Brian Flynn for Congress
Healthcare Advisory Committee

Medicare for All
PRELIMINARY DRAFT

Executive Summary

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Key Analysis of Brian Flynn's *Medicare for All* Plan

We have examined the two proposals in Congress, the House version and the Senate version, both of which will give Medicare-type coverage to all, including those with pre-existing conditions, with better benefits than today at competitive prices. We have found the Senate version to be better and recommend important changes to improve the bill.

Key Advantages of our proposed changes to *Medicare for All*

- We recommend some changes to the Senate version of *Medicare for All*.
- Advantages over the House version:
    - no new government bureaucracy
    - 4-year transition allows time for adjustment and savings
- Advantages of our proposals:
    - Improve transition by encouraging Medicaid expansion.
    - Improve transition by gradually encouraging move away from private insurance to Medicare.
    - Ensure competitive premiums by subsidizing them from healthcare savings.
    - Improve cost restraints by making the value of care important to doctors.
    - Include coverage for all services that improve health outcomes and reduce overall costs of care.
    - Eliminate *all* deductibles and copayments to ensure equal access to care.
    - Eliminate all programs that limit freedom of choice.
    - Make 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.
    - Specify the mechanism for claims processing by private insurance companies.
- We also detail the costs, savings and other benefits of Medicare for All.

Key Points of Brian Flynn's *Medicare for All* Plan

- Within 5 years there will be a transition to a comprehensive *Medicare for All* program that covers all necessary medical needs to ensure high-quality. healthcare for all Americans.
- Healthcare will no longer be a financial burden to any U.S. resident.
- Timely access to affordable healthcare will improve people's health by preventing or reducing medical problems associated with chronic diseases.
- A high-quality healthcare system will raise the standard of living, increase lifespan, increase productivity, and reduce stress.
- No exclusions for pre-existing conditions or caps on coverage.
- A plan that incorporates the best parts of the Senate and Congressional versions of *Medicare for All*.

Key Failings of the Current U.S. HealthCare System

- The U.S. spends more money on healthcare than all other major economies combined ($3.3 trillion in 2016; 18% of the GDP); the average spending per person for healthcare is over $10,000, almost twice the amount in comparable countries.
- The U.S. ranks last of 11 advanced countries in good health outcomes for its citizens like life expectancy, infant mortality and mortality from a range of treatable chronic diseases; prescription drug costs are the highest.
- Over 10% of adults report that they delayed or did not get health care because of cost.
- 28 million people have no health insurance and over 44 million people less than 65 years old are in families that have serious financial difficulties because of medical bills.
- Due to our fragmented system, inefficient delivery of care, unnecessary services, inflated prices, excessive administration costs, and fraud over $1 trillion dollars (30 cents on every dollar spent on medical care) is wasted every year which can be better spent on quality and affordable healthcare.
- In the 19th Congressional District, almost 25% are covered by Medicare, while over 30% are enrolled in either Medicaid, CHIP or an ACA insurance program.

The Problem

The healthcare crisis in the U.S. is evident from the fact that despite the $3.3 trillion spent for healthcare in 2016 (more than Japan, Germany, France, China, the U.K., Italy, Canada, Brazil, Spain and Australia combined), we have 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. The major causes of this long-simmering crisis are many. They affect every hospital, doctor's office, insurance company, and patient. Just as we expect to have clean water and electricity, effective and affordable healthcare is a

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right for all Americans, not a privilege. The very fabric our economy depends on a sustainable healthcare system that ensures its citizens can lead healthy and productive lives. And although the U.S. has the most technologically advanced medical infrastructure in the world--thousands of dedicated doctors and nurses, research breakthroughs that promise exciting new treatments and cures for serious diseases, and enough money—we are still unable to provide our citizens with high-quality healthcare. Our current dysfunctional health system cannot be fixed by focusing piecemeal on single elements such as access, drug costs, deductibles, tax credits, or by offering a bewildering array of insurance policies. It must be rebuilt using the basic programs that we know work well. Our goal must be to guarantee the three foundations of a world-class healthcare system: accessibility, affordability, and effectiveness. We cannot accomplish this by tinkering with the present system, which is highly fragmented, overly bureaucratic, too expensive, and inefficient. We must create a new single-payer system, *Medicare for All*, so that all citizens can enjoy healthy and productive lives.

