THE PATH TO MEDICARE FOR ALL

Recommendations for a well-designed plan: A report of the American Council to Advance Medicare for All

Executive Summary

Introduction

In 1990, our national healthcare expenditures were $1.1 trillion. By 2016 it rose to $3.3 trillion; it is predicted to increase to $5.5 trillion by 2022. And despite having outstanding providers, superb research facilities and rapid development of innovative treatments, by all measures our health is worse than every other advanced country in the world. Unfortunately, all our attempts to improve efficiency and decrease costs have only resulted in the most expensive healthcare system. Healthcare currently takes up 26% of the federal budget and interest on our national debt of $21 trillion consumes another 6%. With a current budget deficit of almost $800 billion and healthcare spending growing faster than the gross domestic product (GDP), healthcare costs and interest on the debt will both increase to levels that will overwhelm the federal budget. According to the Congressional Budget Office (CBO) government debt has doubled in the past 10 years and will increase from 18% to almost 100% of gross domestic product (GDP) by 2028. The risk of unsupportable healthcare costs—to the point of financial collapse—is no longer a possibility, it is inevitable if our current system is not changed. Healthcare costs are now one of the most common causes of severe financial distress and personal bankruptcy. And over 25% of adults in the U.S. report they delayed or did not get healthcare because of the cost. How many people will be unaffected by 2028?

Despite the failure of the U.S. to provide healthcare coverage to 20 million people, other countries that cover 100% of their population have better health outcomes. This attempt in the U.S. to reduce costs by providing less coverage, as we will show, is inefficient and actually makes costs higher. The solution is to do the opposite—to provide health insurance for everyone and to go further by eliminating patient cost-sharing. This potential solution has been overlooked by policy experts because they believe it to be either too expensive or politically impossible to achieve. We show that neither belief is warranted. We show that an appropriately designed *Medicare for All* program will deliver the best outcomes for the population with the most effective cost control. *Medicare for All* can achieve benefits for all Americans and will therefore be able to gain the broadest acceptance throughout the community. Our current system contains so much waste and counter-productive spending that the money to fund *Medicare for All* can be easily obtained.

We have examined the proposals in Congress for Medicare for All, the House and the Senate versions, both of which have some shortcomings. We found that the Senate version can serve as a basic structure on which to base a well-designed *Medicare for All* plan. In addition, we have reviewed proposals for financing *Medicare for All* and have found some ideas suggested by Senator Sanders to have merit. We make recommendations that will create a *Medicare for All* plan with

affordable costs for health insurance coverage for individuals, businesses and government. Everyone in this country will benefit.

Key elements of a well-designed *Medicare for All* plan

- Eliminates all deductibles and copayments ensuring equal access to care and reducing costs by improving compliance with cost-saving care and reducing medical problems associated with chronic diseases.
- Ensures competitive premiums during transition, adjusted according to household income, by subsidizing them from healthcare savings.
- Ensures freedom of choice for patients and doctors.
- Reduces costs for all levels of government, businesses and individuals and provides other significant economic gains.
- Includes coverage for all services that improve health outcomes and reduce overall costs of care.
- Requires no new government bureaucracy.
- Reasonable transition period with provisions to encourage individuals to switch to Medicare allows time for adjustment and for savings to accrue.
- Enlists doctors in cost control by making them more aware of the relative value of services they order.
- Makes all health insurance secondary to Medicare instead of making duplicate insurance illegal—this makes the private insurance industry easier to maintain and relieves the burden of enforcement.
- Specifies the mechanism for claims processing by private insurance companies and provides increased funding for the higher volume of claims.
- Budgets for investments in education, training and infrastructure required for the program to succeed.
- Providers, the pharmaceutical industry and the insurance industry will be more secure compared to continuing our current course and their disruptions will be minimized.

The Problem

Despite the $3.3 trillion spent for healthcare in 2016 we have a lower life expectancy and higher mortality from treatable chronic diseases than any other advanced country. And while most wealthy countries cover almost 100% of their populations with much lower spending, almost 10% of the U.S. population has no health coverage. And although the U.S. has some of the most advanced medical technologies in the world, access to these technologies becomes more limited each year. We have unsuccessfully tried to fix our healthcare delivery system with piecemeal approaches. To have the kind of healthcare system that we should have—with accessibility, affordability and effectiveness—will require an entirely new system.

