷ Eduardo Porter, *When Cutting Access to Health Care, There's a Price to Pay*, THE NEW YORK TIMES (June 27, 2017), <https://nyti.ms/2rXH481>.

¹²⁸ WORLD HEALTH ORGANIZATION, WORLD HEALTH STATISTICS 2018: MONITORING HEALTH FOR THE SUSTAINABLE DEVELOPMENT GOALS, at 31 (June 2018), <https://bit.ly/2xbkW0Z>.

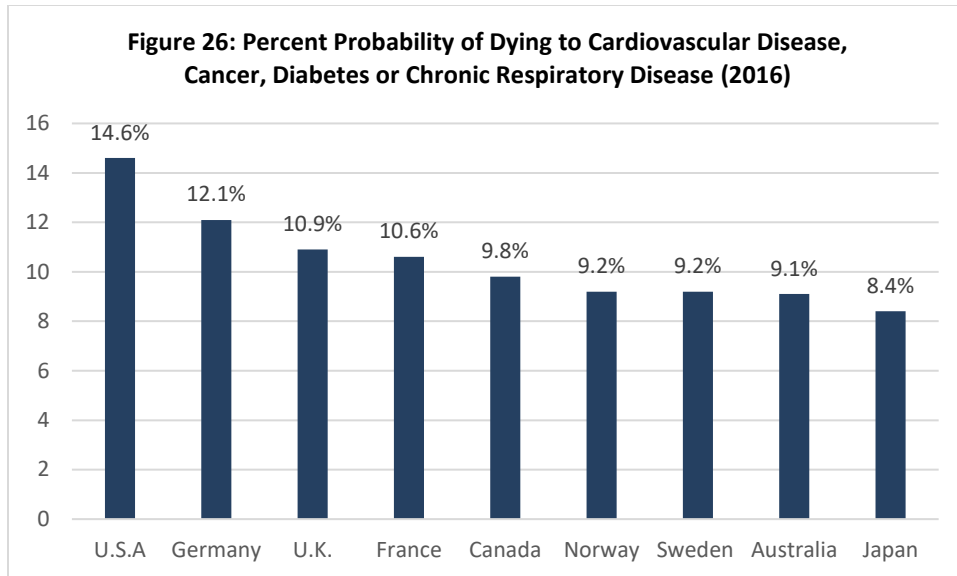


Figure notes: Data are from the WHO Global Health Estimates 2016 and represent the probability of dying from any of cardiovascular disease, diabetes, or chronic respiratory disease between age 30 and age 70.¹²⁹

¹²⁹*Id.*

Question: Why would I want Medicare-for-All if I already have insurance through my employer?**Answer: Because employer-sponsored health insurance is expensive, provides much less than Medicare-for-All would, and is continually getting much worse.**

Employer-sponsored insurance remains the most common type of health insurance in America. In 2016, more than 170 million Americans were insured through their or a family member's job.¹³⁰ That leads to the question: why would so many Americans want to switch from their current arrangement? The answer, in short, is that employer-sponsored coverage is costing employees more while offering less, while still leaving employees at risk of facing catastrophic health care costs. Americans would finally have the comfort of knowing they would have guaranteed access to care even if they lose their job or change careers.

Employer-sponsored insurance also includes a number of inherent disadvantages, such as forcing enrollees to shop for providers in narrowing networks and leaving consumers at risk of shocking "surprise bills" that are often completely out of their control.

Reasons Why Americans with Employer-Sponsored Insurance Would Benefit from Medicare-for-All:**1. Employee-Paid Premiums are Rising**

Premiums continue to rise rapidly for employer-sponsored insurance, creating challenges for both employees and employers. Even when employers contribute the same percentage to their employees' health insurance premiums year after year, rising premiums mean that workers' paychecks continue to shrink. A recent survey found that between 2006 and 2016, the average cost of employer-sponsored family coverage rose from around \$11,500 a year to more than \$18,000 a year, a 58 percent increase.¹³¹ [Figure 27]. At the same time, the average employee's share of their premium rose even faster, from nearly \$3,000 to more than \$5,000, an increase of 78 percent. The rapid rise in health care costs helps explain why more than 50 percent of Americans reported not receiving any wage growth in 2017.¹³²

¹³⁰CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, NATIONAL HEALTH CARE SPENDING IN 2016, at 6 (December 2017), <https://go.cms.gov/2LDPdMG>.

¹³¹KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS: 2016 SUMMARY OF FINDINGS, at 9 (September 2016), <https://bit.ly/2iGSqh9>.

¹³²Jack Moore, *Pay raise? More than half of US workers say 'Not this year'*, WTOP (November 14, 2017), <https://bit.ly/2Pl4EdB>.

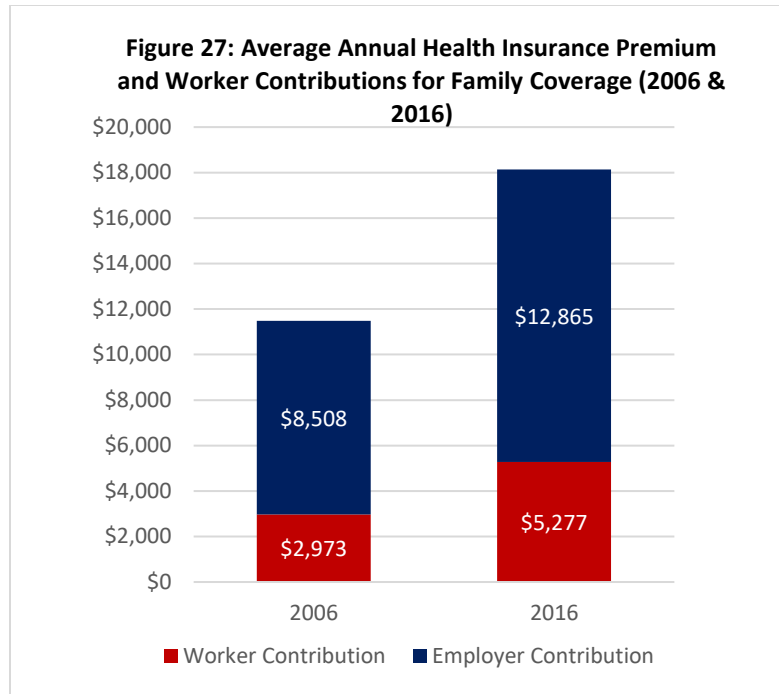


Figure note: Data are based on surveys of the human resource or benefits managers at randomly selected public and private companies of a variety of sizes. The 2016 data were based on interview with nearly 2,000 firms. Data were then weighted based on Census Bureau data to be nationally representative.¹³³

The rising costs of health care also wreak havoc for American business owners, who must take precious time away from their businesses to ensure they adequately understand the health care needs and costs of their employees. Business owners are finding that what they spent on health care 10 years ago now gets them only a fraction of the coverage they could obtain previously.¹³⁴ Many business owners are having to decide between keeping up with rising health insurance premiums or providing fair raises to their employees.¹³⁵

2. Fewer Employers Are Providing Insurance Than in the Past

Higher premiums are a key reason that smaller businesses are less likely to provide insurance. A study found that more than 95 percent of employers with 100 or more employees offered coverage in 2015, a rate that has remained consistent for over a decade [Figure 28].¹³⁶ However, the researchers found that the number of small employers offering insurance had declined in recent years. More than 80 percent of employers with 25 to 99 employees offered insurance in 2008, but that number fell to less than 75 percent in 2015.¹³⁷ Employers with 10 to 24 employees experienced a larger decline, falling from 66 percent in

¹³³KAISER FAMILY FOUNDATION, *EMPLOYER HEALTH BENEFITS: 2016 SUMMARY OF FINDINGS*, at 9 (September 2016), <https://bit.ly/2iGSqh9>.

¹³⁴*Id.*

¹³⁵Jay Hancock, *Hikes in Employees' Health Premiums to Outpace Raises Again*, NPR (August 10, 2016), <https://n.pr/2q9cBV4>.

¹³⁶Paul Fronstin, *Fewer Small Employers Offering Health Coverage; Large Employers Holding Steady*, 37 EBRI NOTES 1-9, 2 (2016).

¹³⁷*Id.*

2008 to under 50 percent in 2015. Employers with fewer than 10 employees also saw a significant decline, from around 35 percent to about 22 percent, a 36 percent decline.

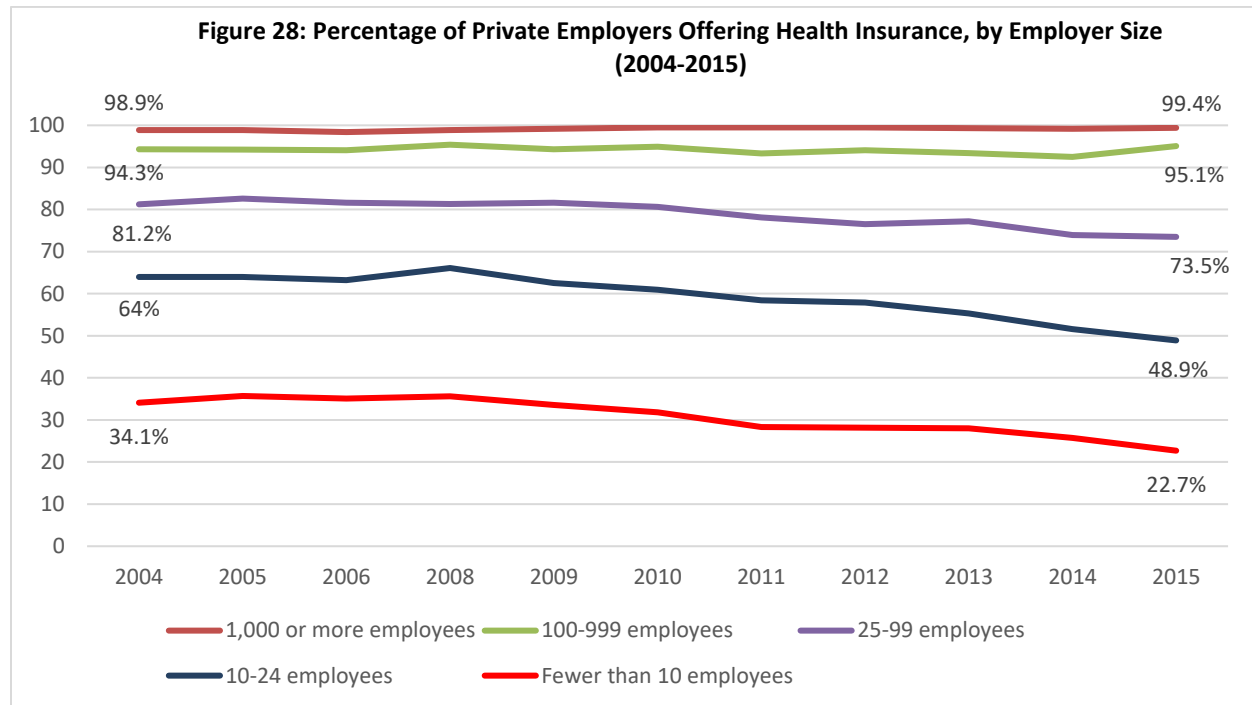


Figure note: Data are from the Insurance Component of the Medical Expenditure Panel Survey. Data for 2007 were unavailable.¹³⁸

3. Quality of Employer-Sponsored Insurance Is Declining, Placing Workers at Risk for Catastrophic Costs

In addition to rising premiums, many workers have experienced increased out-of-pocket costs and decreased options for in-network health care providers, doctors and hospitals. One study found that the percentage of working-age adults with insurance through their job who were underinsured—meaning they face excessive out-of-pocket costs—rose from one in ten workers in 2003 to one in four workers in 2016.¹³⁹ Further, a recent survey found that middle-income Americans with private insurance were the most likely to report increases in their out-of-pocket costs.¹⁴⁰

¹³⁸Paul Fronstin, *Fewer Small Employers Offering Health Coverage; Large Employers Holding Steady*, 37 EBRI NOTES 1-9, 2 (2016).

