# Estimating the Cost of a Single-Payer Plan

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**In June 2018, the Mercatus Center at George Mason University released a report in which they found that the Medicare for All Act of 2017,[1] introduced by Senator Bernie Sanders, would increase federal spending by $32 trillion dollars over its first 10 years of implementation (Blahous 2018). The Medicare for All Act (MFA) would provide universal health insurance coverage with no premiums, no deductibles or other forms of cost sharing (with the possible exception of modest beneficiary contributions for nongeneric prescription drugs and biologics), broad covered benefits, and tight constraints on provider payment rates. The new program would be fully tax financed. The Mercatus Center report received considerable press attention.[2] Frequently, media reports on the Mercatus report mention that the results are similar to those found by the Urban Institute's 2016 analysis of Sanders's presidential health reform proposal (Holahan et al. 2016). In that study, we estimated that Sanders's presidential proposal would increase federal health expenditures by $32.6 trillion dollars over 10 years.**

## Behind the Estimates

These results seem remarkably similar; however, there are important differences between the analyses. In this brief, we delineate the largest differences between the two approaches.

- The studies analyze different time periods; the Mercatus Center study provides estimates for 2022 through 2031, and the Urban Institute provides estimates for 2017 through 2026.

- The Urban Institute assumed an expansion in long-term services and supports as part of the plan, consistent with Sanders's presidential health reform proposal. MFA, the proposal analyzed by the Mercatus Center, does not include an expansion of long-term care benefits initially.
- The main scenario estimated in the Mercatus Center study (and the one most frequently cited) assumed providers would be paid at Medicare payment rates under MFA. The Urban Institute assumed that physicians and other professionals would be paid at Medicare rates, but that hospitals would be paid at rates equal to hospital costs. This means that not only would private rates be reduced, but Medicare and Medicaid rates for hospitals would be increased. Because Medicare and Medicaid rates are about 10 percent below hospital costs,[3] the Mercatus Center therefore assumes a greater cut in hospital payment rates under MFA.
- The Mercatus Center team assumed a four-year phase-in of MFA, consistent with the bill. The Urban Institute did not assume a phase-in.

Because of the research teams' different assumptions, the two sets of findings are not directly comparable. The Urban Institute team's 10-year estimate of the increase in federal spending would be higher, closer to $40 trillion, if we had estimated program costs over the same period as the Mercatus Center. The additional federal costs would be $2.9 trillion lower ($3.6 trillion lower using the later budget window) if we had not assumed expansion of long-term care services. These two adjustments would move the Urban Institute estimates of a 10-year increase in federal costs to roughly $36 trillion dollars, which would be even lower if we had assumed a phase-in period.

The Urban Institute estimates would also be lower if we had assumed hospitals would be paid at Medicare rates, instead of reimbursing hospitals at the level of their costs. The Urban Institute assumed that prescription drugs would be paid for at levels midway between Medicare and Medicaid rates; it is not clear from the Mercatus Center analysis how they derived their prescription drug cost savings. The Urban Institute analysis may also have estimated larger increases in health care utilization because the currently insured would have comprehensive first-dollar coverage under the reform (Blahous 2018, 9; Holahan et al. 2016, 10).

The two research teams have made similar assumptions on the level of administrative costs associated with the single-payer plans, and thus their estimated savings from lower average administrative costs seem similar. Both teams' estimates indicate that federal spending on health care (Medicare, Medicaid, tax subsidies, and other federal payments) would more than double under the Sanders proposal. It would also increase total federal government spending, both mandatory and discretionary, by about 50 percent in 2022 (Blahous 2018) and 60 percent in 2017 (Holahan et al. 2016).[4]