We looked at several possible solutions and found that all had serious problems. The systems used in Canada and Great Britain are more efficient than ours but

require strict government control of budgets and sometimes limit access to timely care. Those systems were also developed many years ago when healthcare was much simpler. It would be much more difficult to develop the tools our country would need to manage a system like those in these complex times. Although the Affordable Care Act (ACA) was a major advance, providing healthcare coverage for millions of people who never had it before, it has done little to restrain costs or improve efficiency. We looked at the previous proposal before the U.S. House of Representatives, H.R. 676, 2015 (*Medicare for All*) and found a number of drawbacks. It had all the problems of Canada's system, requiring a bureaucracy that does not now exist and will be difficult to create and, by eliminating virtually all private insurance, severely impairs Medicare's billing system, which is currently contracted out to private insurers. In addition, it would likely cause significant disruption of the economy with its rapid timetable for enactment. It also requires unexplained new taxes to pay for its costs. It does have some elements, however, that are worthy.

The newest proposal in the House, H.R. 1384, (*Medicare for All Act of 2019)* improves on H.R. 676 but retains most of its disadvantages, including eliminating most private insurance, an inadequate transition period, reliance on national budgets for cost control, and a failure to account for costs and savings.

We found the Senate version of *Medicare for All*, S. 1804, 2017, to have some attractive features, especially its 4-year transition and lack of additional bureaucracy. However, it had a number of problems that also needed to be addressed. We found the structure of S. 1804 provided a good starting point for a practical *Medicare for All* program. Senator Sanders introduced a revised version of this plan in May 2019, S. 1129, 2019. The only major change introduced in S. 1129 is the inclusion of home-based long-term care coverage in Medicare instead of Medicaid. However, the plan he proposed for financing *Medicare for All* during his campaign for presidency included reasonable concepts for basing individual premiums on household income above an initial threshold and similarly basing employer premiums on payroll above an initial threshold (although the amounts he used are unrealistic without resorting to other sources of revenue). [*]

Although the new versions of *Medicare for All* in the House and Senate are somewhat closer to each other than the previous versions were, major differences remain. Both bills still lack details essential for implementation. For simplicity, we present some recommendations here based on the previous version of the Senate bill, S. 1804, 2017. We consider these recommendations to be important considerations for an improved, well-designed *Medicare for All* plan.

[*]His financing plan specifically calls for individuals and employers to pay premiums as an option. He does not mention continuing payroll taxes, but since he does not account for the loss of $1.4 trillion in revenue over 10 years, we assume that his plan also assumed that these would continue.

Recommendations for a well-designed *Medicare for All* plan:

1. **Encourage Medicaid expansion during transition.** The current formula for federal sharing of Medicaid expenses will be changed from one based on income level of a state's residents to one based on the percentage of residents eligible for Medicaid under ACA expansion who are actually enrolled, using enrollment status before enactment of ACA as a baseline. This more correctly aligns the incentives of the state and federal governments. The federal share for previous enrollees would vary proportionately from 40% for no expansion to 60% for full expansion. New enrollees would continue to receive 90% federal sharing. The exemption allowing 90-day temporary insurance (or longer policies) will also be repealed. **Rationale**: Too many households will have inadequate healthcare insurance, both during transition and after full implementation, without full expansion of Medicaid.
2. **Allow private health insurance after implementation.** All private health insurance will be *secondary* to Medicare. Providers will have *no* obligation to file secondary claims on behalf of patients or provide any information other than a receipt with complete description of services provided. The provider will be responsible for ensuring that sufficient information is provided to Medicare so that the patient receives an explanation of benefits from Medicare promptly. Workers' Compensation, no-fault and all liability medical loss coverage will be secondary to Medicare. This will avoid confusion about responsibility for payment and ensure prompt treatment and provider reimbursement. There will be no need to have any of these policies reimburse Medicare for covered expenses. Instead, their costs will decrease. **Rationale**: Making duplication of Medicare coverage illegal, as in other plans, would cause a regulatory burden that would be difficult to enforce. It would also require elimination of many current policies and does not address delayed reimbursement and lack of access to care related to confusion about who the primary payer is. Although *Medicare for All* will significantly reduce out-of-pocket costs for individuals, there will still be out-of-pocket costs for some of the new additional services that will be covered only within limits (see below). Since premium costs will also be lowered, a market for secondary insurance will be guaranteed.
3. **Medicare billing.** Claims for Medicare will continue to be billed by contract with private insurance companies. Due to the increase in volume of claims and the increased importance of Medicare billing as a component of private insurance company business, the administrative budget for Medicare will be *increased*. One part of this increased budget will be for increased payments for the contracts to private insurers. **Rationale**: This will ensure continued access to quality claims processing.
4. **Medicare Advantage Plans.** Standard Medicare will be adding new benefits each year during transition. Therefore, Medicare Advantage Plans (Part C) will be required to inform all current and future enrollees of the differences in benefits offered between Medicare Parts A, B, and D, and Medicare Part C, including any additional restrictions, such as pre-approval requirements and restrictions on use of providers. Incentives for Part C may be revised by the Secretary to ensure program goals are met. **Rationale**: Part C plans currently