We looked at a number of possible solutions and found that current approaches 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 that 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 most popular proposal currently before the House, H.R. 676, but found that it is not workable. It has all the problems of Canada's system, requiring a bureaucracy that does not now exist and will be difficult to create and, by eliminating all private insurance companies severely limits Medicare's billing system, since all Medicare's billing is contracted out to private insurers. In addition, it would cause enormous disruption of the economy and unexplained new taxes would be needed to pay for its costs.

We found the Senate version, S. 1804, offered by Bernie Sanders, Senator from Vermont, more acceptable, especially its 4-year transition plan and lack of additional bureaucracy. However, we think it has a few problems that can easily be addressed. We propose some changes to S. 1804 and also outline how, especially with these changes, the U.S. will be able to pay for the program and achieve benefits well beyond reducing the cost of healthcare while improving outcomes at the same time.

Key Details of the *Medicare for All* Program in S. 1804: The proposal in the Senate bill for creating a *Medicare for All*, single-payer healthcare system in the U.S. can be briefly summarized as follows:

1) Transition to *Medicare for All* over 4 years.

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2) No duplicate private insurance allowed. (It does allow Veterans Administration and Indian Health Service to continue, which is different from the House version, which indicates that the need for those services will be re-evaluated after 2 to 5 years.)
3) Offers comprehensive insurance including dental, vision and hearing, but NOT long-term care.
4) Long-term care will be paid by state Medicaid programs (the only benefits those programs will receive federal cost-sharing for).
5) Patient cost-sharing will be eliminated, with *exceptions* allowed for some prescription drug costs and long-term care.
6) The Secretary of Health and Human Services (the Secretary) is responsible for *national budgets* (the major attempt to control costs).
7) Drugs and devices will be negotiated annually with development of a drug formulary.
8) During transition, there will be an option to buy-in to Medicare at progressively younger ages each year: 55, 45, 35. Premiums are "to be determined by the Secretary" depending on family vs. individual, age and smoking status with premium tax credits as in the Affordable Care Act (ACA) with an amendment to include the "coverage gap." (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% federal cost-sharing for these families and not expand their Medicaid coverage, leaving some families with incomes as low as 44% of federal poverty level without coverage. The ACA provided premium subsidies for families with incomes between 138% and 400% of federal poverty level, but not lower.)
9) During transition, cost-sharing assistance is more limited (out-of-pocket costs are capped at $1500/year, drug costs at $305/year and only inpatient deductibles are eliminated).
10) A new universal Medicare fund is created from which all services will be paid. Current sources of Medicare funding would continue.

<u>Key Problems with the *Medicare for All* Program in S. 1804</u>: We have identified the following issues that need to be improved in this bill:

1) <u>Improve Medicaid expansion during the transition phase</u>. There remain too many people who will have inadequate healthcare insurance under this plan, even after full implementation, without full expansion of Medicaid.
2) <u>Allow private health insurance</u>. We see no reason to make duplication of Medicare coverage illegal; the burden of enforcing this regulation would be excessive. Simply making all coverage secondary to Medicare would accomplish the required goal of a single-payer health insurance system. However, neither Medicare Part C (Medicare Advantage) nor Medicare Part D are cost-effective. They both detract from the value of a single-payer system by adding billing complexities for patients and providers and should be abandoned.

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3) Ensure competitively priced health insurance. This is important to address so that S. 1804 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 their premiums are tax exempt). These plans are getting more and 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 point, at least when taking into account out-of-pocket costs and the additional services provided under *Medicare for All*.
4) Include long-term care in *Medicare for All*. This is essential, not just to ensure comprehensive care, but also to reduce overall healthcare 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" will use less physical therapy visits and other skilled care. Patients with access to personal care at home will use less nursing home days. This is too important to leave to individual states and it is inappropriate to burden families with cost-sharing.
5) Include coverage for nursing and other professional education as a separate service. 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 and they lower healthcare costs by improving patient compliance, reducing physician visits, procedures, emergency room visits and hospitalizations.
6) Specify covered services. Some covered services, such as vision and hearing, are not specified. This is important to prevent confusion and avoid unnecessary costs.
7) Eliminate all coinsurance. Although it is reasonable to use some cost-sharing during transition to reduce program costs as savings accrue, all coinsurance (deductibles and copayments) should be eliminated by the time of full implementation due to their discriminatory nature and lack of effectiveness in affecting behavior appropriately. We prefer to gradually reduce the percent of copayments required for all services and eliminating all deductibles, which are the most significant barrier to care.
8) There is inadequate encouragement for the move from private health insurance to *Medicare for All* during the transition. This must be done with a combination of competitive pricing of premiums, gradually adding more services and reducing copayments and gradually (instead of suddenly) removing the tax advantage given to private insurance premiums.
9) Avoid use of a universal fund. Changing the funding to a universal fund has its attractiveness, but we feel the less that is changed the better. Retaining Medicare Part A as a separate fund allows a certain amount of protection against using Medicare savings for other purposes.