The studies' estimates of national health expenditures also differ. The Urban Institute estimates that, under Sanders's presidential campaign plan, national health spending would have increased by $450.5 billion in 2017 (without long-term services and supports), or by about 13 percent. The Mercatus Center study estimates $93 billion in health savings in 2022, or a 2.0 percent decrease in spending,

though savings would decrease once the plan was fully phased in. The difference between a 13 percent increase and a 2 percent decrease in national health spending is largely attributable to the studies' different assumptions about hospital payment rates and the Mercatus Center's use of a phase-in schedule. And, although the Mercatus Center study assumed Medicare provider payment rates in its central estimates, the report includes estimates with higher assumed payment rates too. Charles Blahous, author of the Mercatus Center study, has said that, although he used Medicare hospital and physician payment rates as specified in the MFA bill, he believes the payment rates would be significantly higher in practice.[5] The Mercatus Center paper does provide alternative estimates of the effects of MFA with higher payment rates that yield a $219 billion increase in national health expenditures in 2022. This compares with the Urban Institute's estimated increase in National Health Expenditures of $450.5 billion in 2017, noted above.

Although the studies' findings are not directly comparable as published, after taking different assumptions into account and making adjustments for them, the estimates of the impact on both federal and national health spending are not substantively different. A health reform that provides such a large increase in coverage with very broad benefits and essentially no cost-sharing requirements will lead to higher levels of national expenditures, even when private sector provider payment rates are reduced to the level of provider costs. Reducing provider payment rates further risks creating provider supply shortages and impeding access to necessary medical care. Having the federal government take responsibility for national health spending would mean an extremely large impact on the federal budget, although it would create substantial private sector savings by eliminating employers' and households' premium and direct spending on care.

Lowering provider payment rates to the levels suggested in the Urban Institute analysis would still best be phased in over a considerable period to minimize disruption to the health care system. Even the payment rate cuts assumed in the Urban Institute study could be politically infeasible to implement. If so, estimates in both studies could significantly understate the federal and system-wide costs of this reform.

Rather than significant, abrupt reductions in provider payment rates, a more practical goal may be to put a system in place that would focus more on slowing the rate of growth in per capita health care spending to approximate the growth in per capita gross domestic product. Once that goal is reached, further savings could be achieved by modest, incremental reductions in provider payment rates. If that can be achieved, increases in economic output would not be disproportionately devoted to increasing health spending. Per capita health spending in the US could remain considerably higher than that of other nations, but the difference would decrease over time.

# A Path Forward

Although our analysis, the Mercatus Center analysis, and a prior analysis by Kenneth Thorpe all find that the MFA plan would necessitate large increases in federal government spending,[6] other approaches could approximate universal coverage at lower levels of new government spending.

Requiring smaller increases in tax revenue to support them, these approaches could make significant advances toward improving affordability and accessibility of medical care while possibly engendering broader political support than the MFA strategy. MFA is extremely comprehensive—universal coverage for all US residents, a broad benefit package, almost no cost-sharing requirements, and complete elimination of private health insurance. This expansive approach, even with administrative cost savings and large provider payment rate cuts, will inevitably increase the federal budget substantially.

Even the current Medicare program is different than the MFA formulation of a single-payer plan. Medicare covers fewer benefits and imposes substantial deductibles and other cost-sharing requirements on beneficiaries, and the coverage through the traditional program has no overall out-of-pocket maximums. Program costs are heavily subsidized, but most beneficiaries pay about 25 percent of the cost for both Part B (professional services) and Part D (prescription drugs) in the traditional plan. Many traditional Medicare enrollees also purchase private supplementary coverage to reduce cost-sharing requirements and cover additional benefits. Medicare also has a "Medicare Advantage" component that allows beneficiaries to enroll in one of several private managed care plans. These private plans offer combined benefits from the traditional plans' Parts A, B, and D. MFA would eliminate these Medicare Advantage options and all other private insurance.