extract savings by negotiating lower rates from providers, reducing patients' choice of providers and increasing costs to patients. The Medicare Payment Advisory Commission (MedPAC) notes the costs to the Medicare program are 4% higher for Part C plans than for standard Medicare. Part C plans detract from the value of *Medicare for All* by increasing administrative complexity. Their administrative costs are much higher than standard Medicare (19.4% vs. 2.7%). Their value to patients is likely to decrease considerably throughout transition and after full implementation. Patients should be given all the information required to make the choice that is best for them. The Secretary should be given the authority to ensure, at the least, that Part C plans save Medicare money, if they are continued.

5. **Drug benefits**. Eliminate Part D as a separate benefit and include drug reimbursements in Part B as of the first day of transition. **Rationale**: Part D plans extract savings by negotiating discounts from drug companies. The Medicare trustees note that the bulk of savings from price reductions negotiated by Part D plans is retained by the plans, resulting in higher costs to the Medicare program and its beneficiaries. Part D plans also detract from the value of *Medicare for All* by increasing administrative complexity. However, Medicare may want to continue to contract with a Part D facilitator or with a pharmacy benefit manager on a competitive basis to administer the drug benefit on a cost-efficient basis. There is also no reason why several sponsors and/or managers could not achieve this goal in different regions, as long as there is one coordinated approach to drug benefits across the country.
6. **Transition of Medicaid services to Medicare.** Transfer all Medicaid services, including long-term care and home health care, from Medicaid to Medicare by the implementation date. At full implementation, Medicaid and CHIP will be discontinued as separate benefit programs. Payments for services for everyone on Medicare, regardless of original service plan, will be equal, although additional benefits may be available to those eligible for Medicaid and CHIP. Anyone eligible for Medicaid or CHIP will have, at a minimum, the same benefits under *Medicare for All* as they had previously (e.g., subsidized premiums, transportation costs reimbursed, additional dental services covered). Eligibility criteria for these supplemental benefits will be uniform, regardless of state of residence and will be determined by the Secretary in accordance with expanded access under the ACA. **Rationale**: Using a separate system to pay healthcare costs for the disabled and low-income families leads to reduced access to care, poorer health and, as a result, higher costs. Different criteria for coverage and reimbursement depending on state of residence allows for too much variability in the quality and cost of care and difficulties accessing care out-of-state. Inclusion of long-term care is critical to lower costs. Patients who have access to nursing home care have shorter hospital stays. Patients whose nursing home care is paid for without a skilled need use fewer physical therapy visits and other skilled care. Patients with access to personal care at home use fewer nursing home days. Medicaid and CHIP also have higher administrative costs than Medicare does (10.9% vs. 7%).
7. **Cost control.** Beginning with year 2 of transition, the Secretary will develop a Sustainable Health Index Fund Target (SHIFT) to measure the average cost of

services ordered by providers exclusive of their own fees, including imaging, laboratory, drugs and medical devices. The information will be collected into quarterly reports and forwarded to providers with comparisons to their peers. Significant outliers, adjusted for patient mix, may be considered for targeted chart review by CMS, which may result in suggested changes in practice and/or further follow-up. In addition, reports may be forwarded to appropriate medical specialty societies to assist with their own educational programs on value-based medical care. This will replace any specific national budgets and will replace the current Merit Based Incentive Payment System (MIPS). We recommend using Germany's model as a fair way to negotiate drug prices.