¹³⁹A person in the study was considered underinsured if they had out-of-pocket cost, excluding premiums, over the prior 12 months were 10 percent or more of household income (or 5 percent of household income for households making less than 200 percent of the federal poverty level) or if their deductibles was 5 percent or more of their household income. SARAH R. COLLINS, MUNIRA Z. GUNJA, AND MICHELLE M. DOTY, THE COMMONWEALTH FUND, HOW WELL DOES INSURANCE COVERAGE PROTECT CONSUMERS FROM HEALTH CARE COSTS? — FINDINGS FROM THE COMMONWEALTH FUND BIENNIAL HEALTH INSURANCE SURVEY, 2016, at 1 (October 2017), <https://bit.ly/2D3WbG5>.

Rich Daly, *Narrow Networks Spread From ACA Plans to Employers*, HMFA (December 5, 2017), <https://bit.ly/2O6GLSo>. Stephen Miller, *Employers May Adopt 'Narrow Networks' of Health Care Providers*, SHRM (January 10, 2017), <https://bit.ly/2ikrVLj>.

¹⁴⁰Nearly sixty percent of respondents with private insurance responded that their out-of-pocket health care spending had increased, compared with 51 percent of the uninsured, 46 percent for Medicare, 43 percent for Medicaid and 39 percent for VA & TRICARE.

Another study found that the percentage of enrollees with more than \$1,000 in total out-of-pocket spending in a given year rose from 17 percent in 2005 to nearly 25 percent in 2015.¹⁴¹ Given that nearly one in four workers have less than \$1,000 in savings, rising deductibles can create serious financial hardship.¹⁴² A recent survey found that between 2006 and 2017, average health plan deductibles rose from around \$300 to more than \$1,200 a year [Figure 29].¹⁴³

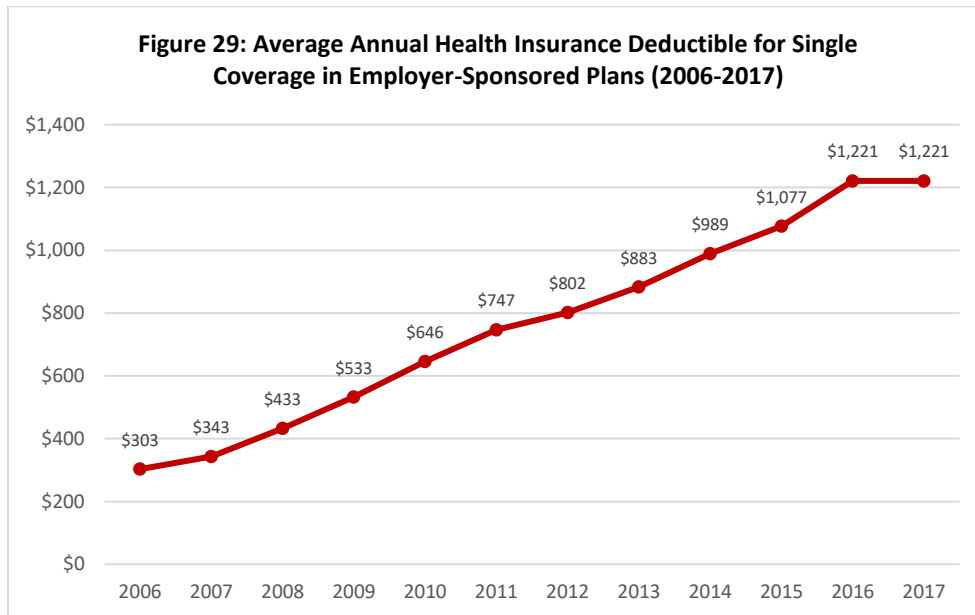


Figure note: Data are based on surveys of the human resource or benefits managers at more than 2,000 randomly selected public and private companies. Data were then weighted based on Census Bureau data to be nationally representative.¹⁴⁴

Another area that reflects the decline in the quality of employer-sponsored insurance is the lack of ability to choose doctors and hospitals under employer plans. The rising costs of coverage means employers face constant pressure to change plans, including to plans with narrower networks.¹⁴⁵ One survey found that nearly 60 percent of employers reported considering switching insurers or shopping for a new health plan in the past year.¹⁴⁶ Employers with fewer than 200 employees were the most likely to consider making a change, while the largest employers, those with 5,000 or more employees, were the least likely to consider changing plans. Nearly a third of the firms that considered switching insurers or shopped for a new plan in the past year made a change, with the largest companies being were the most likely to end up

IPSOS, HEALTH CARE EXPERIENCE STUDY, at 3 (April 2018), <https://bit.ly/2TjJRpr>.

¹⁴¹BRADLEY SAWYER, CYNTHIA COX AND GARY CLAXTON, KAISER FAMILY FOUNDATION, AN ANALYSIS OF WHO IS MOST AT RISK FOR HIGH OUT-OF-POCKET HEALTH SPENDING, at 1 (October 2017), <https://bit.ly/2zbH7jf>.

¹⁴²Katie Lobosco, *1 in 4 Workers have Less than \$1,000 Saved for Retirement*, CNN MONEY (March 21, 2017), <https://cnnmon.ie/2Plgp3W>.

¹⁴³KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS: 2017 ANNUAL SURVEY, at 106 (September 2017), <https://bit.ly/2RfuLOx>.

¹⁴⁴*Id.* at 14.

¹⁴⁵Les Masterson, *Could Narrow Networks be the Next Big Cost Cutter?*, HEALTHCARE DIVE (January 9, 2018), <https://bit.ly/2EugcSl>.

¹⁴⁶KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS: 2017 ANNUAL SURVEY, at 211 (September 2017), <https://bit.ly/2RfuLOx>.

making a change.¹⁴⁷ A new insurance carrier or health insurance plan would likely mean big changes for employees when it comes to premiums, out-of-pocket costs, and understanding in-network versus out-of-network providers.

4. Employer-Sponsored Insurance Requires Employees to Navigate a Minefield to Avoid Surprise Bills

Even when employees receive treatment at hospitals or other facilities that are in their insurer's network, they face the risk of unexpected bills that can devastate their finances and even send them into medical debt or even bankruptcy. This is because some providers in those facilities may not be included in their insurer's network. Referred to as "surprise billing" or "balance billing," this practice leaves patients on the hook for the difference between the amount the insurance company is willing to pay and a provider's total fee.¹⁴⁸

Even a patient who is vigilant and tries to ensure they are being treated by in-network providers may have trouble avoiding surprise bills. For example, during an emergency, a patient doesn't have time or the ability to check whether each provider that is treating them is considering in-network by their plan. And during surgery, there could be multiple doctors and nurses, some of whom may not be in-network. For example, nearly 18 percent of workers with coverage through a large employer (businesses with 100 or more employees) who had an inpatient admission to a hospital or other setting received a bill for out-of-network services.¹⁴⁹

A survey in 2016 by the Kaiser Family Foundation found that nearly 70 percent of respondents who experienced surprise bills that they were unable to pay did not know that the health care provider was considered out-of-network when they received care.¹⁵⁰ Another survey found that while fewer than 10 percent of individuals used out-of-network care, around 40 percent of those claims for out-of-network care involved surprise billing. This was particularly common for emergency care.¹⁵¹ Another recent survey showed that more than half of Americans received a medical bill for something they thought their health insurance covered, and more than one in four Americans had a medical bill turned over to a debt collection agency.¹⁵²

A comprehensive review of state protections against surprise billing found that fewer than half of states, 21 total, had any sort of protections for consumers against surprise billing.¹⁵³ Only six states include safeguards in both emergency and hospital settings, and researchers found potential gaps within the protections those six states enacted.

¹⁴⁷*Id.*

¹⁴⁸ADAM CROWTHER, PUBLIC CITIZEN, OUT OF CONTROL: PATIENTS ARE UNWITTINGLY SUBJECTED TO ENORMOUS, UNFAIR, OUT-OF-NETWORK 'BALANCE BILLS', at 4 (April 2014), <https://bit.ly/2yvzrda>.

¹⁴⁹GARY CLAXTON, ET AL., KAISER FAMILY FOUNDATION, AN ANALYSIS OF OUT-OF-NETWORK CLAIMS IN LARGE EMPLOYER HEALTH PLANS, at 3 (August 2018), <https://bit.ly/2OOHNaN>.

¹⁵⁰KAREN POLLITZ, KAISER FAMILY FOUNDATION, SURPRISE MEDICAL BILLS, at 1 (March 2016), <https://bit.ly/2ObKpe0>.

¹⁵¹Kelly A. Kyanko, Leslie A. Curry and Susan H. Busch, *Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?*, 48 HEALTH SERVICES RESEARCH 1154-1172, 1163 (2012).

¹⁵²NORC AT THE UNIVERSITY OF CHICAGO, AMERICANS' VIEWS ON HEALTHCARE COSTS, COVERAGE AND POLICY, at 7 (March 2018), <https://bit.ly/CuBUXo>.

¹⁵³KEVIN LUCIA, JACK HOADLEY AND ASHLEY WILLIAMS, THE COMMONWEALTH FUND, BALANCE BILLING BY HEALTH CARE PROVIDERS: ASSESSING CONSUMER PROTECTIONS ACROSS STATES, at 2 (June 2017), <https://bit.ly/2O99HJA>.