A number of central design choices affect the federal costs of a universal or near-universal coverage program. The key decisions that affect government budget costs are as follows:

1. What levels of beneficiary cost-sharing requirements are acceptable, and how should they vary by family income to assure affordable access to necessary care for the full population?
2. Is there a role for premiums (as in many other countries' universal systems), and, if so, how might they be structured to account for differing abilities to pay?
3. What services will be covered by the benefit package? Should they be the same as, or less generous than, the Affordable Care Act's essential health benefit? Should they also include long-term services and supports, vision, hearing, and dental care?
4. At what levels will health care providers (e.g., physicians, hospitals, pharmaceutical companies) be paid for their services? How much below current private payment levels is feasible? How will changes from current payment rates be phased in to reduce system disruption?
5. Will there be options for individuals to keep employer-based insurance coverage? Will people have a choice to purchase private individual insurance or supplements to the public insurance?
6. How fast will people transition from their pre-reform coverage to their new insurance?

In table 1, we summarize a number of proposed reforms that address these design issues differently than the MFA and would significantly expand care coverage, affordability, and access to care. Some have been introduced by members of Congress (Senator Elizabeth Warren; Senators Tim Kaine and Michael Bennet; Senators Jeff Merkley and Chris Murphy; and Senator Bernie Sanders) and others by academic or research organizations (Jacob Hacker of Yale University; The Center for American Progress; and Linda Blumberg, John Holahan, and Stephen Zuckerman of the Urban Institute). The

proposals vary in how close they would get to universal coverage, scope of benefits, treatment of current Medicaid and Medicare programs, employer requirements (if any), use of premiums and cost sharing, how provider payment rates are set, and whether there is autoenrollment for some groups or for all. They also would differ in their impact on national health spending and the federal budget.

# Conclusion

Although, if adopted and implemented, the MFA approach would largely eliminate private spending on health care services, significantly lower average administrative costs, and lead to universal insurance coverage, the proposal raises several practical concerns. Lowering provider payment rates to the extent proposed could significantly disrupt US health care providers, risking supply constraints. Extensive benefits with virtually no enrollee cost-sharing requirements would increase demand for health care services. Combined with the proposed elimination of private insurance, these changes would necessitate very large increases in federal government spending and sufficient revenue sources to finance it. The political barriers to such a broad-based change, particularly moving from where we are now, may prove insurmountable. Several alternative approaches could dramatically reduce the number of uninsured, improve affordability and adequacy of coverage, further contain per capita health care spending, and have less impact on the federal budget. These approaches could be seen as goals in themselves or as first steps toward a unified national system.

TABLE 1

**Health Reform Proposals**

| | Medicare-X (Kaine-Bennet) | Consumer Health Insurance Protection Act (Warren) | Choose Medicare Act (Murphy-Merkley) | Healthy America (Blumberg, Holahan, Zuckerman of Urban Institute) | Medicare Part E (Hacker of Yale University) | Medicare Extra (Center for American Progress) | Medicare for All (Sanders) |
|---|---|---|---|---|---|---|---|
| Who is eligible for the new program? | ACA Marketplace–eligible individuals and small groups | No new program; enhancements to existing programs | All residents except Medicare, Medicaid, or CHIP eligibles | All people lawfully present younger than age 65 | All people lawfully present in the US | All people lawfully present in the US | All US residents |
| What's in the program? | New public plan option offered on ACA Marketplaces as an alternative to participating private plans | Enhancements to the ACA, including increased premium and cost-sharing subsidies, limits on prescription drug cost sharing, "family glitch" fix, and strengthened private insurance regulations | New public plan available in individual and small- and large-group markets; enhanced cost-sharing protections; extension of Marketplace tax credits to 600% FPL; Medicare out-of-pocket maximum; and Rx price negotiation | New public plan option; restructured private nongroup insurance market; enhanced premium and cost-sharing subsidies; new incentive to remain insured | New public plan option available to all people lawfully present in the US | New public program with broad benefits and income-related premiums and cost-sharing; all are autoenrolled with no opt-out option | Single-payer system enrolling all US residents in a single plan |
| Does the separate Medicaid program continue? | Yes | Yes | Yes | Medicaid acute care program and CHIP end, with enrollees folded into other programs; long-term services and supports program continues as under current law | Yes, but with some increased reimbursement rates | No | No |