8. **Rationale**: SHIFT will ensure that providers help patients make the best choices regarding the value of care received by giving them relevant information about costs. SHIFT will also provide motivation to keep drug prices in line with value. A most favored nation approach to drug pricing will allow drug companies to continue high-quality research and development to provide innovative products while spreading the cost more fairly around the world.
9. **Funding.** The current funding process for Medicare will remain unchanged during transition, except that a new Medicare **Part E** Plan will be created to fund costs for those newly eligible as of the first day of transition. The Secretary will also be authorized to use surplus Part A funds (as determined by the Congressional Budget Office) to provide additional funding to Part B and/or Part E services as necessary to achieve the highest standards of care, including ensuring adequate reimbursement for underserved specialties, such as primary care, mental health and addiction services, with the advice of the Directors of the National Institutes of Health and the Centers for Disease Control and Prevention. **Rationale**: Changing the funding to a universal fund has its attractiveness, but we feel the less that is changed initially the better. Retaining Medicare Part A as a separate fund allows for continued funding of hospital and hospice payments while program costs and savings are assessed. Giving control of the flow of funds to the Secretary, after appropriate consultation, minimizes the risk of Congressional changes based on political expediency. However, after transition, creation of a universal fund may be desirable.
10. **The following are recommendations for the four-year transition plan:**
    a) **Eligibility.** All adults age 18-64 will be eligible for Medicare beginning the first day of transition (Enhanced Eligibility Medicare—EEM). Dependent children will also be eligible. **Rationale**: Making everyone eligible for Medicare from the first day of transition will improve the effectiveness of the transition to a balanced patient population.
    b) **New services.** A new coverage benefit for patient education by nurses, nutritionists and other health professionals will be available beginning with the first year of transition as will dental services (preventive care, fillings and extractions) and vision (up to one refraction and one pair of glasses each year, as medically necessary). Long-term care will be added by year 2 and hearing (up to one pair of hearing aids with audiologist follow-up for one year, with replacements every 5 years, as medically indicated) by

implementation. **Rationale**: Early addition of these new services will make it more attractive for people with private insurance to transition to Medicare. The time course of added services is based on a combination of benefits and costs.

c) **Copayments** will be gradually reduced each year from 20% to 15%, then 10%, then 5%, then eliminated. **Rationale**: Some cost-sharing during transition will be needed to reduce program costs as savings accrue, but all coinsurance will be eliminated by the time of full implementation due to their discriminatory nature and lack of effectiveness in affecting behavior appropriately. Cost-sharing is a major barrier to care that must be eliminated to enhance cost savings by other methods.

d) **Tax exemptions** for employer-sponsored health insurance premiums and tax deductibility for other private health insurance will be gradually decreased during transition to 90% in year 1, 75% year 2, 50% in year 3, 25% in year 4 and eliminated after implementation. **Rationale**: This will encourage the move from private health insurance to Medicare during the transition. These tax subsidies will be diverted to help pay for additional services for everyone.

e) **Health Savings Accounts**, Health Reimbursement Accounts and Flexible Savings Accounts will be eliminated as of the first day of transition. **Rationale**: These arrangements are designed to offer tax savings that supplement health insurance plans with high deductibles. They unfairly favor those with higher incomes and lack transparency.

f) **Premiums.** During transition, the Secretary will be authorized to calculate premiums for Part B and EEM to ensure that they are both affordable and sufficient to maintain program integrity. Premiums for children will be 40% of adult premiums. The Part B premium paid by those eligible for standard Medicare will be calculated by adding a small cost to account for elimination of deductibles and copayments and the average current Part D premium. EEM premiums will be calculated by the Secretary to be not significantly above the current cost to individuals available through an employer, considering the additional coverage offered. *After transition, premiums will be calculated as 5% of household adjusted gross income, after excluding an amount equal to 138% of the federal poverty level*. Premiums for workers on payroll will be billed through payroll deductions. Individuals not on payroll deduction or Social Security may be given the option to pay premiums monthly or to have an annual amount calculated as an addition to their income tax at the end of the year, which will be the default. Low-income individuals will be eligible for subsidies that will lower or eliminate their premiums (see below). **Rationale**: This will ensure that *Medicare for All* does not have the same problem that the ACA has been plagued with—the inability to attract people who want adequate coverage at an affordable price. *Medicare for All* will be competing against the health insurance plans available through employers, which are now subsidized both by employers and by the federal government (since they are tax exempt). These plans are getting more expensive for both employers and workers and harder to

sustain, but *Medicare for All* must be able to provide coverage at a cost to workers that is reasonably close to the same price.