Many people with insurance have difficulty paying their bills. The risk of expensive medical bills is a key reason that more than one in four working age adults reported being concerned about being able to pay for normal health care, and almost half reported being worried about being able to afford their medical bills if they get sick.¹⁵⁴ Many working-age adults are forced to pay their medical bills over time, sometimes with high rates of interest. Nearly one in four working-age adults reported they are currently paying off medical bills over time.¹⁵⁵ Only around one-third of the Americans who had difficulty paying medical bills were uninsured, highlighting that being insured doesn't necessarily protect enrollees from medical debt due to the high out-of-pocket costs and deductibles for many insurance plans as well as surprise bills from out-of-network providers [Figure 30].¹⁵⁶

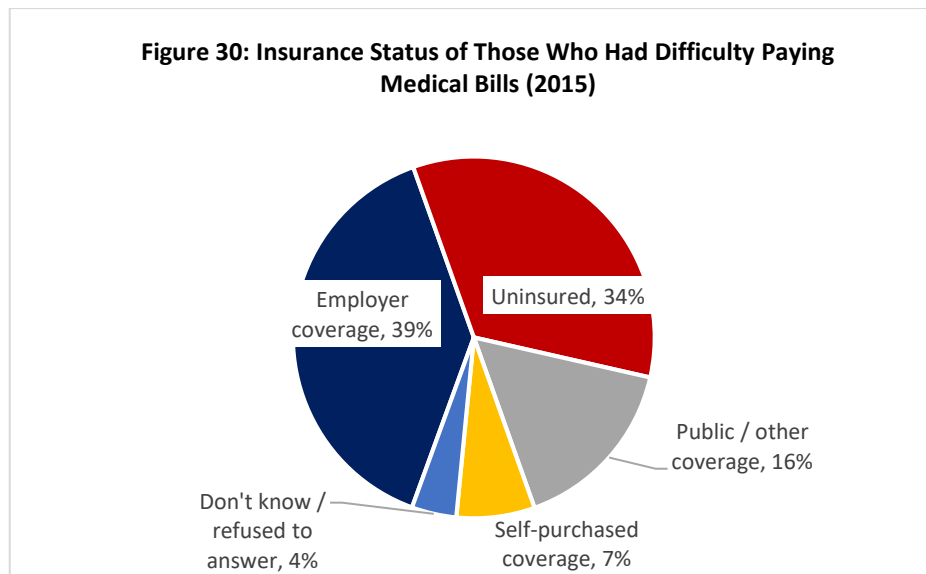


Figure note: Data are from a survey that randomly sampled of respondents ages 18-64 and included longer interviews with adults who reported problems paying medical bills within the past 12 months.¹⁵⁷

Medicare-for-All would resolve these fears and put an end to medical debt and bankruptcy, which continue to plague millions of Americans. Since under Medicare-for-All there will no longer be any “in-network” versus “out-of-network”, it will end to harmful practices, including large out-of-pocket costs and surprise billing, Americans would finally be able to focus on getting the treatment they need without worrying about whether the bill will mean financial ruin.

5. Americans are at Risk of Catastrophic Health Care Expenses if They Lose Their Job

If you plan to move, change jobs, go back to school, or start a business, ensuring access to health insurance is among the first issues with which you must contend. A recent survey found that loss of a job or change in employer was the second leading cause of being uninsured, following only the cause of

¹⁵⁴KAISER FAMILY FOUNDATION, KEY FACTS ABOUT THE UNINSURED POPULATION, at 6 (September 2017), <https://bit.ly/2q8AEU7>.

¹⁵⁵*Id.*

¹⁵⁶LIZ HAMEL, ET AL., KAISER FAMILY FOUNDATION, THE BURDEN OF MEDICAL DEBT: RESULTS FROM THE KAISER FAMILY FOUNDATION/NEW YORK TIMES MEDICAL BILLS SURVEY, at 1 (January 2016), <https://bit.ly/1VqyqN>.

¹⁵⁷*Id.*

insurance being too expensive [Figure 31].¹⁵⁸ Even with the improvements under the ACA, nearly 30 million Americans remain uninsured, leaving them at risk for undiagnosed disease, higher costs for care, and medical debt or bankruptcy.

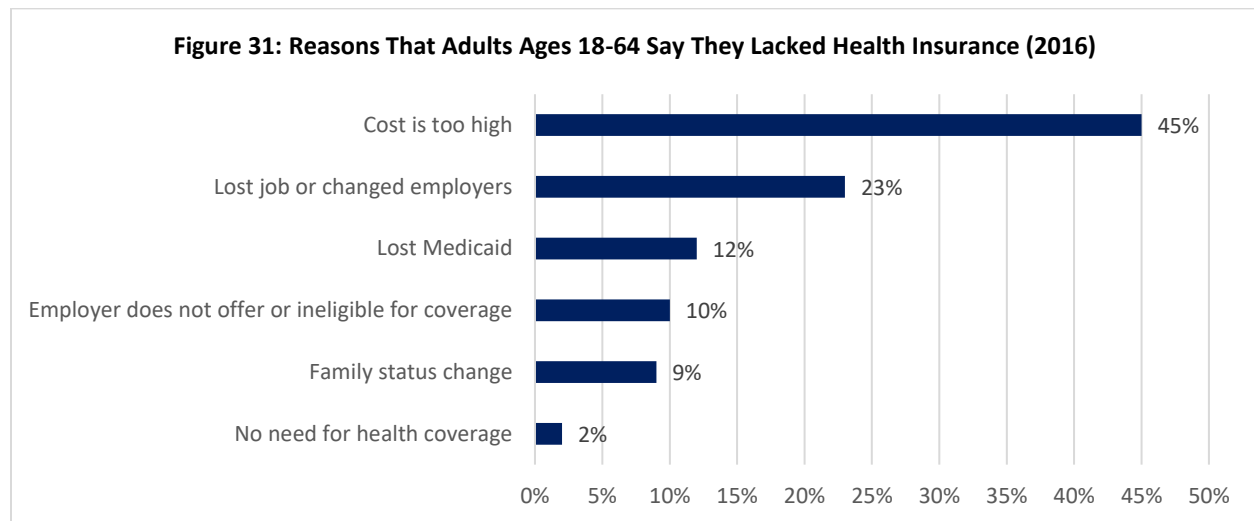


Figure note: Data based on author's analysis of the 2016 National Health Interview Survey. Survey respondents were able to select multiple reasons. Family status change includes a change in marital status, the death of a spouse or parent, aging out of insurance, or leaving school.¹⁵⁹

Losing affordable insurance often means being unable to access needed care and facing huge bills if a person is struck by illness. Nearly half of uninsured Americans reported being unable to access health care when they needed it within the past two years.¹⁶⁰ And uninsured Americans understand the need to have insurance. According to a recent poll, most uninsured Americans, more than 75 percent, believed that they needed health insurance, highlighting that it isn't people just thinking they are invincible.¹⁶¹ However, 71 percent of uninsured Americans who were aware of the ACA marketplaces said they did not plan to shop for insurance on the marketplace because they did not think they could afford the cost.¹⁶²

Medicare-for-All would bring consistent coverage for workers, giving them peace of mind. Americans have gotten used to the idea of health care as an ongoing struggle. A Medicare-for-All system would mean everyone in the U.S. would be able to access health care wherever they moved. And because the coverage would be consistent across the country, enrollees could focus on finding a provider that meets their needs, instead of figuring out which providers are actually in their network. Workers could focus on finding the career they want in their community of choice, instead of feeling trapped in a job because they need to keep their current insurance.

¹⁵⁸KAISER FAMILY FOUNDATION, KEY FACTS ABOUT THE UNINSURED POPULATION, at 3 (September 2017), <https://bit.ly/2q8AEU7>.

¹⁵⁹*Id.*

¹⁶⁰This is nearly twice the rate of respondents with Medicaid, 26 percent, and more than three times the rate of those with Medicare, 12 percent, or private insurance, 15 percent. IPSOS, HEALTH CARE EXPERIENCE STUDY, at 26 (April 2018), <https://bit.ly/2TjJRpr>.

¹⁶¹ASHLEY KIRZINGER, ET AL., KAISER FAMILY FOUNDATION, KAISER HEALTH TRACKING POLL - MARCH 2018: NON-GROUP ENROLLEES, at 15 (April 2018), <https://bit.ly/2yyGv9Q>.

¹⁶²SARA R. COLLINS, ET AL., THE COMMONWEALTH FUND, AMERICANS' VIEWS ON HEALTH INSURANCE AT THE END OF A TURBULENT YEAR, at 4 (March 2018), <https://bit.ly/2OaMqgy>.

Question: Why would I want Medicare-for-All if I already have Medicare or Medicaid?

Answer: Medicare services would be improved and out-of-pocket costs eliminated and Medicaid beneficiaries would receive improved access to care and face fewer coverage transitions.

Reasons Why Americans with Medicare or Medicaid Would Benefit from Medicare-for-All:

1. Medicare-for-All Would Largely Improve and Expand an Existing Program, Medicare, Rather than Start from Scratch

Medicare provides access to a wide variety of high-quality services for adults age 65 or older or younger adults with permanent disabilities, many of whom are in poor health or have functional or cognitive impairment. Medicare achieves efficiencies that private insurance cannot, largely because of its straightforward and efficient administration and low overhead.

Medicare-for-All would improve and simplify Medicare by eliminating premiums and out-of-pocket costs. This would ensure access to the care for everyone in the U.S. and reduce the administrative burden of collecting and processing those payments. Studies have found that out-of-pocket costs cause consumers to decrease their use of potentially valuable health care.¹⁶³ Under Medicare-for-All, improved payment mechanisms would be used to reduce wasteful health spending while improving access to high value care. Such payment mechanisms would be refined over time through ongoing research from the data generated by the Medicare-for-All system.

Eliminating premiums and out-of-pocket costs would simplify the program and help current Medicare beneficiaries, particularly low-income seniors, as they move to Medicare-for-All. As of 2013, the average Medicare beneficiary had out-of-pocket health care spending that accounted for around 40 percent of their Social Security income.¹⁶⁴ By 2030, that number is expected to rise to 50 percent, putting increased pressure on seniors' budgets. Further, about half of traditional Medicare beneficiaries spent nearly 15 percent of their total income on out-of-pocket health care costs, while around 10 percent of beneficiaries spent at least 59 percent of their total income on such costs.¹⁶⁵ Many seniors are on a fixed income, particularly elderly women in their 70s and 80s, which can make out-of-pocket expenses difficult to afford.

Medicare-for-All would also simplify the system by improving provider choice for current Medicare enrollees, especially those enrolled in Medicare Advantage. More than one-third of Medicare Advantage enrollees have to deal with narrow networks—defined as included less than 30 percent of physicians in a

¹⁶³Zarek C. Brot-Goldberg, et al., *What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 THE QUARTERLY JOURNAL OF ECONOMICS 1261-1318, 1261 (2017).

¹⁶⁴JULIETTE CUBANSKI, ET AL., KAISER FAMILY FOUNDATION, MEDICARE BENEFICIARIES' OUT-OF-POCKET HEALTH CARE SPENDING AS A SHARE OF INCOME NOW AND PROJECTIONS FOR THE FUTURE, at 2 (January 2018), <https://bit.ly/2Sm50zy>.

¹⁶⁵*Id.* at 4.

given county—and less than one in four Medicare Advantage enrollees has access to a broad network of providers [Figure 32].¹⁶⁶ Medicare-for-All would mean no more networks, as nearly every provider in the U.S. would be part of the program. As a result, enrollees would have much broader choice of doctors and hospitals.

