



ACAMFA has a detailed plan to implement Medicare for All including complete analysis of all costs, savings and financing. You can read our full plan or our executive summary on our website as well. A brief outline is provided below.

1. Transition. SUMMARY—ACAMFA recommends a 4-year transition period, similar to Sen. Sanders’ bill, with some changes to improve the way it works. We would change our current system gradually and as little change as possible during transition to make the move to Medicare for All smooth and easy. We anticipate with the changes we recommend a gradual increase in enrollment in Medicare and decrease in use of the ACA and employer-sponsored health insurance. As more individuals sign up for Medicare, the savings initiatives built into the transition will increase, automatically paying for any additional cost of the new enrollees beyond the premiums collected.

a. Use existing programs to continue providing insurance coverage to reduce the risk for a disruptive transition: standard Medicare, ACA exchanges, Medicaid and CHIP, and employer-sponsored health insurance.

b. Encourage expansion of Medicaid by changing the formula for federal cost-sharing to reflect the percentage of a state’s population actually enrolled in Medicaid instead of the average income of the state relative to the rest of the U.S. This will better reflect the burden of care a state is required to provide for those in need, including the working poor, disabled and elderly, and encourage states to provide care for them. This will save money by preventing more expensive care provided to the uninsured when they become severely ill and allow for them to be cared for in the home and in nursing facilities instead of getting more expensive hospital care.

c. Everyone not already on Medicare, including children, will be eligible to join Medicare by paying a premium. The cost of the premium will be set by the Secretary of Health and Human Services (HHS) to be competitive with the

current cost to a family on employer-sponsored health insurance.

d. Premiums for low-income households will be subsidized to reduce their costs (their premiums will be lower—this will not be just a tax credit). High-income households may be subject to a modest surcharge.

e. Premiums would gradually increase as benefits increase.

f. Medicare payroll taxes will continue.

g. Employers will pay 6% after the first \$500,000 in payroll for the premiums of all employees who opt-in to Medicare for All (considerably lower than their current cost of healthcare expenses, 8.3%). Since the average payroll of small businesses is \$300,000, most small businesses will pay no premiums.

h. Enrollment will be encouraged by gradually making Medicare more attractive.

i. Deductibles for Medicare will immediately be eliminated.

ii. Copayments for Medicare will be gradually reduced over the course of the 4-year transition from 20% to 0%.

iii. Drug benefits will be included for all Medicare enrollees. The average cost of current drug plans (Part D) will be added to the standard Medicare premium (Part B).

iv. The tax-exempt status of employer-sponsored health insurance will be gradually decreased from 100% to 0% over the course of the 4-year transition.

v. Coverage will be gradually added for dental, nursing and other professional services provided in doctors' offices, hearing, and long-term care.

i. Medicare will negotiate prices with drug manufacturers using the well-established model used currently in Germany. This should lower prices per person by 30% (the same level as Germany currently pays).

j. All Medicare Part C plans will be required to offer the same benefits as Medicare for All. This will make them less attractive, resulting in a gradual decrease in Part C enrollment.

k. The administrative budget for Medicare will be gradually increased to allow it to pay more to private insurance companies to process its claims and improve enforcement of rules for proper billing, including the development of new tools to match procedures billed to proper situations.

l. Current loopholes in the law against self-referral of patients will be closed, reducing the excessive use of procedures by providers who own their own facilities.

m. The use of new payment models and models of care, especially for patient with chronic disease, that have been shown to improve care and reduce costs will be encouraged.

n. The use of nurse practitioners and physician assistants will be encouraged with improved reimbursement to practices.

2. Full implementation: SUMMARY—After full implementation all the methods used during transition to reduce costs will be continued. Everyone will be enrolled on Medicare for All, including everyone previously on Medicaid and CHIP. States and local governments will no longer be responsible to pay for those programs. Their employees will pay premiums and governments will pay 6% of payroll after the first \$500,000 to Medicare for All, like all other employers. Altogether, this will **save them \$295 billion a year** (\$2.9 trillion over 10 years). Private employers will **save \$243 billion a year** (more than half, \$136 billion, going to small businesses) by having all their employees on Medicare for All (\$2.4 trillion over 10 years). Individuals will see their premiums (adjusted for income) decrease by \$289 billion and their other out-of-pocket costs go down \$274 billion, minus \$130 billion increase in taxes due to elimination of subsidies for tax-exempt premiums (mostly paid by wealthier taxpayers) for total **savings of \$432 billion a year** (\$4.3 trillion over 10 years). We expect the balance to be sufficient for **small net revenues** each year. Premiums will be automatically deducted or added to income taxes for ease of collection. Nobody will be denied coverage for lack of paying premiums. We have detailed all costs, savings and financing related to implementing a comprehensive Medicare for All plan. [Note: This summary rounds numbers for ease of presentation. They therefore differ somewhat from our comprehensive analysis, which uses somewhat different categories for some costs and savings. The accuracy of our calculations, however, will be found to be unchanged.]

a. Costs: SUMMARY—We estimate the cost of increasing coverage to all residents (universal coverage) and increasing services to cover all essential needs (comprehensive coverage) to be about \$2.3 trillion a year. Another \$110 billion a year is recommended for additional program support (decreasing to \$50 billion after year 5) for a total of about \$2.2 trillion a year (\$22 trillion over 10 years). Amounts below are annual costs.

i. Cost of increasing coverage to all (new enrollees): about \$1.8 trillion (including increasing payment for Medicaid and CHIP to Medicare rates)

ii. Cost of increasing services covered (including elimination of coinsurance): about \$500 billion