g) **Premium reductions** (*not tax credits*) during transition will be available for EEM for all families with incomes <400% federal poverty level, using the same guidelines as the ACA, as appropriately amended to include the "coverage gap," during transition. (When the ACA was written, it was assumed that anyone with a family income below 138% of federal poverty level would receive Medicaid, since they would qualify for coverage under the expanded ACA guidelines. It was not anticipated that some states would resist accepting 90-100% federal cost-sharing for these families and not expand their Medicaid coverage. This left some families with children with incomes as low as 17% of federal poverty level without coverage and those without children ineligible for Medicaid regardless of income. The ACA provided premium subsidies for families with incomes between 138% and 400% of federal poverty level, but not lower.) After transition, the calculation based on income excluding the threshold below 138% of federal poverty level will ensure affordability for all. **Rationale**: Low-income households cannot afford to wait for tax credits. It is more appropriate to reduce their premiums.

h) **Employers** will continue to pay premiums for their employees newly enrolled in EEM during and after transition, just as they pay for their private insurance. However, the total premiums will be much lower. Employers will pay 6% of payroll after the first $500,000 as opposed to the current average of 8.3% of total payroll. In addition, small businesses (with fewer than 100 employees) have an average payroll of $300,000 so very few of them will pay any premiums at all. Currently, about 53% offer health insurance for their workers at an average cost of 8.3% of payroll. In addition, payments for Medicare Part E premiums will be authorized on unearned income similar to the current Medicare Part A tax on unearned income (for filers above set income levels) at the rate of 5%. Medical care under workers compensation will be covered by Medicare, reducing the cost of workers compensation to employers. **Rationale**: It is reasonable for employers to continue to take some responsibility for the health of their workers during and after transition. Employers need their workers to be healthy and productive. Employers' costs will be much lower than the amount they currently pay. Exempting the first $500,000 of payroll will ensure that all businesses will be able to afford even these lower costs. Concerns about rising costs will be eliminated. Payments on unearned income will prevent an unfair burden on workers and avoid the shifting of income from payroll to investment income merely to avoid payments.

11. **Budgets.** Although we do not recommend a global health care budget, we do recommend the Secretary be given authority to recommend specific budgetary expenses to promote improved healthcare utilization. The specific recommendations included here are initial recommendations that should be reviewed at least every 5 years by the Secretary with input from the Congressional Budget Office and the Center for Disease Control and Prevention (CDC).

a) **Increase funding for biomedical research, including healthcare outcomes research, through the NIH.** We recommend increased research funding beginning with the second year of implementation, increasing to $15 billion by implementation. **Rationale**: Private companies should not bear the burden of research costs for healthcare. Research geared to the needs of the nation, rather than company profits, need to be prioritized.

a) **Funding for advanced practice clinician support.** This should include methods to encourage states to allow increased privileges for advanced practice clinicians (nurse practitioners and physician assistants). We recommend funding beginning with the first year of transition, gradually increasing to $15 billion at implementation and thereafter. **Rationale**: There will be an increased need for clinical services with improved access to care. Advanced practice clinicians are a valuable and cost-effective means to provide those services.

b) **Increase funding for graduate medical education.** This should include loan forgiveness programs, with an emphasis on encouraging increased numbers of primary care providers, dentists, mental health providers and addiction specialists starting during transition, increasing gradually to $15 billion at implementation and thereafter. **Rationale**: This will provide a method to encourage career choices that meet community needs while simultaneously reducing the burden of educational debt faced by many practitioners.

c) **Provide funding to support other professionals.** In anticipation of shortages of trained clinicians due to improved reimbursement and access we recommend funding to support other professionals providing patient education in doctors' offices (such as nurses and nutritionists). We recommend funding beginning with the first year of transition, gradually increasing to $15 billion at implementation and thereafter. **Rationale**: This is a missed opportunity for considerable cost savings. These services are currently bundled into physician services, limiting their availability since it requires physician practices to pay extra for services for which they receive no additional reimbursement. The physician practice effectively loses money when it provides these services even though the patient benefits from them. These services lower healthcare costs by improving patient compliance, reducing physician visits, procedures, emergency room visits and hospitalizations.

d) **Provide funding for job training.** We recommend a specific allocation for healthcare administrators in insurance and providers' offices for job training for workers who may need to change jobs, beginning during transition, increasing to $15 billion at implementation and continuing for another 5 years. **Rationale**: Changes in the need for administrative personnel will be inevitable under *Medicare for All*, which is designed to lower administrative complexity.

a) **Provide funding for a Home Health Corps.** We recommend a new nationwide Home Health Corps be developed and funded beginning during transition, increasing to $15 billion at implementation and continuing

thereafter. **Rationale**: Increased access to care will increase the need for home health services, and more trained personnel will be needed. The funds will be allocated to help train, deploy and support these personnel.