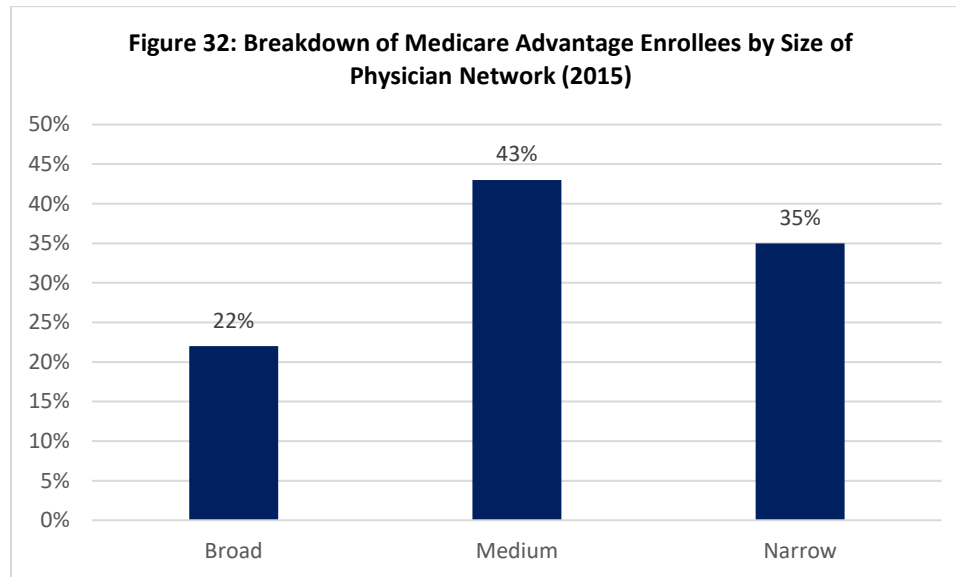


Figure note: Researchers analyzed the 2015 networks of Medicare Advantage plans in 20 counties. A network was categorized as broad if it included 70 percent or more of physicians in the county. Medium networks included 30 to 69 percent of physicians in the county and narrow networks included less than 30 percent of physicians in a given county.¹⁶⁷

Finally, Medicare-for-All would improve access to vision and dental services, something that can be challenging for seniors to afford. Seniors would be better able to access treatments for glaucoma and cataracts, which can threaten eyesight if left untreated. Lack of access to dental services can put beneficiaries at risk for infection, decreased quality of life, and difficulty eating. A 2012 study found that less than half of all Medicare beneficiaries had any dental visits in the prior 12 months.¹⁶⁸ Low-income seniors were particularly likely to not have had a visit, with only around one in four having done so in the past year, compared to nearly 75 percent of beneficiaries with incomes around 400 percent of the federal poverty level or higher.¹⁶⁹ By including vision and dental services in Medicare-for-All, beneficiaries would finally be able to be guaranteed access to the services they need to live a full life.

2. Medicare-for-All Would Incorporate Medicaid, Improving Access to Care and Reducing Coverage Transitions

Medicaid is the second largest source of coverage in the U.S. and combined with the Children’s Health Insurance Program (CHIP) was responsible for the coverage of more than 70 million Americans in

¹⁶⁶GRETCHEN JACOBSON, ET AL., KAISER FAMILY FOUNDATION, *MEDICARE ADVANTAGE: HOW ROBUST ARE PLANS’ PHYSICIAN NETWORKS?*, at 4 (October 2017), <https://bit.ly/2D714Ri>.

¹⁶⁷*Id.*

¹⁶⁸Amber Willink, Cathy Schoen, and Karen Davis, *Dental Care and Medicare Beneficiaries: Access Gaps, Cost Burdens, and Policy Options*, 35 *HEALTH AFFAIRS* 2241-2248, 2243 (2016).

¹⁶⁹*Id.*

2016.¹⁷⁰ The expansion of Medicaid under the ACA is responsible for the coverage of more than 10 million of the total 70 million people covered through Medicaid. However, not all states chose to expand their Medicaid programs. As of November 2018, 14 states had not implemented the Medicaid expansion, but a handful have the potential do so in the coming years.¹⁷¹

Medicaid enrollees currently face the loss of coverage or unanticipated transitions to other forms of insurance for a variety of reasons. These unintended transitions can create significant challenges for Medicaid enrollees, in terms of both maintaining access to care and being able to afford the care they need. Current Medicaid enrollees lose coverage if their income gets too high or if they miss a deadline for reassessing their Medicaid eligibility, among other circumstances that vary state to state. For some workers, especially those who work seasonally or intermittently, fluctuations in income can mean losing and gaining Medicaid or other types of insurance throughout a given year.

In a look at just a few states, researchers found that about one in four low-income survey respondents had experienced at least one change in coverage.¹⁷² More than half of respondents that had to change coverage ended up experiencing a gap in coverage, with almost a third experiencing a gap of more than four months. Further, nearly half reported a decline in their overall health, which is not surprising given that many reported stopping or skipping doses of prescription medication or having to switch one or more physicians during coverage changes or gaps. Another study found that many patients with type one diabetes experienced challenges controlling their condition due to changes in insurance.¹⁷³ Nearly one in four adults with type one diabetes experienced an interruption in health care, and each interruption was associated with an increased likelihood of health complications and the need for care. Such interruptions were also associated with lower life satisfaction and with worsening of their health status.¹⁷⁴ By improving access to care for existing enrollees while reducing their costs, Medicare-for-All would greatly enhance quality of life.

¹⁷⁰CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, NATIONAL HEALTH CARE SPENDING IN 2016, at 6 (December 2017), <https://go.cms.gov/2LDPdMG>.

CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEDICAID & CHIP: JULY 2016 MONTHLY APPLICATIONS, ELIGIBILITY DETERMINATIONS AND ENROLLMENT REPORT, at 2 (September 2016), <https://bit.ly/2iBwjg6>.

¹⁷¹FAMILIES USA, A 50-STATE LOOK AT MEDICAID EXPANSION: 2018, at 1 (November 2018), <https://bit.ly/2COcWT5>.

¹⁷²Benjamin D. Sommers, et al., *Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many*, 35 HEALTH AFFAIRS 1816-1824, 1818 (2016).

¹⁷³Mary A. M. Rogers, et al., *Interruptions in Private Health Insurance and Outcomes in Adults with Type 1 Diabetes: A Longitudinal Study*, 37 HEALTH AFFAIRS 1024-1032, 1029 (2018).

¹⁷⁴*Id.*

Question: Would adopting a Medicare-for-All system lead to long waits for care?**Answer: No. Based on the track record of Medicare, there is no reason to worry that broadening the system to the entire population should lead to increased wait times.**

Given that Medicare-for-All would be improving and expanding access to care, including to the 30 million Americans who are currently uninsured, some have raised concerns about how to ensure adequate access for everyone in America without lengthy waits for care. It is one of the most common critiques of such proposals and of single-payer systems internationally, particularly in Canada. Opponents of universal health care often identify specific instances where a given country has longer wait times for a certain procedure than the United States. However, the perception that countries with universal health care systems generally have long wait times is unfounded. By looking at the experience of current Medicare beneficiaries, exploring relevant studies that compare our wait times to those of other countries, and by identifying certain advantages of our current health care system, we can allay such concerns.

Reasons Why Medicare-for-All Would Not Lead to Long Waits for Care:**1. Medicare-for-All Would Build on the Success of Medicare, Which Has an Admirable Record of Providing Timely Care**

As Medicare-for-All would improve Medicare and expand it to everyone in the U.S., it is instructive to explore wait times for current beneficiaries. Medicare is among the most popular forms of health insurance in the United States, with close to 80 percent of enrollees reporting they are satisfied with the way the health care system is working [Figure 33].¹⁷⁵ One reason that Medicare is popular is that it does not impose long wait times. Medicare beneficiaries generally have a wide choice of doctors and few report challenges accessing care.¹⁷⁶

¹⁷⁵REBECCA RIFKIN, GALLUP, AMERICANS WITH GOVERNMENT HEALTH PLANS MOST SATISFIED, at 1 (November 2015), <https://bit.ly/2JiBkPz>.

MIRA NORTON, BIANCA DIJULIO AND MOLLYANN BRODIE, KAISER FAMILY FOUNDATION, MEDICARE AND MEDICAID AT 50, at 1 (July 2015), <https://bit.ly/2PYwDwW>.

¹⁷⁶ADELE SHARTZER, RACHAEL ZUCKERMAN, AUDREY McDOWELL AND RICHARD KRONICK, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCESS TO PHYSICIANS' SERVICES FOR MEDICARE BENEFICIARIES, at 7 (August 2013), <https://bit.ly/2ELGeWH>.

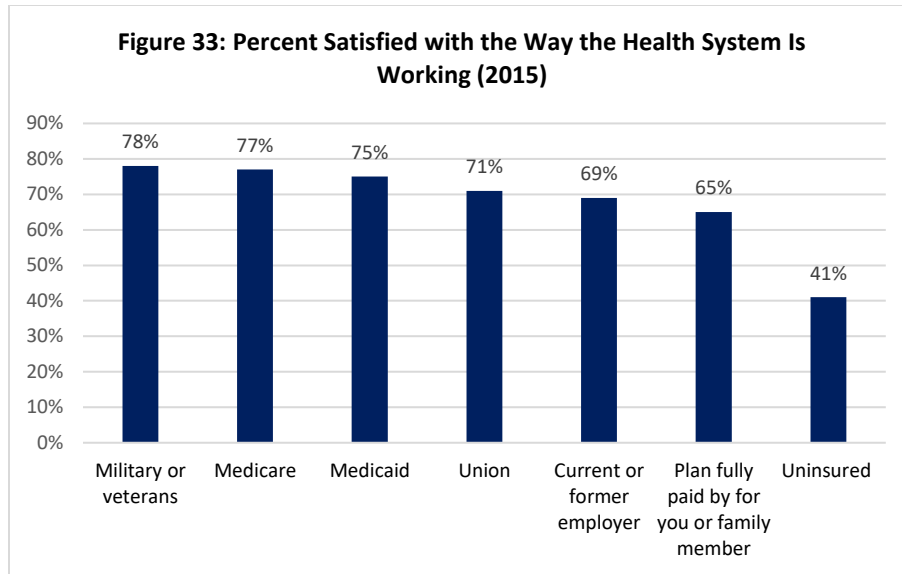


Figure note: Results were based on a random sample of nearly 150,000 adults ages 18 and older in all 50 U.S. states and D.C. in 2015.¹⁷⁷

Some charge that because Medicare pays lower rates than private insurers, beneficiaries face challenges accessing care. However, one study found that Medicare patients reported having consistent access to care, with more than 95 percent reporting having a usual source of care, such as a doctor's office or primary care clinic.¹⁷⁸ Around 90 percent of Medicare beneficiaries reported that they were able to schedule timely appointments for primary and specialty care.¹⁷⁹ Seniors with Medicare were more likely than adults age 50-64 with private insurance to report that they had never had to wait longer than they wanted for a routine care appointment [Figure 34].¹⁸⁰

¹⁷⁷REBECCA RIFKIN, GALLUP, AMERICANS WITH GOVERNMENT HEALTH PLANS MOST SATISFIED, at 1 (November 2015), <https://bit.ly/2IiBkPz>.