1. Dental care: \$14 billion
2. Nurse and other professional visits: \$19 billion
3. Elimination of deductibles: \$8 billion
4. Short- and long-term care: \$265 billion
5. Hearing care: \$12 billion
6. Elimination of copayments: \$169 billion
7. Additional dental care and transportation for Medicaid eligible: \$16 billion

iii. Cost of additional support programs: \$110 billion (\$50 billion after the first 5 years)

1. \$20 billion to increase Medicare administrative budget
2. \$15 billion for additional biomedical research
3. \$15 billion for advanced practitioner training
4. \$15 billion for graduate medical training
5. \$15 billion for additional professional and dental support

b. Savings: SUMMARY—We estimate single-payer healthcare and other policies to result in savings of \$1.1 trillion a year. Counting funds previously spent by the Federal government on programs now included in Medicare for All (Medicaid, CHIP and ACA subsidies), savings total \$1.6 trillion a year. The *net* cost of the program is about \$600 billion a year (\$6 trillion over 10 years). Amounts below are annual savings.

- i. Cost of administration: \$148 billion
- ii. Elimination of uncompensated care: \$59 billion
- iii. Improved use of current tools to reduce waste: \$239 billion (includes audits of outliers, linking claims to diagnoses and other demographics, quality initiatives, use of guidelines, electronic medical records)
- iv. Improved chronic disease management: \$59 billion (includes reduction of inefficient delivery and missed prevention under single-payer)
- v. New payment and care models: \$201 billion (includes reduction in fraud, missed prevention, inefficient delivery, and unnecessary services)
- vi. Decrease cost of drugs: \$108 billion (using German model for negotiation with 30% decrease in cost)
- vii. Decrease cost of devices: \$6 billion (bulk negotiation, assuming 10% decrease)
- viii. Decrease provider administrative costs: \$75 billion
- ix. Elimination of excessive pricing: \$133 billion (Medicare prices)
- x. Close Stark (self-referral) loopholes: \$68 billion (reduced unnecessary services)
- xi. Promote use of advanced practitioners: \$42 billion
- xii. Decrease in hospitalizations: \$123 billion (10% decrease due to increased access to drugs and physician visits and increased coverage for long-term care)
- xiii. Funds previously spent on ACA, Medicaid, CHIP: \$450 billion

c. Financing: SUMMARY—The cost of Medicare for All will be financed through continued premium payments and payroll taxes. Part A payroll taxes will remain unchanged. Individuals will pay premiums at a rate of 5% of adjusted gross income, excluding an amount equal to 133% of the federal poverty level (which varies according to household size). For a family of four in 2020, this amount is \$35,511. A family of four with an income of \$75,000 a year would pay an annual premium of \$1,974. This will save individuals \$289

billion a year in premiums, in addition to the \$274 billion in other out-of-pocket savings. However, since some of the premiums paid by individuals were previously tax-exempt, the increased income from them will be taxable, saving the Federal government another \$130 billion a year, but reducing savings to individuals by \$94 billion (mostly wealthier ones). Total savings for individuals will be \$469 billion a year (about \$4.7 trillion over 10 years). Private employers will save \$243 billion a year (\$2.4 trillion over 10 years). Total premiums are estimated to equal about \$659 billion a year with an additional \$131 billion saved in tax subsidies (\$8 trillion over 10 years), more than enough to fund the program. (We anticipate small net revenues each year after implementation.)

i. Premiums from those on previously eligible for Medicare will be based on a percentage of family income instead of the current subsidies and surcharges for various income levels, as with those newly enrolled (see below). There will be no separate premiums for drugs (Part D) and Part C will no longer be a separate program.

ii. Premiums from those newly enrolled on Medicare for All will be set at 5% of household income, excluding the amount below 133% of the federal poverty level (which varies by family size). For an average family of four with an income of \$75,000 a year, the annual premium would be \$1,974. There will be no deductibles or copayments and all drugs will be covered completely. Total annual premiums collected from all enrollees would be \$343 billion. Premiums would be automatically deducted from payroll or Social Security, paid directly or added to income tax.

iii. Employers will be asked to pay 6% after the first \$500,000 of payroll to supplement the cost of premiums for their employees. Since small employers (with fewer than 100 employees) have an average payroll of \$300,000, the vast majority of them will not have to pay any premiums. Total payments collected from employers is projected to be \$394 billion a year. This includes premiums from state and local governments, which will save \$295 billion a year (\$2.9 trillion over 10 years) since they will no longer pay for Medicaid, CHIP, state payments to Medicare or private insurance premiums.

iv. Tax exemptions for employer-sponsored health insurance results in about \$200 billion in lost revenue. We estimate after the effects of the Tax Cut Act of 2017 and accounting for the exemption for businesses for their cost of premiums, the Federal government will receive additional revenues of \$131 billion a year due to no longer subsidizing private health insurance sponsored by employers.

v. Unearned income from individuals with income above a threshold will also contribute toward Medicare for All premiums to ensure that workers are not unfairly shouldering the costs. Total income from these premiums is projected to be \$4 billion a year.

vi. Enrollment will be automatic. Premiums will be paid by automatic deduction from payroll or Social Security payments and other individuals may opt to pay premiums directly or have the cost added to their annual income tax, which will be the default (low-income individuals not subject to tax would be below the threshold that would require premiums). Nobody would be denied coverage due to lack of payment of premiums.