As an additional cost control measure, we recommend a "Medical Products and Services Sunshine Act" that would require provider organizations, hospitals, health insurance companies, pharmaceutical and medical device companies and their lobbyists to report expenditures relating to any federally elected official or federal election campaign to the Federal Elections Commission, which would be required to report such contributions annually to the Secretary. This would become part of the information considered when the Secretary updates Medicare reimbursement rates for drugs and devices. **Rationale**: This will help guard against inappropriate political interference in healthcare policy, without limiting free speech.

A final measure we recommend to protect providers is an amendment to the Health Insurance Portability and Privacy Act. It would require all insurance providers, on request, to verify insurance eligibility with a termination date. A verification of insurance will serve as a guarantee of payment of any valid claim for services performed up to the termination date. **Rationale**: This will improve appropriate reimbursement to providers during transition by preventing insurance companies from inappropriately denying claims.

Key Cost and Savings Analysis of *Medicare for All* with proposed recommendations: It is reasonable to ask, "How can we pay for *Medicare for All* without raising taxes? The following is an outline of the estimated costs associated with implementing the major features of a well-designed *Medicare for All* program:

Costs for *Medicare for All*[*]

Provide Medicare to new enrollees:	about $1,600 billion
Increase Medicare administrative budget:	$20 billion
Cover short-term and long-term care:	about $270 billion
Cover dental, vision, hearing:	about $50 billion
Reduce coinsurance:	about $170 billion
Patient education by nurses and other health professionals:	about $15 billion
Increase basic and clinical research budget:	$15 billion
Advanced practice clinician training and support:	$15 billion
Other professional/dental training and support	$15 billion
Job training (up to 5 years after implementation)	$15 billion
Home health corps	$15 billion
Total costs over 5 years:	***about $2.2 trillion***

Where do we find the money needed to fund this program? By simplifying our healthcare system into one with less complexity we will be able to decrease waste and improve efficiency. The money is buried in the current dysfunctional U.S. healthcare system.

A number of features of our healthcare system are responsible for much of this waste. Its disjointed nature results in a lack of coordination of care. Patients may see multiple providers who have little or no communication between them. Electronic medical records are different from one office to another and one hospital to another. Tests performed may be reported to one provider and not another. These miscommunications lead to repeated and unnecessary services, inaccurate diagnoses and missed opportunities for preventing illness. Areas of the country that have more abundant supply of a particular service have higher utilization than other areas, without improvement in patient outcomes, only increased cost. The need for income also leads providers of all types—physicians, hospitals, home care services—to find ways to refer patients to facilities with which they are affiliated. Although the Stark Law limits these arrangements, there are exceptions that allow for continued excesses.

Simplifying our healthcare delivery into a less complex system will improve efficiency and create immediate savings. Here is a rough breakdown of some savings that can be expected:

[*] These represent additional costs compared to our current system assuming no other changes, including increases or changes in population or increases in healthcare costs over time.

Savings for *Medicare for All*[*]

Recover tax subsidy for private insurance premiums:	about $130 billion
Decrease cost of uncompensated care	about $60 billion
Decrease providers' administrative costs:	about $75 billion
Eliminate providers' excessive prices:	about $135 billion
Improve efficiency in detecting fraud and excess services:	about $300 billion
Improve efficiency of disease management and use of improved practice and payment models:	about $220 billion
Decrease hospital costs due to better access to care:	about $120 billion
Improve efficiency of negotiation of drug and device prices:	about $110 billion
Promote use of advance practice clinicians	about $40 billion
Use funds previously dedicated to other programs	about $450 billion
Total savings at implementation:	***about $1.6 trillion***

(About $150 billion in savings from decreased cost of providing insurance is included in the discounted cost of new enrollees.)

New premium contributions about $650 billion

NET SAVINGS APPROXIMATELY EQUALS NET COSTS
Annual savings after completion of job training support about $10 billion (beginning after transition)

We recommend businesses continue to pay a portion of their workers premiums during transition. However, they will pay only 5% of payroll (after the first $500,000) compared to the current average of 8.3%. In addition, since small businesses (with fewer than 100 employees) have an average payroll of $300,000, the vast majority of them will not have to pay any premiums (compared to 53% of small employers now paying premiums for their employees' health insurance). All businesses will be able to contribute to the health and productivity of their employees without having to worry about budgeting for rising healthcare costs or managing complex decisions about healthcare insurance. We also recommend that individuals currently subject to Medicare Part A tax on unearned income (those earning more than $200,00 for an individual or $250,000 for those filing jointly) should also contribute part of their unearned income to Medicare Part E premiums, at the rate of 5%. This is to ensure that those who have a significant source of unearned income pay their fair share into Medicare. In order to reduce bureaucracy, medical care provided for workers compensation claims will be covered by Medicare so premiums for this portion of workers compensation will be considerably reduced.