¹⁷⁸CRISTINA BOCCUTI, CHRISTINA SWOOPE, ANTHONY DAMICO AND PATRICIA NEUMAN, KAISER FAMILY FOUNDATION, MEDICARE PATIENTS' ACCESS TO PHYSICIANS: A SYNTHESIS OF THE EVIDENCE, at 2 (December 2013), <https://bit.ly/2D6KFtl>.

¹⁷⁹*Id.* at 3.

¹⁸⁰*Id.*

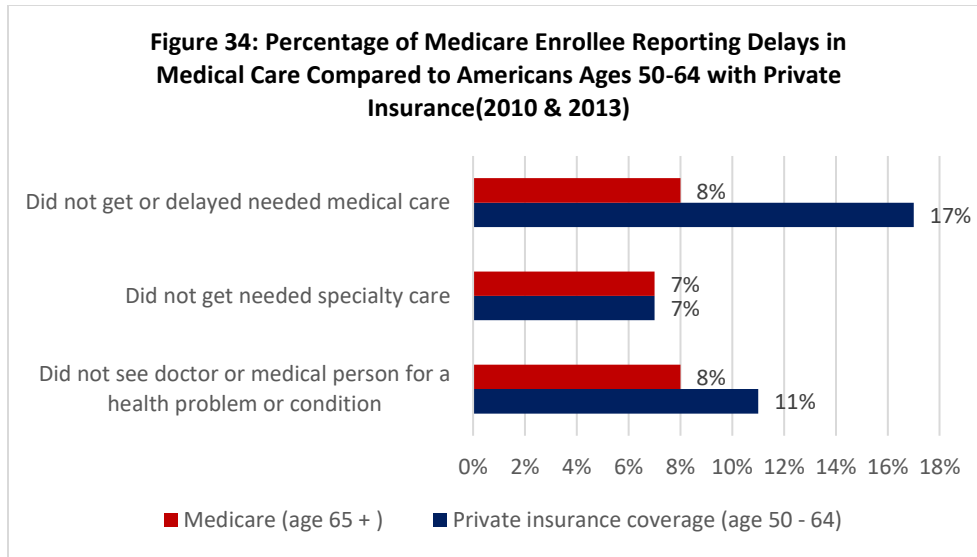


Figure note: Data for the first two comparisons came from a Kaiser Family Foundation analysis of the 2010 Health Tracking Household survey and included privately insured adults ages 55-64. Data for the third comparison came from a 2013 Medicare Payment Advisory Commission Survey and included privately insured adults ages 50-64.¹⁸¹

2. The Concern that Other Countries' Universal Coverage Systems Have Long Waits for Care Usually Focuses on Care Provided by Specialists, Which Are in Ample Supply in the United States

When critics raise concerns about citizens of other countries having to wait for care, it is generally about access to specialists or certain elective surgeries. This is unlikely to be a problem in the United States. A recent study found that the U.S. had the third-highest proportion of specialists to primary care physicians of the 11 countries that the researchers examined.¹⁸² The study also found that the United States did better than average on having no more than a two-month wait time for an appointment with a specialist, with only France and Germany reporting have lower percentage of people having no more than a two-month wait to see a specialist [Figure 35].¹⁸³

¹⁸¹*Id.*

¹⁸²Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1031(2018).

¹⁸³*Id.* 1036.

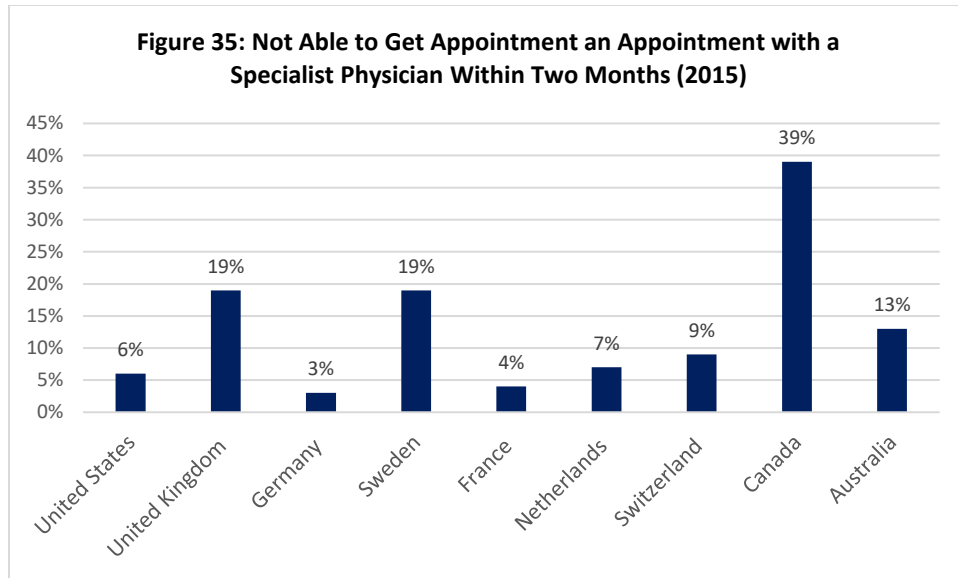


Figure note: Data were from the Organization for Economic Cooperation and Development, which collects data on the extent to which patients had to wait no longer than two months for an appointment with a specialist.¹⁸⁴

Implementing Medicare-for-All would likely not alter that ratio immediately, though it may change over time as Medicare-for-All will be better able to provide incentives to ensure doctors are filling essential roles across the health care system. Thus, we could continue to draw on our deep reserve of specialists to ensure that patients have access to the range of specialty services they need.

3. Access to Care in the United States is Not as Great as Defenders of our System Claim

When looking specifically at access, the previously cited study looked at the ability to get a same- or next-day appointment.¹⁸⁵ Under our current system, the United States was below average on being able to get a same- or next-day appointment, with five countries reporting better access on that measure [Figure 36].

¹⁸⁴Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1036 (2018).

¹⁸⁵*Id.*

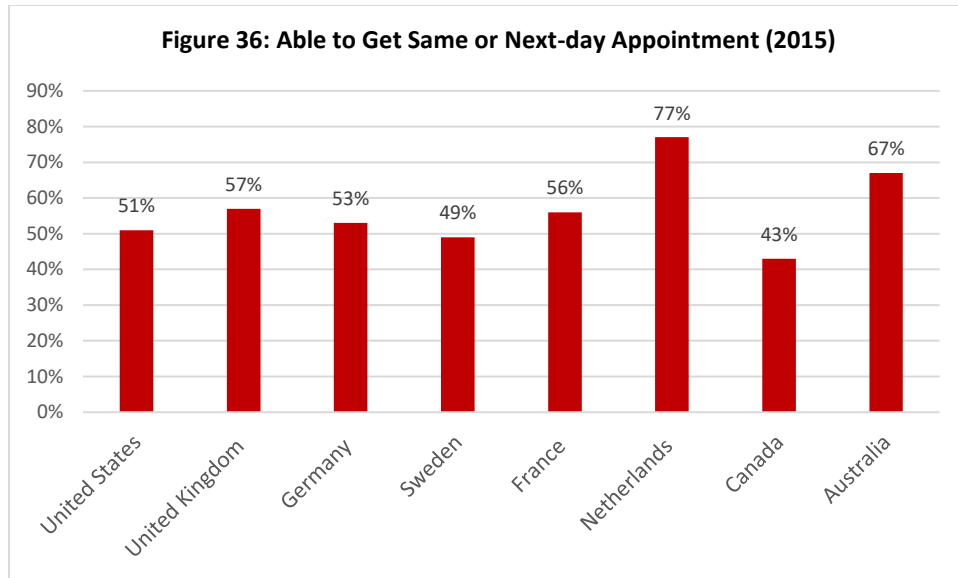


Figure note: Data were from the Organization for Economic Cooperation and Development, which collects data on the extent to which patients were able to get same or next-day appointments when sick but excluded those who did not need to see a provider.¹⁸⁶

Previous studies found similar results, with U.S. wait times being about average or somewhat below average on a variety of wait time measures when compared to other countries.¹⁸⁷ However, these findings may understand the problem in the U.S. as many Americans essentially experience infinite wait times because they cannot afford the care they need. Many Americans struggle to access basic care at much higher rates than citizens of other comparably wealthy nations.¹⁸⁸ Studies on wait times require someone to have to have tried to get care, but many Americans cannot even can't afford attempt to access the care they need and so don't even queue for care.

Studies that looks specifically at unmet health care needs due to cost paint a particularly stark portrait of the U.S. health care system. The study cited above found that the U.S. had the highest rate of respondents reporting being unable to receive the care they need of the 11 wealthy countries they compared. Nearly one in four Americans reported skipping a health care appointment due to the cost, a number more than double the average across all 11 countries [Figure 37].¹⁸⁹

¹⁸⁶Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1036 (2018).

¹⁸⁷ERIC C. SCHNEIDER, ET AL., THE COMMONWEALTH FUND, MIRROR, MIRROR 2017: INTERNATIONAL COMPARISON REFLECTS FLAWS AND OPPORTUNITIES FOR BETTER U.S. HEALTH CARE, at 21 (July 2017), <https://bit.ly/2PTfYe2>.

¹⁸⁸Robin Osborn, et al., *In New Survey of Eleven Countries, US Adults Still Struggle with Access to and Affordability of Health Care*, 35 HEALTH AFFAIRS 2327-2336, 2333 (2016).

Ryan M. Barber, et al., *Healthcare Access and Quality Index based on mortality from causes amenable to personal health care in 195 countries and territories, 1990–2015: a novel analysis from the Global Burden of Disease Study 2015*, 390 THE LANCET 231-266, 236 (2017).

¹⁸⁹Irene Papanicolas, Liana R. Woskie and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1024-1039, 1037 (2018).

