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Understanding Medicare-for-All

What is Medicare-for-All?

At its most basic, a single-payer Medicare-for-All system simplifies the health care system by having the government act as the single payer for everyone's health care—as it currently does for seniors through Medicare—and takes the middle-man (private, for-profit insurance companies) out of the equation. Every American resident would be enrolled automatically at birth and beneficiaries could access high-quality care with little or no out-of-pocket expenses. Covering all Americans under Medicare-for-All would allow improved access to care throughout a person's life, including improved access to preventative measures and earlier detection of acute and chronic illnesses, allowing earlier treatment.

Medicare-for-All, whether H.R. 676 or Sen. Sanders' forthcoming legislation, would be similar in many ways to today's Medicare, but with improved access, decreased health system costs, and more consistent care standards. The federal government would be the primary payer, but health care delivery would still be provided by a mix of private and public doctors and hospitals, as it is today.

Medicare-for-All would streamline payments to physicians and free up substantial physician time for patient care by reducing burdensome interactions with multiple insurers. Medical providers would be compensated either through negotiated global budgets (for institutions) or set rates (for private practitioners). Provider salaries will continue to vary by specialty and geography, with the potential for better management, through negotiated rates, of the balance between primary care and specialty providers. The federal government would handle program administration, including payment and oversight. Federal management could reduce the cost of prescriptions drugs through direct negotiation with drug companies and improve care through cost-effectiveness research and better data collection.

What challenges does the current U.S. health care system face?

The U.S. spends far more, per capita, than any other country—even countries with universal health care coverage. This is true despite the fact that nearly 30 million Americans remain uninsured under our current system. Many of the countries that spend far less than the U.S. actually achieve better health outcomes. In addition, the U.S. ranks last out of 16 industrialized countries when it comes to preventing deaths with proper medical care.

Depending on how the estimates are calculated, federal, state, and local government currently pay between 46 percent and 64 percent of U.S. health care costs. This is because government heavily subsidizes employer-sponsored health insurance and also covers a number of vulnerable and expensive populations through public insurance, including elderly Americans, many Americans with disabilities, veterans, and many children.

Nearly one-third of total U.S. health care spending is on administration instead of patient care. In addition, administrative costs consume 25 percent of U.S. hospital spending. If our administrative costs were similar to other countries, we could potentially save more than $150 billion a year. For example, around 40 percent of the difference in health spending between U.S. and Canada is due to higher U.S. administrative costs.

Despite improvements in coverage through passage of the Affordable Care Act, tens of thousands of Americans still die each year because they lack access to quality health care. Further, Americans struggle to access care (doctor, hospital, surgery, etc.) at much higher rates than citizens of other comparable nations. In addition, over half of uninsured Americans and one out of five insured Americans reported difficulty paying medical bills. Medical bills contribute to more than 60 percent of all bankruptcies. Three-fourths of those bankrupted had health insurance at the time they got sick. While the Affordable Care Act reduced the accumulation of medical debt, it has not ended medical bankruptcy.

How much would a single-payer Medicare-for-All system cost and how would it be funded?

Under a Medicare-for-All system, total health spending would be funneled into the single-payer system, albeit after implementation of more effective cost controls (including global budgeting, negotiated drug prices, improved cost-effectiveness research, etc.). Potential additional funding options include a progressive tax on high-income earners, modest payroll taxes, a small tax on stock and bond transactions, changes to capital gains and dividend taxes, among other ideas. The exact taxes necessary will depend on final estimates of the cost of any given proposal.

Over forty studies have been conducted by a range of economists and actuarial firms estimating the impact of implementing Medicare-for-All legislation at the national or state level. Virtually all studies have found that a single-payer system could provide universal coverage at lower costs than our current health care system, findings that mirror the experience of countries with universal health care.

However, two outlier studies were published during the 2016 Democratic primaries by the Urban Institute and Kenneth Thorpe, claiming that a proposed single-payer plan would cost more than proposed revenues. Both estimates were critiqued by single-payer advocates (Urban issued a response to one of the critiques). More recently, the *Washington Post* used some back-of-the-envelope numbers to put the $32 trillion estimate of the Urban Institute into context by comparing it with an estimate for $49 trillion cost over ten years for the U.S. health care status quo.

Why single-payer Medicare-for-All over smaller changes to the status quo?

In addition to the moral argument that health care is a human right requiring universal access, there are economic reasons to move to a single-payer Medicare-for-All system. Our fragmented multi-payer health care system makes it impossible to control costs as efficiently as a Medicare-for-All system would. Switching to Medicare-for-All could potentially save $600 billion per year through reducing overhead costs and negotiating lower drug prices. Without reform, health costs will continue to rise quickly, across both public and private coverage. More incremental changes will be unable to attain the same level of administrative savings as other countries.

How do current Medicare-for-All proposals compare to health care systems in other countries?

Of the 25 wealthiest countries, the U.S. remains the only country without universal coverage. Similarly, nearly all of the 35 Organization for Economic Co-operation and Development (OECD) countries also have universal health coverage, though some of these countries are far less wealthy. 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.