Additional Benefits of a well-designed *Medicare for All* plan: With net savings during every year of transition, *Medicare for All* would wind up with *cumulative savings* after expenses of almost $600 billion after transition

[*] Savings and net savings (after costs) are in comparison to our current system assuming no other changes, including increases or changes in population or increases in healthcare costs over time. True savings are likely to be much larger.

compared with our current system and over $630 billion 5 years later (we project $9 billion in additional annual savings compared to our current system during this time). Included in these calculations are costs for additional healthcare research, graduate medical education and training for nurse practitioners and physician assistants. The savings would be enough to support job training programs during transition and for the first 5 years after implementation. It would also allow for a major investment for development and support of a new Home Health Corps to ensure the availability of properly trained personnel needed to care for people in their homes, ensuring the expansion of this important job market.

Other benefits, not directly related to improving healthcare delivery, are immediately obvious. Private businesses will be relieved of over $240 billion in medical expenses with $136 billion going to small businesses. They will never have to worry again about rising healthcare costs. As a result, businesses will be better able to compete in the world market, provide more jobs to U.S. employees and increase wages. And employers will no longer be involved in decisions about what healthcare services are provided—decisions that never belonged in the workplace.

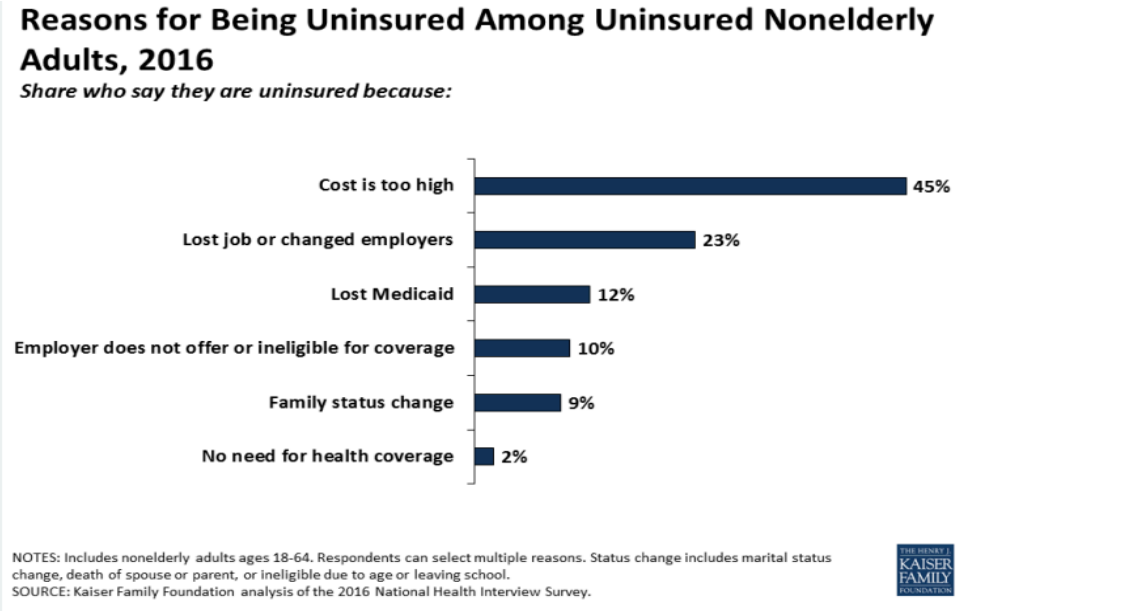
Other direct beneficiaries will be state and local governments. By eliminating the costs of Medicaid and CHIP completely from state and local governments, over $200 billion will be eliminated from their budgets. In addition, private health insurance costs for employees are a major item in virtually every state and local government budget. This includes not only government workers, but those paid indirectly by the government, such as teachers, police, firemen, legislators, healthcare workers and others. Total savings to state and local governments would be over $290 billion. The savings to individuals in state and local taxes will be significant. This could actually *increase* federal revenues through a decrease in personal deductions for taxes. (States would have more savings and lower taxes; individuals would pay less taxes, but relatively more to the federal government than to states than they do now.)