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10) Account for claims processing. There are no specifics about how claims processing will be handled. This is critical to address to ensure that *Medicare for All* works. It will undoubtedly require an additional budget allowance.
11) Address specific costs and savings. There is no discussion in S. 1804 about the costs of the program and very little discussion of how cost savings will be achieved. The cost control measures amount to no more than budgetary restrictions. There is no model for putting the people with the most knowledge about the cost effectiveness of services (doctors) in a position to affect their utilization. The cost of services that most doctors order is four times as much as the value of services they perform. If doctors are made responsible for the costs of the services they order, there is a much better chance to contain costs than if they are only responsible for their own services, as with the current Sustainable Growth Rate Formula, that has not worked well. The plan also fails to account for the changes required to transition Medicaid services into *Medicare for All*, which will have a major effect on costs. We must be able to show how easily we can afford to make the necessary changes to achieve these positive outcomes.

Our proposals for changes to S. 1804 will be discussed in the next section. Costs and savings will be discussed separately.

Key Proposals for changes to the *Medicare for All* Program in S. 1804:
We propose the following changes to the *Medicare for All* program in S. 1804 to achieve the goals required of a world-class healthcare system, affordability, accessibility and effectiveness:

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. The federal share would vary proportionately from 40% for zero expansion to 60% for 100% expansion for previous enrollees. New enrollees would continue to receive 90% federal sharing. The exemption allowing 90-day temporary insurance (or longer policies) will also be repealed.
2) **Allow private health insurance after implementation.** All private health insurance will be SECONDARY to Medicare. Providers will have NO obligation to file 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.

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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, assuming the need to pay more for the contracts to private insures. This will ensure continued access to quality claims processing.
4) **Medicare Advantage Plans.** Eliminate Medicare Part C as of the first day of transition.
5) **Drug benefits**. Eliminate Part D as a separate benefit and include drug reimbursements in Part B as of the first day of transition.
6) **Deductibles.** Eliminate all deductibles immediately from Medicare as of the first day of transition. No other limitation of coverage will be allowed, including monetary caps on spending, time limits, number of services covered, or place of service other than the requirement that the service must be certified by the patient's health care provider to be medically necessary at the level of care provided, based on clinical information as documented in the medical record. The Secretary may develop regulations that provide guidance regarding medical necessity.
7) **Transition of Medicaid services to Medicare.** Transfer all Medicaid services, including long-term care, from Medicaid to Medicare by the implementation date. At implementation, Medicaid and CHIP will be discontinued as separate benefit programs. Payments for services for all enrollees, regardless of original service plan, will be equal, although additional benefits may be available to those eligible for Medicaid and CHIP (such as reimbursement for travel expenses). The source of funds will continue to be managed separately for accounting purposes. Anyone eligible for Medicaid will have the same benefits after *Medicare for All* as previously (i.e., premiums subsidized, transportation costs reimbursed, additional dental services covered).
8) **Cost control.** Beginning with year 2 of transition, Medicare with use a Sustainable Health Index Fund Target (SHIFT) to adjust payment rates for all standard services, including physician fees, imaging, laboratory, drugs and medical devices. The formula will allow for cost of living increases and will account for expected savings from new programs implemented under *Medicare for All* (during transition and after the implementation date), adjusted appropriately for variation from model predictions, as determined by the Secretary. After the implementation date, new services will be added to the SHIFT as necessary, at the recommendation of the Secretary. This will replace the plan for specific national budgets. For pharmaceuticals, Medicare will require a "most favored nation status" in comparison with other developed countries when negotiating prices.
9) **Funding.** The current funding process for Medicare will remain unchanged, 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 calculation of premiums will also be adjusted to ensure that they are competitive (see below).
10) **The following changes will be made to the transition plan:**

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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.
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.
c) **Copayments** will be gradually reduced each year from 20% to 15%, then 10%, then 5%, then eliminated.
d) The **tax exemption** 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.
e) **Health Savings Accounts** and Flexible Savings Accounts will be eliminated as of the first day of transition.