| | Medicare-X (Kaine-Bennet) | Consumer Health Insurance Protection Act (Warren) | Choose Medicare Act (Murphy-Merkley) | Healthy America (Blumberg, Holahan, Zuckerman of Urban Institute) | Medicare Part E (Hacker of Yale University) | Medicare Extra (Center for American Progress) | Medicare for All (Sanders) |
|---|---|---|---|---|---|---|---|
| Are states required to make maintenance-of-effort contributions? | Not applicable | Not applicable | Not applicable | Yes, but only for spending on acute care for the nonelderly | No | Yes, for all spending, including care for the elderly and LTSS | No |
| Does the separate Medicare program continue? | Yes | Yes | Yes, with federal Rx price negotiation and new out-of-pocket maximum for Parts A and B | Yes | Yes | Yes, people can stay in Medicare or switch to Medicare Extra for superior benefits, out-of-pocket limits | No |
| Does the private insurance market remain? | Yes | Yes, with strengthened regulations in small- and nongroup markets | Yes | Yes, for group and nongroup private insurers; no firewall between employer coverage and new program | Yes; employer insurance and Medicare Advantage plans continue to be offered | Employer market remains; employers can choose to enroll their workers in Medicare Extra | No |
| What benefits are offered? | ACA essential health benefits | ACA essential health benefits | ACA essential health benefits plus others offered in Medicare | ACA essential health benefits | ACA essential health benefits | ACA essential health benefits plus dental, vision, and LTSS | All medically necessary acute care and dental, vision, and hearing care; LTSS stay the same as under current Medicaid program |

| | Medicare-X (Kaine-Bennet) | Consumer Health Insurance Protection Act (Warren) | Choose Medicare Act (Murphy-Merkley) | Healthy America (Blumberg, Holahan, Zuckerman of Urban Institute) | Medicare Part E (Hacker of Yale University) | Medicare Extra (Center for American Progress) | Medicare for All (Sanders) |
|---|---|---|---|---|---|---|---|
| How much are household premiums? | Same as under current law | Marketplace premiums range from 0 to 8.5% of income; premium subsidies are tied to 80% actuarial value plan | Premium subsidies tied to 80% actuarial value plan plus extension of Marketplace tax credit schedule to 600% FPL | Premiums range from 0 to 8.5% of income; premium subsidies are tied to 80% actuarial value plan | Related to income | Premiums range from 0 to 10% of income | None |
| What are the cost-sharing requirements? | Same as under current law | Cost-sharing subsidies increase Marketplace plan actuarial value above 80% for people with incomes up to 400% of FPL | Enhancement of ACA Marketplace cost-sharing subsidies and extension to 300 percent of FPL | Cost-sharing subsidies increase actuarial value above 80% for people with incomes up to 300% of FPL; cost-sharing options with actuarial value below 80% also available | Similar to ACA | Deductibles, copayments, and out-of-pocket limits vary with income, but none are below 80% actuarial value | None, except limited cost-sharing for non-generic Rx drugs possible |
| Are people automatically enrolled? | No | No | No | Only SNAP and TANF enrollees, who face no premiums are autoenrolled; others without premiums can enroll in public plan at any time | Yes, all are enrolled and required to pay premiums; no open enrollment period | Yes, premiums are collected through the tax system so that no one can avoid premium payments | Yes |