Related to this would be an overall improvement in the financial health of state and local governments. Benefit programs that are now in danger of default would have much lower medical costs (since all insurance would be secondary to Medicare) and their financial outlook would dramatically improve. State and local bond rates would likely improve as a result, further improving state budgets.

Individuals would have over $270 billion less in out-of-expenses. They could see other insurance premiums decrease as well. With Medicare as the primary insurer for all medical problems, medical liability insurance, such as for auto and homeowners' insurance, and workers compensation insurance premiums should all be lower.

Unlike the ACA, *Medicare for All* will truly provide affordable healthcare insurance for all. With *no* out-of-pocket costs and premiums for coverage that are *lower* than

the current average cost of a policy a worker can currently get from an employer* there will be no concerns about millions of people not wanting to pay for health insurance. Medicare premiums would be no more than current costs, but without deductibles or coinsurance. When asked why they do not have health insurance now, almost half say it is because the cost is too high. Only 2% say it is because they have no need for coverage. That amounts to less than 1 million people. It is clear that the overwhelming majority of Americans disagree with them.



Finally, everyone will benefit from the improvement in the healthcare system. With a healthier population and no barriers to care, productivity will improve. With better access to long-term care, including home care, family members will not need to take time off from work to care for the chronically ill. With medical care no longer a financial burden, the most common cause of financial distress and personal bankruptcy will disappear, improving the nation's economy. And we will have a less stressful nation.

Summary: The current U.S. healthcare system is facing rising costs that are unsustainable. Bowing to pressures to contain these costs, both public and private payers are reducing covered services, decreasing reimbursements and increasing premiums and coinsurance. The same pressures are driving an increasing number of hospital mergers and acquisitions resulting in patients having to pay more while reducing their choices. Despite this, costs keep rising. More people decide not to get needed care because they cannot afford it, worsening healthcare outcomes and intensifying the healthcare crisis in America. These problems are insurmountable

* Based on family coverage. Since insurers provide group policies to employers, they cannot charge different premiums to employees based on risk factors, such as age. However, they can charge different premiums for single and family coverage. Since single employees tend to be younger than married employees, their premiums are discounted and family coverage is disproportionately more expensive. Under *Medicare for All*, this imbalance would be erased.

if we maintain the current system of financing healthcare in the U.S. Our recommendations use many tools that are demonstrated to work in our current system. Our plan takes full advantage of a less complicated system to decrease wasteful spending and increase the savings that have been impossible to achieve in our current system.

When asked if they think health insurance costs for the average American is reasonable only 30% of those with private insurance from their employers said yes. And less than half said they thought most Americans be better off with the plan they have. Almost 80% think costs will go up in the next two years. That is a problem. So when the insurance industry says most people are satisfied with the plan they get from their employer, what does that really mean? Plans are getting more confusing—and many employees never have any health care visits for an entire year. Too often, only when someone gets a serious illness do they find out about hidden rules that result in treatment delays or large out-of-pocket costs. Most employees really have no way of knowing what they are paying for.

Our recommendations for a well-designed *Medicare for All* plan address a number of problems that will ensure lasting success of the program:

- Costs will be lowered for everyone: individuals, employers, government and providers.
- Comprehensive coverage that is critical to improved access to care and lowered healthcare costs will be ensured and offered early in the transition.
- Patients and providers will be guaranteed freedom of choice.
- Initiatives to ensure a gradual transition from our current system to *Medicare for All* will be ensured. There will be immediate availability of the program to all, a gradual increase in benefits, gradual decrease in government support for private insurance, and competitive premiums.
- No new administrative systems or bureaucracy and no changes to the health insurance industry structure will be required.
- Changes to our current methods for paying for healthcare are minimized during a reasonable transition period to clarify the importance of changing the method of funding and the amount of time needed to make the change.
- Specific plans for savings are addressed, including limiting the influence of lobbyists on healthcare costs.
- All costs and savings have been carefully evaluated and accounted for, with sufficient savings found to ensure that *Medicare for All* is affordable for everyone.
- Investments in education, training and infrastructure required for the program are budgeted.
- The costs of healthcare to the states and local governments will be reduced allowing for significant reductions in state and local taxes.
- The burden of medical care currently carried by employers will be drastically reduced.
- Additional benefits beyond healthcare alone have been evaluated.