11) **Premium reductions** (*not tax credits*) will be available for EEM for all families with incomes <400% federal poverty level, using the same guidelines as the ACA, as amended in S.1804 to include the "coverage gap," during and after transition.
    a) **Premiums.** 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 without requiring an increase in funding from general revenues, while maintaining affordable premiums for all (see item 12). Premiums for children in families covered under EEM will be 40% of adult premiums. The Part B premium paid by standard Medicare enrollees will be calculated by adding a small cost equivalent to a current average Part D premium. EEM enrollees will premium calculated by the Secretary to be not significantly above the current cost available through an employer, taking into account the additional coverage offered. Premiums for workers on payroll will be billed through payroll deductions.
12) In order to maintain **program integrity**, a Medicare Part A Tax on taxable, unearned, non-retirement income equal to the current rate for the Medicare Part A Payroll Tax (currently 2.9%) and paid into the Medicare Part A fund, and a large-employer (100+ employees) Health Care Benefits Payroll Tax (employer contribution only) of up to 4.15% will be authorized, as recommended by the Secretary each year. The payroll taxes will be used exclusively to fund the *Medicare for All* program.
13) **Budgets.** Although we do not recommend a global health car 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 every 5 years by the Secretary with input from the Congressional Budget Office and the CDC.

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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 $50 billion by implementation.
b) **Increase funding for advanced practitioner training and deployment.** This should include methods to encourage states to allow increased privileges for advanced practitioners. We recommend increased funding beginning with the first year of transition, gradually increasing to $20 billion at implementation and thereafter.
c) **Increase funding for graduate medical education for physicians.** This should include loan forgiveness programs, with an emphasis on encouraging increased numbers of primary care providers, mental health providers and addiction specialists starting during transition, increasing gradually to $20 billion at implementation and thereafter.
d) **Provide funding for job training.** Rather than the proposal in S. 1804 for up to 1% of the healthcare budget provided for job training for displaced workers in health insurance administration, we recommend specific allocation for healthcare administrators in insurance and providers' offices beginning during transition increasing to $25 billion at implementation and continuing for another 5 years.
e) **Provide funding for a Home Health Corps.** Given the need for increased home health services, we recommend a new nationwide Home Health Corps be developed and funded beginning during transition, increasing to $25 billion at implementation and continuing thereafter.

As an additional cost control measure, we recommend a "Medical Products Sunshine Act" that would require pharmaceutical and medical device companies and their lobbyists to report expenditures made that relate to any federally elected official to the Federal Election Commission, which would be required to report such contributions annually to the Secretary. This information would become part of the information considered when the Secretary updates Medicare reimbursement rates for drugs and devices.

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.

- **<u>Key Cost and Savings Analysis of *Medicare for All* with proposed changes to S. 1804</u>:** It is reasonable to ask, "How can we pay for *Medicare for All* without raising taxes? Where do we find the money needed to fund this program?" The answer is straightforward: by simplifying our highly fragmented healthcare system into one *Medicare for All* we will be able to decrease waste and improve efficiency. The money is buried in the current dysfunctional and wasteful U.S. healthcare system.

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A number of features of our healthcare system are likely to be responsible for much of this waste. Due to the disjointed nature of our healthcare system, there is a lack of coordination of care. Patients often 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. All of these lead to repeated and unnecessary services, inaccurate diagnoses and missed opportunities for preventing illness. Areas of the country that have more abundant supply of particular services have higher utilization than other areas, without any 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 there are laws to limit these arrangements (the Stark Law) there are exceptions that allow for continued excesses.