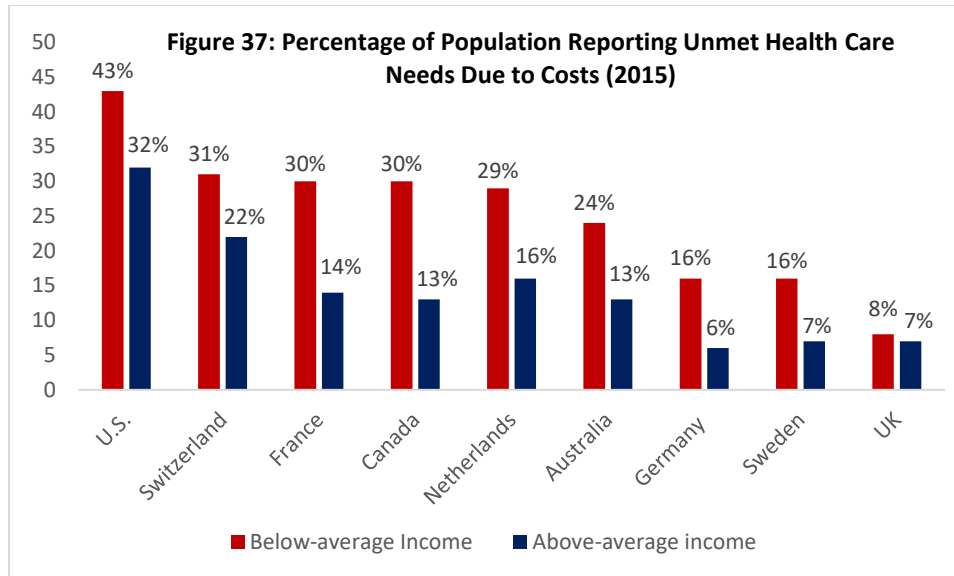


Figure note: Authors used data from the Commonwealth Fund International Health Policy Survey, which collects data from a representative sample for a number of countries. Unmet need, for the purposes of that survey, meant not going to the doctor; skipping a test, treatment or follow up; or not filling a prescription or skipping doses, due to costs. Below-average income was defined as having household income less than 50 percent of the country median and above-average income was defined as having income greater than 50 percent of the country median.¹⁹⁰

Further, more than 40 percent of Americans with below-average income reported having unmet health care needs due to cost, meaning not going to the doctor; skipping a test, treatment or follow up; or not filling a prescription or skipping doses, all due to costs.¹⁹¹ Americans reported experiencing these deprivations at twice the average of the 11 countries. Even around one-third of Americans with above-average incomes reported having unmet health care needs due to the cost of care, more than twice the average rate of the other countries surveyed.¹⁹²

Another study looked at a number of measures of access and found the United States ranked worst overall for access among the 11 countries they examined.¹⁹³ Finally, the U.S. ranked worst out of 16 industrialized countries for deaths that could be prevented with proper medical care.¹⁹⁴ Medicare-for-All would ensure that Americans can finally access the care they need and end their currently incalculable wait times because health care would no longer be tied to ability to pay rising premiums and out-of-pocket costs.

While no country is perfect when it comes to wait times, the United States performs better than some countries on certain measures and worse than comparable countries on many others, particularly those related to costs. By moving to Medicare-for-All, we can improve our unmet need while utilizing our

¹⁹⁰*Id.*

¹⁹¹*Id.*

¹⁹²*Id.*

¹⁹³Eric C. Schneider, et al., The Commonwealth Fund, *Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care*, at 5 (July 2017), <https://bit.ly/2PTfyE2>.

¹⁹⁴Ellen Nolte and Martin McKee, *Variations in amenable mortality—Trends in 16 high-income nations*, 103 *HEALTH POLICY* 47-52, 49 (2011).

advantage of having more specialists than many other countries to help ensure that everyone in the U.S. can finally access the care they need in a timely manner.

Question: Is our system just too complex to change?

Answer: No. Because Medicare is an existing program, it could be expanded to cover a broader population relatively easily.

Though an overhaul of our health care system will take significant willpower and effort, Americans often overestimate how difficult it would be to transition to Medicare-for-All. The lessons from previous health care expansions, including Medicare, highlight that Americans are generally eager and quick to take up new coverage and will fight to protect health care expansions once they are implemented. Even President Obama recently noted that Medicare-for-All was a good idea and previously said he would have preferred a single-payer approach to that of the Affordable Care Act if we were starting from scratch.¹⁹⁵ In many ways, the criticism that our system is too complex to change underscores the case for why reform is necessary. Our system is hopelessly fragmented, and staggering sums of money are wasted on costs other than providing necessary health care. Medicare-for-All would finally allow everyone in the United States to have consistent health care throughout their lives. When other countries have implemented universal health care systems, they have been able to ensure coverage, guarantee access to care, and keep costs much lower than our fragmented system.

Reasons Why Our System Can Be Transitioned to Medicare-for-All:

1. We Already Have Implemented Medicare and Created the Infrastructure Upon Which Medicare-for-All Would Build

Our country's transition to the traditional Medicare system serves as an example of a successful transition to a universal health care system for America's seniors. After being signed into law in 1965, Medicare enrolled more than 19 million people in its first year.¹⁹⁶ Prior to the implementation of Medicare, only around half of America's seniors had health coverage, and the coverage available to them was not very good.¹⁹⁷ A survey in 1963 found that 80 percent of seniors paid for their own health costs out of pocket, without help from either government programs or private insurance.¹⁹⁸

Medicare has grown steadily since implementation and covered more than 58 million seniors and people with disabilities in 2017.¹⁹⁹ Supporting the transition to Medicare-for-All would be the more than 50 years of experience that the country already has with implementing and running Medicare. While the scope of the population served will expand significantly, the necessary functions and infrastructure are already in place. The Centers for Medicare and Medicaid Services already has the capacity to enroll

¹⁹⁵Jessie Hellmann, *Obama Calls 'Medicare for All' a 'Good' Idea*, THE HILL (September 7, 2018), <https://bit.ly/2z7fWIs>.
Angie Drobnic Holan, *Obama Statements on Single-Payer have Changed a Bit*, POLITIFACT (July 16, 2009), <https://bit.ly/20UNlvn>.

¹⁹⁶Steve Anderson, *A Brief History of Medicare in America*, MEDICARE RESOURCES (February 27, 2018), <https://bit.ly/298fU4W>.

¹⁹⁷Louis Jacobson, *Were the Early 1960s a Golden Age for Health Care?*, POLITIFACT (April 12, 2012), <https://bit.ly/2UpFvxs>.
¹⁹⁸*Id.*

¹⁹⁹Steve Anderson, *A Brief History of Medicare in America*, MEDICARE RESOURCES (February 27, 2018), <https://bit.ly/298fU4W>.

beneficiaries and physicians, process claims, and engage stakeholders. This expertise will serve the program well both during the transition to Medicare-for-All and upon full implementation.

2. Implementation of Medicare-for-All Would Likely Take Place Over a Few Years

A key question about Medicare-for-All is how to transition from our current fragmented health care system to a more efficient, single-payer system. A slow and drawn-out transition may allow powerful interests more opportunities to hamper crucial reforms, but a too rapid transition may create challenges in ensuring everyone maintains access to the care they need as implementation proceeds.

A possible transition from our current system to Medicare-for-All would look something like the following, ideally over the course of a couple years from the passage of such legislation.

First, the 30 million uninsured should be immediately enrolled. This should include immigrants of all types, including those who are currently undocumented. While some have raised concerns about the effect of immigration on the cost of health care, immigrants to the U.S. are generally in better health than their U.S.-born counterparts.²⁰⁰ Other populations that could be rapidly transitioned into Medicare-for-All, potentially within a year of passage, including children currently enrolled in CHIP, beneficiaries of all ages enrolled in Medicaid, and adults age 50 or 55 and older. All other populations should be transitioned to Medicare-for-All within 2 to 3 years of passage.

Workers who receive their coverage through employer-sponsored insurance should be given the option to transition to Medicare-for-All. Employers should be given the option to continue providing coverage for their employees through any transition period, if they so choose, as long as employers maintain their contribution toward their workers' health insurance premiums (either as a percentage of the total worker's premium or the total premium contribution amount, whichever is greater) over the transition period.

Certain populations, including patients with complex long-term care needs, would need particular attention in the transition to Medicare-for-All, as any disruption in their care could lead to serious health consequences. For example, beneficiaries with complex medical needs would need to have consistent access to necessary services throughout the transition. Even a small gap in services could lead to significant challenges.

Once everyone is enrolled in Medicare-for-All, there would be no further need for additional coverage transitions. Everyone in the U.S. would finally be covered when they were born and remain covered throughout their lives.

We recommend that some health programs retain their autonomy, including the Veterans Health Administration and the Indian Health Service, as they provide specialized care to populations with unique medical needs. However, beneficiaries of such program would be able to supplement their coverage with services through Medicare-for-All, when appropriate.

²⁰⁰PEW RESEARCH CENTER FOR THE PEOPLE AND THE PRESS & PEW HISPANIC CENTER, AMERICA'S IMMIGRATION QUANDARY: NO CONSENSUS ON IMMIGRATION PROBLEM OR PROPOSED FIXES, at 7 (March 2006), <https://pewrsr.ch/2R50AJQ>.
Neil K. Mehta, et al, *Life Expectancy Among U.S.-born and Foreign-born Older Adults in the United States: Estimates from Linked Social Security and Medicare Data*, 53 DEMOGRAPHY 1109-1134, 1110 (2016).

3. Many Other Countries Already Have Implemented Universal, Single-Payer Health Care Systems, Including Taiwan and Canada

Of the 25 wealthiest countries in the world, the United States remains the only one that does not provide universal health care coverage.²⁰¹ Similarly, nearly all of the 35 countries in the Organization for Economic Co-operation and Development (OECD) have universal coverage, though some of those countries are far less wealthy than the United States.²⁰² Even though all countries continue to refine their health care systems over time, none of these countries would seek to create a system where they would pay more, cover fewer people, and deliver worse health outcomes.²⁰³

Taiwan is a good example of a country that implemented a single-payer health care system relatively recently. Since implementation in 1995, the Taiwanese health care system has grown into a high-quality system where enrollees can receive care from the doctor of their choice with almost no wait times.²⁰⁴ Having achieved universal coverage, Taiwan continued to make reforms to improve the long-term financial health of the program. Taiwan spent around 6.6 percent of its GDP on health care in 2012 and 2013, compared with the U.S. spending more than 16 percent of its GDP.²⁰⁵

Canada transitioned to a single-payer health care system more gradually, beginning with Saskatchewan in 1962, and subsequently to the rest of the country.²⁰⁶ By 1971, all Canadian provinces had implemented single-payer health care. Canada passed its universal health care legislation in 1966 with a start date of 1968.²⁰⁷ This relatively rapid uptake ensured that the momentum of the original passage continued through expansion into additional provinces.

By passing Medicare-for-All and ensuring a rapid but well-organized transition, the U.S. can finally slow spending, improve access, and improve the equity of health care for everyone in America. The longer we wait to begin the transition, the more lives are lost and more money is squandered unnecessarily.

²⁰¹Judith Rodin and David de Ferranti, *Universal Health Coverage: The Third Global Health Transition?*, 380 THE LANCET 861-862, 861 (2012).

²⁰²ORGANIZATION FOR ECONOMIC COOPERATION AND DEVELOPMENT, UNIVERSAL HEALTH COVERAGE AND HEALTH OUTCOMES, at 3 (July 2016), <https://bit.ly/2PYgAiq>.

²⁰³DANIEL COTLEAR, ET AL., WORLD BANK GROUP, GOING UNIVERSAL: HOW 24 DEVELOPING COUNTRIES ARE IMPLEMENTING UNIVERSAL HEALTH COVERAGE REFORMS FROM THE BOTTOM UP, at 53 (September 2015), <https://bit.ly/2GAlwlb>.
Anu Partanen, *The Fake Freedom of American Health Care*, THE NEW YORK TIMES (March 18, 2017), <https://nyti.ms/2nEdHFX>.

²⁰⁴Jonathan Cohn, *If You Don't Believe Single Payer Can Work, See How They Do It in Taiwan*, THE HUFFINGTON POST (September 8, 2018), <https://bit.ly/2N0elhh>.

²⁰⁵Tsung-Mei Cheng, *Taiwan's Health Care System: The Next 20 Years*, BROOKINGS (May 14, 2015), <https://brook.gs/2OH822i>.