| | Medicare-X (Kaine-Bennet) | Consumer Health Insurance Protection Act (Warren) | Choose Medicare Act (Murphy-Merkley) | Healthy America (Blumberg, Holahan, Zuckerman of Urban Institute) | Medicare Part E (Hacker of Yale University) | Medicare Extra (Center for American Progress) | Medicare for All (Sanders) |
|---|---|---|---|---|---|---|---|
| Do individuals face a penalty for remaining uninsured? | Current law (no, as of 2019) | Current law (no, as of 2019) | Current law (no, as of 2019) | Yes, structured as loss of a tax benefit, which can be partially refunded if people enroll in coverage later | No, all are enrolled | No; all are autoenrolled in Medicare Extra unless they choose an employer plan | No, all are enrolled in a single plan |
| Are there limits on provider payment rates? | Yes, for public plan | Prohibits balance billing for emergency room services | Yes, for public plan | Yes, for nongroup insurance markets | Yes, for Medicare Part E | Yes, for Medicare Extra and employer plans | Yes |
| Do employers face a penalty for not insuring workers? | Current law | Current law | Current law | No | Yes, varies with firm's average wage | Yes, "play or pay" requirements | No |
| Are there minimum standards for employer coverage? | Current law | Current law | Current law | No | Yes | Yes | Not applicable; employer insurance eliminated |
| Does the program lead to universal coverage? | No, but it will increase coverage | No, but it will increase coverage | No, but it will increase coverage | Close to universal for legal residents (not for undocumented people) | Yes, for legal residents (not for undocumented people) | Yes, for legal residents (not for undocumented people) | Yes |

**Sources:** Medicare-X Choice Act of 2017, S. 1970, 115th Cong. (Oct. 17, 2017); Consumer Health Insurance Protection Act of 2018, S. 2582, 115th Cong. (Mar. 21, 2018); Choose Medicare Act, S.2708, 115th Cong. (Apr. 18, 2018); Blumberg, Holahan, and Zuckerman (2018); Jacob S. Hacker, "The Road to Medicare for Everyone," *American Prospect*, January 3, 2018; "Medicare Extra for All: A Plan to Guarantee Universal Health Coverage in the United States," Center for American Progress, February 22, 2018; Medicare for All Act of 2017, S. 1804, 115th Cong. (Sept. 13, 2017).

**Notes:** ACA = Affordable Care Act; FPL = federal poverty level; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families, LTSS= Long-Term Services and Supports.

# Notes

[1] Medicare for All Act of 2017, S.1804, Sec. 202. No Cost-Sharing, 115th Cong. (Sept. 13, 2017).

[2] For examples of the Mercatus Center report's press coverage, please see the following: "'Medicare for All' Could Cost $32.6 Trillion, George Mason Study Says," *Time*, July 30, 2018; Louis Jacobson, "Did conservative study show big savings for Bernie Sanders' Medicare for All plan?" *Politifact*, August 3, 2018; James Freeman, "What Kind of Socialist is Bernie Sanders?" *Wall Street Journal*, August 21, 2018; Jeff Stein, "What would Sanders's 'Medicare-for-all' plan mean for doctor pay?" *Washington Post*, August 27, 2018; Michael Hiltzik, "A Koch-funded think tank tries hard to pretend that it didn't find savings from Bernie Sanders' Medicare plan," *Los Angeles Times*, August 22, 2018; Dylan Scott, "The revealing Medicare-for-all fact-check debate roiling the internet, explained," *Vox*, August 23, 2018

[3] "Table 4.4: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1995– 2016," *Trendwatch Chartbook 2018*, American Hospital Association, accessed September 28, 2018, https://www.aha.org/system/files/2018-05/2018-chartbook-table-4-4.pdf.

[4] In calculating the percent increase in total government spending per the analyses' estimated increases in federal health care spending, we relied upon Congressional Budget Office (2018)'s estimates of total government spending of $4.0 trillion in 2017 and $5.3 trillion in 2022. The Urban Institute estimated a $2.5 trillion increase in federal government spending in 2017, and Mercatus Center estimated an increase of $2.5 trillion in 2022.

[5] Robert Farley, "The Cost of Medicare For All," FactCheck.Org, August 10, 2018, https://www.factcheck.org/2018/08/the-cost-of-medicare-for-all/.

[6] Kenneth Thorpe, "An Analysis of Senator Sanders Single Payer Plan," Emory University, January 27, 2016, https://www.healthcare-now.org/296831690-Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal.pdf.

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**John Holahan** is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

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