Simplifying our healthcare delivery into one *Medicare for All* system will also improve efficiency and some immediate savings. Here is a rough breakdown of some of the savings that can be expected:

Savings for *Medicare for All*

Recover tax subsidy for private insurance premiums:	about $300 billion
Decrease the cost of providing insurance:	about $150 billion
Decrease providers’ administrative costs:	over $50 billion
Eliminate providers” excessive prices:	over $100 billion
Improve efficiency in detecting fraud and excess services:	over $200 billion
Improve efficiency of disease management and use of improved practice and payment models:	over $200 billion
Decrease hospital costs due to better access to care:	over $100 billion
Improve efficiency of negotiation of drug and device prices:	over $50 billion
Total savings:	***about $1 trillion***

The following is an outline of the costs associated with implementing the major features of *Medicare for* All:

Costs for *Medicare for All*

Expand Medicaid:	about $15 billion
Cover all the uninsured:	about $100 billion
Increase Medicare budget:	about $40 billion
Cover Long-term care:	about $100 billion
Cover Dental Care:	about $10 billion
Equalize Medicare/Medicaid Fees:	about $65 billion
Reduce Coinsurance:	about $150 billion
Patient education by nurses and other health professionals:	about $20 billion
Increase Basic and Clinical Research budget:	about $25 billion

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Advanced Practitioner Training and support:	about $20 billion
Total costs over 5 years:	about **$550 billion**

NET SAVINGS: OVER $400 BILLION

We recommend adding unearned income to the Medicare Part A payroll tax. This is to ensure that those who make money on unearned income pay their fair share into the Medicare Part A fund. (H.R. 676 also recommends a "modest tax on unearned income" but does not specify a rate or a rationale.) We also recommended that only large corporations (1.8% of all businesses in the U.S.) pay a Healthcare Benefits payroll tax for those workers enrolled in *Medicare for All*. The rate for this tax, 4.15%, is set at one-half the current average cost of healthcare expenses for businesses. We feel it is important to reduce the cost of medical expenses to businesses and believe the burden is greatest for small businesses that are more and more frequently eliminating healthcare benefits from their compensation. Even smaller large corporations are finding medical costs difficult to manage and are turning to cost-sharing methods that place increasing burdens of healthcare costs on workers. By removing healthcare costs completely from small businesses and reducing costs for large businesses by half, these burdens are reduced in an equitable manner for everyone. (H.R. 676, in contrast, recommends "a modest and progressive excise tax on payroll." It also recommends additional taxes on personal income and stock and bond transactions. These tax structures do not accomplish these same goals and, having fully analyzed the costs and savings associated with *Medicare for All*, unlike the sponsors of H. R. 676, we are certain these are unnecessary.)

Additional Benefits of *Medicare for All* with proposed changes to S. 1804: With an initial investment of less than $100 billion over the first 2 years of transition, *Medicare for All* would wind up with net savings after expenses of over $400 billion by implementation and over $1.5 trillion 5 years after implementation. This includes costs for additional healthcare research, graduate medical education and training for nurse practitioners and physicians' 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 major investment for development and support of a new Home Health Corps to help provide the personnel needed to care for people in their homes. In addition, Medicare Part A would see annual savings of almost $40 billion by implementation, ensuring the integrity of this fund.

Other benefits, not directly related to improving healthcare delivery, are immediately obvious. Small businesses (with fewer than 100 employees, making up over 98% of businesses) will be relieved of over $140 billion in medical expenses. They will never have to worry again about rising healthcare costs. Similarly, large businesses will have their healthcare costs reduced by over $150 billion by implementation and will also not have to worry about rising costs. Retiree benefit plans would also see reduced medical expenses, since all insurance plans would be secondary to *Medicare for All*. The result will be better

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ability of businesses to compete in the world market, provide more jobs to U.S. employees and increase wages. And businesses will no longer be involved in decisions about what healthcare services get 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, virtually every state and local government budget includes health insurance costs for employees as a major item. This includes not only government workers, but those paid indirectly by the government, such as teachers, police, firemen, legislators, healthcare workers and countless others. The cost savings are difficult to estimate, but certainly large. The savings to individuals in state and local taxes is certain to be significant. This, in turn, 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 for All*) and their financial outlook would dramatically improve. State and local bond rates could improve as a result.