²⁰⁶Lorne Brown and Doug Taylor, *The Birth of Medicare: From Saskatchewan's Breakthrough to Canada-wide Coverage*, CANADIAN DIMENSION (July 3, 2012), <https://bit.ly/1HuijmW>.

²⁰⁷*Id.*

Question: Would doctors and providers be paid less and, if so, how could they afford to pay off their medical school loans?

Answer: No, funding Medicare-for-All would not depend on reducing provider salaries and would provide great benefit to physicians and other providers.

Potential changes to pay for doctors and other health care providers remains a central question when considering Medicare-for-All. Provider pay would vary—as it does today—by specialty, care setting, and region. The extent to which provider pay under a Medicare-for-All system would differ from current pay will depend on the details of any final Medicare-for-All proposal.

Reasons That Medicare-for-All Would Improve Life for Physicians:

1. Doctors Account for Less than 10 Percent of Overall Medical Costs

Physician compensation accounts for less than 10 percent of total health care costs while physician and clinical services combined account for about 20 percent of health care spending.²⁰⁸ Therefore, developing a more affordable health care system would not rely significantly on driving down pay for physicians or other health care providers. Some providers, such as certain specialists and those who make significant ancillary income from related medical businesses, might find their overall pay is reduced or levels off over time. However, a recent estimate found that doctors would likely see no more than a 5 to 10 percent decrease in income under the Medicare-for-All plan proposed by Sen. Bernie Sanders (I-Vt.).²⁰⁹

But other providers, particularly family physicians, primary care doctors, and internists, likely would see pay increases because everyone in the United States would finally have health care coverage they can afford to use. Similarly, mental health providers may also find their compensation increase as demand for services increase because more people would be able to afford mental health care. Most insurers currently pay less for mental health care through a mental health provider than they do for similar services through primary care.²¹⁰ In addition, all types of insurance had significantly lower acceptance rates for psychiatrists than for other physician specialties, posing a challenge to accessing mental health services.²¹¹

²⁰⁸Press Release, Jackson Healthcare, *U.S. Physician Compensation Among Lowest of Western Nations, Survey Finds* (May 14, 2012), <https://bit.ly/2SccyHE>.

CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURES 2016 HIGHLIGHTS, at 1 (January 2018), <https://go.cms.gov/1V5YDcl>.

²⁰⁹Kevin Drum, *Bernie's "Medicare For All" Plan Would Cut Physician Payments About 10 Percent*, MOTHER JONES (August 21, 2018), <https://bit.ly/2ACbuDA>.

²¹⁰STEPHEN P. MELEK, DANIEL PERLMAN, AND STODDARD DAVENPORT, MILLIMAN, ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: ANALYZING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT RATES, at 4 (December 2017), <https://bit.ly/2nd7Adb>.

²¹¹Tara F. Bishop, et al., *Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care*, 71 JAMA PSYCHIATRY 176-181, 179(2014).

2. Medicare-for-All Would Provide Many Benefits for Physicians

A Medicare-for-All system would provide additional benefits to health care workers that may be even more important than pay alone. They potential benefits are a likely reason that that a growing number of doctors support single-payer health care.

A recent survey found that more than 55 percent of doctors now support a single-payer system, while in 2008 nearly 60 percent expressed opposition.²¹² In interviews conducted by the survey firm, physicians expressed exhaustion with all the paperwork and billing, which takes away time from treating patients.²¹³

These findings are bolstered by previous findings of dissatisfaction with the current system among providers.²¹⁴ A streamlined payment system would free up substantial time for providers to focus on providing care, instead of doing paperwork. A recent study that focused on four states found that physicians spent about two hours on administrative work for every hour they spent with patients.²¹⁵ Providers then spent another hour or two of their personal time each night on additional administrative tasks.

The excess level of paperwork is hurting physicians. A recent survey found that more than four in ten physicians reported experiencing burnout.²¹⁶ More than half of all physicians who reported experiencing burnout cited too many bureaucratic tasks (including filling out paperwork) as a key reason and nearly 40 percent reported spending too many hours at work as another contributing factor.²¹⁷

3. Medicare-for-All Would Mean Doctors No Longer Fear Their Own Health Care Costs

In addition—as with everyone else in America under Medicare-for-All—doctors and other providers would no longer have to worry about being one diagnosis away from catastrophic health care costs themselves. Just like the rest of us, medical professionals face the harsh reality of rising out-of-pocket costs and the potential for medical debt and bankruptcy. Through enacting Medicare-for-All, physicians and other providers will gain the peace of mind that should they get sick, they can focus on getting well instead of on fighting insurers over medical bills.

4. Medicare-for-All Could also Pay for Medical School, Thereby Reducing the Need for Outsized Salaries

Medical students often take on significant debt in the course of their training, with a median debt of around \$200,000. Though it has not yet been included in recent legislative proposals, a Medicare-for-All system could pay students' medical school tuition. Such a system would likely require participating

²¹²Rachel Bluth, *Doctors Warm to Single-Payer Health Care*, U.S. NEWS AND WORLD REPORT (August 16, 2017), <https://bit.ly/2yQYx7F>.

²¹³*Id.*

²¹⁴CAROL PECKHAM, MEDSCAPE, MEDSCAPE NATIONAL PHYSICIAN BURNOUT & DEPRESSION REPORT 2018, at 1 (January 2018), <https://wb.md/2Sy9ZNo>.

Liselotte N. Dyrbye And Tait D. Shanafelt, *Physician Burnout: A Potential Threat to Successful Health Care Reform*, 305 JAMA 2009-2010, 2009 (2011).

Susan Adams, *Why Do So Many Doctors Regret Their Job Choice?*, FORBES (April 27, 2012), <https://bit.ly/2QaD05a>.

²¹⁵Christine Sinsky, et al., *Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties*, 162 ANNALS OF INTERNAL MEDICINE 753-760, 758 (2016).

²¹⁶CAROL PECKHAM, MEDSCAPE, MEDSCAPE NATIONAL PHYSICIAN BURNOUT & DEPRESSION REPORT 2018, at 2 (January 2018), <https://wb.md/2Sy9ZNo>.

²¹⁷*Id.* 13.

physicians to agree to certain conditions to fill needs in the system. For example, having the government fund medical school could be tied to having medical students subsequently engage in some form of service, such as serving some part of their career in rural or underserved areas.

Medicare-for-All could therefore relieve physicians of debt that would otherwise follow them around for decades and limit their ability to pursue the medical practice of their choice. A recent study found that total debt and economic background played a key role in determining a physician's choice of medical specialty. This led to lower numbers of physicians choosing lower-paying specialties, such as primary care or family medicine.²¹⁸

One estimate found that paying for medical school for all doctors would cost somewhere between \$22 billion and \$29 billion a year.²¹⁹ That is less than 1 percent of the \$3.5 trillion dollars we spent on health care last year. Such an investment could help ensure that the pipeline of doctors better matches the changing health needs of an aging population, instead of pushing medical students into specialties with the highest salaries. In addition, providing such funding could improve opportunities for low-income Americans to enter medical professions. Building a more diverse pool of physicians that reflects America's future can only help to ensure patients are served by medical providers that understand them and can best meet their needs.

In addition, federal and state governments already fund a significant portion of doctors' medical education and training. Medicare currently pays for many doctors' residency—the program puts in about \$10 billion a year to teaching hospitals around the country to fund salaries for residents.²²⁰ In addition, other government programs pay more than \$4 billion a year, while state Medicaid agencies pay close to \$2 billion.²²¹ Medicare-for-All could improve the planning and coordination of this funding, particularly by tying it to health care system needs, to ensure there are sufficient doctors in the types of residency programs needed to treat the population as a whole.

By investing in our future doctors and other medical professionals, Medicare-for-All could help build a health care system that continues to recruit and train the best doctors, nurses, and other professionals while best meeting the needs of communities.

²¹⁸Andrew Bazemore, et al., *Over Half of Graduating Family Medicine Residents Report More Than \$150,000 in Educational Debt*, 29 JOURNAL OF THE AMERICAN BOARD OF FAMILY MEDICINE 180-181, 181 (2016).

²¹⁹The final amount may end up being lower given that these numbers do not include scholarships and other sources of support that students receive that could continue to help fund medical school education.

Dylan Scott, *Why Free Medical Training Might be the Key to Medicare-for-All*, VOX (August 20, 2018), <https://bit.ly/2CSBw6S>.

²²⁰U.S. GOVERNMENT ACCOUNTABILITY OFFICE, PHYSICIAN WORKFORCE: HHS NEEDS BETTER INFORMATION TO COMPREHENSIVELY EVALUATE GRADUATE MEDICAL EDUCATION FUNDING, at 18 (March 2018), <https://bit.ly/2E5Lz5p>.

²²¹*Id.*

Question: What would happen to workers in the health insurance industry?**Answer: A just transition to Medicare-for-All would ensure that former private insurance workers received the training and support necessary to pursue new careers.**

Under a Medicare-for-All system, private insurance companies would provide only those benefits not covered through the single-payer system. As such, there would be a significant decline in total employment within the private insurance industry. Such a reduction is necessary if we are to achieve Medicare-for-All's promise of significantly reducing administrative costs. Estimates for the number of workers who may be affected by implementation of Medicare-for-All range from around one to two million workers, with the median salary for many of these jobs being around \$40,000 a year.²²²

The transition to Medicare-for-All will not mean lost jobs for everyone, though. Insurance industry employees may continue to work in administrative functions, such as working for companies that Medicare-for-All may contract with to assist with billing and payments. Some of those affected would be health professionals, such as nurses or physician assistants, who have been relegated to administrative work and would now be able to provide health care. In addition, expansion of certain types of services, including long-term services and supports, mental health, and public health, may provide new opportunities for some former private insurance industry workers. Medicare-for-All will also lead to the creation of some additional government positions related to fraud detection and general administration of the program, which could be an additional opportunity for employment of those currently in the private industry sector.

Even with those opportunities, a number of workers will need to transition to other types of jobs or other sectors of the economy. The Medicare-for-All bills under consideration last Congress in both the House of Representatives and in the Senate included funding to help workers retrain and transition into other careers. The House version of the bill proposed establishing a fund to help clerical, administrative, and billing personal receive the necessary training and support to transition into other careers.²²³ In addition to retraining and job placement, workers would be eligible to receive two years of transition benefits equal to their salary during their last 12 months of employment.²²⁴ The Senate version allocated up to 1 percent of the total health care budget for programs to assist workers who performed health care administrative jobs that are no longer necessary under Medicare-for-All.²²⁵ This funding would be provided for up to five years from the date that Medicare-for-All is fully implemented. While it's true that many workers would no longer be needed to process paperwork, Medicare-for-All legislation has thoughtfully provided

²²²Steffie Woolhandler, et al., *Can Medicare for All Succeed?*, THE NATION (August 16, 2017), <https://bit.ly/2fp447P>.
Occupational Outlook Handbook: Healthcare Occupations, BUREAU OF LABOR STATISTICS, <https://bit.ly/2ioPBWl> (viewed on October 31, 2018).

Occupational Employment and Wages, May 2017: 43-6013 Medical Secretaries, BUREAU OF LABOR STATISTICS, <https://bit.ly/2yKAUgP> (viewed on October 31, 2018).

²²³Expanded and Improved Medicare for All Act, H.R. 676, 115th Cong. § 303(a) (2017), <https://bit.ly/2EUrdC2>.

²²⁴Such transition benefits are not to exceed \$100,000 a year.

²²⁵Medicare for All Act of 2017, S. 1804, 115th Cong. § 601(a)(4), <https://bit.ly/2l6llLZ>.

a path forward for affected individuals. Other transformational moments in our nations' history did not come with such guarantees like when wainwright and farrier jobs were no longer needed after the invention of the automobile.

Question: OK, Medicare-for-All sounds a lot better than our current system. But aren't there just too many powerful interests to get it passed?

Answer: Medicare-for-All opponents are likely to spend even more than they already do to ensure they continue profiting of our fragmented health care system but politicians must stand with the American people to pass Medicare-for-All.

Health care special interests spend typically more than \$500 million a year on lobbying—the largest share spent by any one industry and more than 15 percent of total lobbying spending across all industries and on all subjects.²²⁶ In 2017 alone, companies that profit from our fragmented health care system spent the overwhelming majority of the \$660 million total that was spent on health care lobbying, highlighting the robust opposition Medicare-for-All will face.²²⁷ However, support for Medicare-for-All continues to grow both in Congress and among the American public. Congressional support is at a record level in both the Senate and the House of Representatives, with 16 Senators co-sponsoring the most recent version of Sen. Sanders' Medicare-for-All bill and 124 members of the House of Representatives co-sponsoring the Medicare-for-All bill in the House in the 115th Congress.²²⁸ Many of the senators co-sponsoring Medicare-for-All are considered potential presidential contenders in 2020 and beyond, highlighting how much Congress has moved toward embracing single-payer health care. However, the ongoing power of corporate cash in influencing policy can be seen in the fact that Democratic senators who did not co-sponsor the bill received nearly twice as much money from the health care industry, on average, since 2010 as did Democrats that chose to co-sponsor the bill.²²⁹

Americans across the country are demanding a better health care system generally and Medicare-for-All specifically, including growing support from Republicans. In a recent poll, nearly 75 percent of Americans said there needed to be changes to the health care system.²³⁰ More than half of respondents that supported reform were in favor of making big changes to the health care system, as opposed to just smaller changes. Another recent poll found that 70 percent of Americans support Medicare-for-All, including 85 percent of Democrats and a majority of Republicans (52 percent) [Figure 38].²³¹

²²⁶Emily Rappleye, *Top 25 Lobbyists by Spending: Who Spent on Healthcare Issues in 2016*, BECKER'S HOSPITAL REVIEW (February 8, 2017), <https://bit.ly/2Oja7x9>.

²²⁷CRAIG SANDLER, PUBLIC CITIZEN, THE \$660 MILLION HURDLE, at 4 (October 2018), <https://bit.ly/2S4m6of>.

²²⁸Medicare for All Act of 2017, S. 1804, 115th Cong. § 601(a)(4), <https://bit.ly/2l6llLZ> and Expanded and Improved Medicare for All Act, H.R. 676, 115th Cong. § 303(a) (2017), <https://bit.ly/2EUrdC2>.

²²⁹Cosponsors of Sanders' bill received nearly \$24,000, on average, from the insurance industry since 2010 while Democratic senators who have yet to cosponsor the legislation received more than \$55,000, on average.

ANDREW PEREZ, MAPLIGHT, DEMOCRATIC HOLDOUTS ON "MEDICARE FOR ALL" HAVE RECEIVED TWICE AS MUCH INSURANCE INDUSTRY CASH AS SPONSORS, at 1 (September 2017), <https://bit.ly/2eY10Eb>.

²³⁰IPSOS, HEALTH CARE EXPERIENCE STUDY, at 34 (April 2018), <https://bit.ly/2TjJRpr>.

²³¹Megan Keller, *Seventy Percent of Americans Support 'Medicare for All' in New Poll*, THE HILL (August 23, 2018), <https://bit.ly/2xCbVLU>.

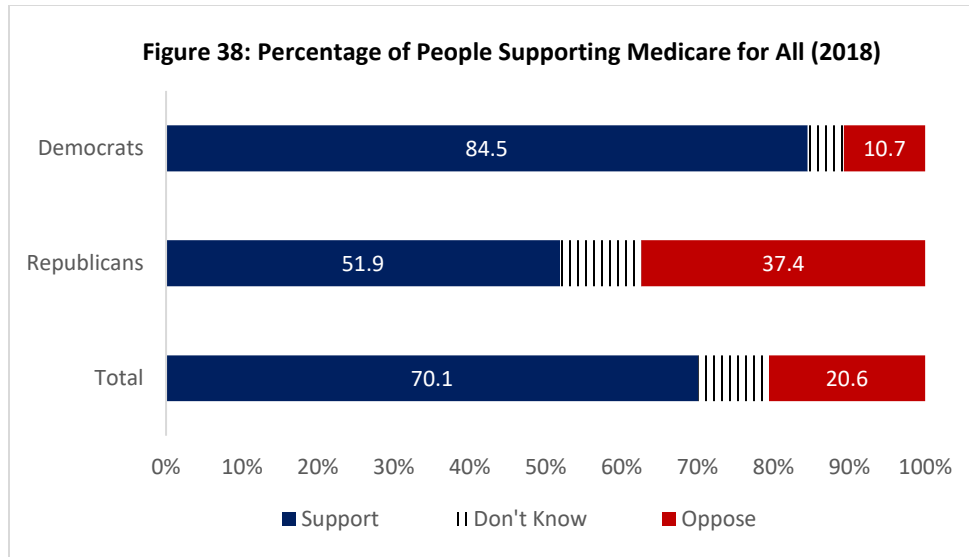


Figure note: Survey was of a random sample of nearly 3,000 American adults between June and July 2018.²³²

Rising drug prices and out-of-pocket costs, combined with insurers limiting provider choice and denying necessary coverage has created a health care affordability crisis for many Americans. A recent poll found that most Americans, 85 percent, had concerns about the cost of health care.²³³ Concerns about health care ranked higher than concerns about other important issues, including the cost of retirement, higher education, housing, and child care. The top concerns cited by respondents were the cost of health insurance premiums and out-of-pocket costs, including co-pays for services or deductibles.²³⁴

This should not be a surprise given that so many Americans are struggling to get the care they need, despite recent reforms. While the Affordable Care Act (ACA), commonly referred to as Obamacare, has improved access to insurance and care, we still trail behind comparable countries in both access to care and health outcomes.²³⁵ While the ACA expanded coverage to millions, it did so by building upon our already fragmented health care system, without challenging entrenched interests.

The ACA led to health care coverage for 20 million Americans through the Medicaid expansion and the ACA marketplaces. Coverage through the ACA has been a lifeline for many Americans. However, since coming into office, the Trump administration and allies in Congress have taken a number of steps to undermine the ACA, including ending the individual mandate that required that all Americans have

²³²Megan Keller, *Seventy Percent of Americans Support 'Medicare for All' in New Poll*, THE HILL (August 23, 2018), <https://bit.ly/2xCbVLU>.

²³³IPSOS, HEALTH CARE EXPERIENCE STUDY, at 8 (April 2018), <https://bit.ly/2TjRpr>.

²³⁴*Id.* 11.

²³⁵In 2013, 37 percent of respondents (and 51 percent of low-income respondents, defined as those whose annual income was below \$25,000) had cost related access problems within the past year. By 2016, that number had decreased somewhat, to 33 percent of respondents (and 43 percent of low-income respondents). This compared to an average of 13 percent, which was consistent between 2013 and 2016, across 10 other high-income countries (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the United Kingdom).

DANA O. SARNAK, ET AL., THE COMMONWEALTH FUND, FEWER AMERICANS SAY COST IS A BARRIER TO GETTING CARE, BUT U.S. STILL HAS A LONG WAY TO GO, at 1 (November 2016), <https://bit.ly/2OfPqIG>.

insurance and expanding the availability of health plans that do not protect Americans with pre-existing conditions.

We will be able to pass Medicare-for-All only by continuing to build grassroots support and taking on entrenched health care interests. The people power on this issue continues to intensify as Americans feel the pain of a health care system that is focused more on profit than it is on providing health care. Polls show that Americans are hungry for bold, systemic transformation of the system. While it's true that those who profit from the current system will put everything they have behind hindering reform, it is impossible to override the moral imperative that everyone in the U.S. deserves access to health care. The American people won't stop pushing for significant change. The question is not if we will win, it is when.

Conclusion

It is inhumane to have 30 million Americans lack any form of health care coverage, placing them at risk for personal and financial ruin if they get sick. Further, having so many Americans uninsured leads to tens of thousands of needless deaths each year.²³⁶ The United States has too long debated creating a universal health care system without delivering. Despite this failure, Medicare has successfully achieved universal coverage for Americans 65 and older since its passage more than 50 years ago. The success of Medicare highlights the importance of building on that program's success and finally extending guaranteed access to health care to everyone in America.

Everyone depends on the health care system at some time in their lives. From the moment you are born (likely at a hospital) to the day you die, you are part of the health care system whether you are healthy or sick. Even when we feel perfectly fine and haven't had a checkup, the health care system serves and protects us through development of vaccines, control of infectious disease, and research on ailments likely to befall us, our family, or our community.

And because we rarely know when we might experience our next brush with illness or injury, we need the health care system ready and waiting, just in case.

Despite recent reforms, many Americans continue to struggle to get the care they need. In addition, we continue to trail behind comparable countries in both access to care and health outcomes. Recent Congressional and Administration efforts to end the individual mandate and weaken ACA protections have only made things worse. And with a federal judge in Texas striking down the Affordable Care Act, setting up the likelihood of case reaching the U.S. Supreme Court, health care for millions of Americans remains under intense threat, including extremely popular provisions of the law such as protections against discrimination against people with pre-existing conditions.²³⁷

Thankfully, momentum for a better system is growing. The public outcry for a fairer system that allows everyone access to the care they need will only get stronger as costs continue to rise.

Medicare-for-All would improve the current Medicare program and expand it to everyone in the United States. Such a health care system would provide better access to care and would be far more efficient than our fragmented health care system. The successful experience of other nations implementing similar programs for their citizens shows what great potential such a system has for improving the lives of everyone in the United States.

Though a single-payer health care system should have been implemented decades ago, as was suggested shortly after the passage of Medicare, the current political and legal battles over our existing health care system provide us the perfect opportunity to create a system that will stand the test of time. By ensuring that everyone in the U.S. has access to high-quality health care throughout their lives, including

²³⁶Steffie Woolhandler and David U. Himmelstein, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 *Annals of Internal Medicine* 424-431, 429 (2017).

²³⁷Ariane de Vogue and Tami Luhby, *Federal judge in Texas strikes down Affordable Care Act*, CNN (December 15, 2018), <https://cnn.it/2QZ7rKe>.

preventative services and consistent treatment for chronic illnesses, Americans will be able to live healthier and more fulfilling lives.