Individuals could see other insurance premiums decrease as well. With *Medicare for All* as the primary insurer for all medical problems, medical liability insurance, including for auto insurance 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 family coverage that are *lower* than the current average cost of a policy a worker can currently get from an employer (about $100 a month lower) and for costs for individual coverage that are only slightly higher (probably less than $140 a month) there will be no concerns about millions of people not wanting to pay for health insurance. Standard 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.

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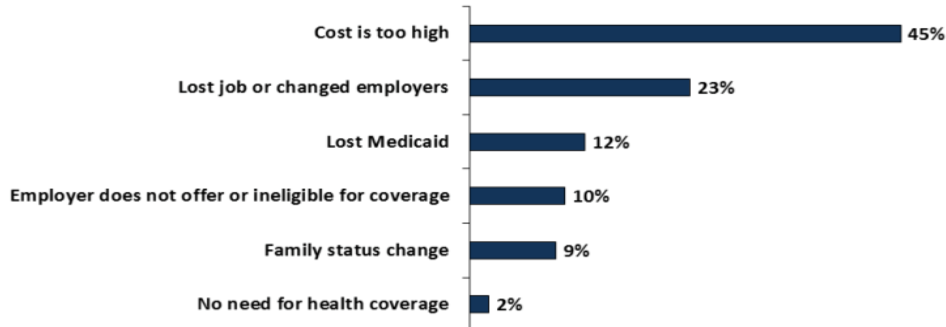
Reasons for Being Uninsured Among Uninsured Nonelderly Adults, 2016

Share who say they are uninsured because:



NOTES: Includes nonelderly adults ages 18-64. Respondents can select multiple reasons. Status change includes marital status change, death of spouse or parent, or ineligible due to age or leaving school.
SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.

Figure 3: Reasons for Being Uninsured Among Uninsured Nonelderly Adults, 2016

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 personal bankruptcy will disappear, improving the nation's economy. And we will have a less stressful nation. The chart below shows some basic cost comparisons.

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Some Cost Comparisons Before and After *Medicare for All*

	Before Medicare for All	After Medicare for All
Year	-1	5
Federal		
General revenues		
Medicare	$282	$340
Medicaid	$390	$0
Subsidies	$10	(incl)
Total	$682	$340
Medicare Part A Fund	-	($40)
Additional costs and revenues		($30)
Total costs	$682	$300
State & local		
Medicaid	$209	$0
Employers		
Small	$165	$0
Medium-Large	$426	$200
Total	$591	$200
Individuals		
Premiums	$852	$400
Payroll taxes	$89	$95
Out-of-pocket	$352	$50
Total	$1293	$550
Grand total	$2,775	About $1,100

Summary: The current U.S. healthcare system is facing rising costs that are unsustainable. Bowing to severe pressures to contain these costs, both public and private payers are reducing covered services, decreasing reimbursements, increasing premiums and coinsurance. Simultaneously, the same pressures are driving an increasing number of hospital mergers and acquisitions resulting in patients having to pay more and more while affording them reduced choice. Despite this, costs keep rising, more and more people opt not to get needed care because they cannot afford it, worsening healthcare outcomes and extending and intensifying the healthcare crisis in America. These problems are insurmountable if we maintain the current system of financing healthcare in the U. S. healthcare market. Our recommended changes to adjust the Senate proposal for a *Medicare for All* program are neither theoretical nor radical. They involve the use of many of the tools that are demonstrated to work in our current system applied in a rational manner. *Medicare for All* takes full advantage of a

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single-payer system to leverage these tools to decrease wasteful spending and increase the cost savings that have been impossible to achieve in our current system.

Our recommended changes to *Medicare for All* as proposed in S. 1804 addresses a number of problems that will ensure lasting success of the program:

- Our plan includes initiatives to ensure a gradual transition from our current system to *Medicare for All,* with immediate availability of the program to all, gradual increase in benefits, gradual decrease in support for private insurance, and measures to ensure competitive premiums.
- Our plan requires no new administrative systems or bureaucracy, no changes to the health insurance industry structure and minimizes changes to our current methods for paying for healthcare.
- Patients and providers will have more freedom through elimination of programs that limit choice.
- Comprehensive coverage that is critical to improved access to care and lowered healthcare costs will be ensured and offered early in the transition.
- 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 the plan is affordable.
- Additional benefits beyond healthcare alone have been evaluated.

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