

## How Can We Afford Medicare for All?

(Adapted from Physicians for a National Health Program)

**Medicare for All will have one payer. This change in how healthcare is funded will mean healthcare costs will be far less for 95% of Americans and no higher for the remaining 5% top income earners.**

- **How does one payer make our costs less than now, especially when we cover everybody?**

One risk pool is created by putting everybody into one national health program. When everybody is in one national risk pool, costs are automatically reduced for everybody because the number of healthy individuals to sick individuals is maximized. The more healthy individuals there are in a risk pool to balance out the sick individuals, the lower the costs for healthcare to all. Insurance companies have small group risk pools so the number of healthy to sick is far less so costs are much more.

- **How does this specifically cut costs?**

For-profit health insurance companies are no longer allowed to offer basic coverage. Without hundreds of different health insurance companies and different health insurance plans to deal with, complexity will automatically be reduced, especially for hospitals and doctors. Unnecessary administrative excesses and waste can be drastically reduced. We would keep the current public funding of healthcare (Medicaid, Medicare, CHIP, Indian Health Services, etc.) and **replace** premiums, co-pays, and deductibles with modest new progressive taxes.

Because we pay for health care through a patchwork of private insurance companies, about one-third (31 percent) of our health spending goes to administration. Replacing private insurers with a national health program would recover money currently squandered on billing, marketing, underwriting and other activities that sustain insurers' profits but divert resources from care. Potential savings from eliminating this waste have been estimated at \$400 - \$600 billion per year. Combined with what

we're already spending, this is more than enough to provide comprehensive coverage for everyone.

- **Background**

We already pay enough for health care for all – we just don't get it. Americans already have the highest health spending in the world, but we get less care (doctor, hospital, etc.) than people in many other industrialized countries. The United States ranks last behind every other industrialized democratic republic on population measures of health system quality. We pay twice as much as these other nations, yet research study after research study over the years shows that our medical outcomes are no better. Some our outcomes are worse. For example, our maternal and infant mortality rates are higher, our life expectancies are lower. About 46,000 Americans die each year of preventable causes because they can't afford health care. Most bankruptcies are from medical debt and most of those people had insurance at the time they got sick.

The system would be funded in part by the savings obtained from replacing today's muddle of inefficient, profit-oriented, private insurance companies – and the system-wide administrative\_waste they generate – with a single streamlined, nonprofit public payer. Such savings, estimated in 2017 to \$400 to \$600 billion annually, would be redirected to patient care.

Existing tax revenue would fund much of the system. According to a 2016 study in the American Journal of Public Health, tax-funded expenditures already account for about two-thirds of U.S. health spending. That revenue would be retained and supplemented by modest new taxes based on ability to pay, taxes that would typically be fully offset by the elimination of today's premiums and out-of-pocket expenses for care. The vast majority of U.S. households – one study says 95 percent – would come out financially ahead.

The system would also reap savings from its powerful bargaining clout, e.g. its ability to negotiate with drug and medical supply companies for lower prices. The VA gets about a 40% to 50% discount on medications. Medicare has been prohibited from negotiating discounted prices for medications.

Medicare for All would also save money by giving hospitals annual lump-sum (“global”) budgets to run their operations, rather than have them bill for every Band-Aid, and by regulating hospitals’ capital expenditures (new buildings, major equipment) on the basis of community need. All hospitals would be required to transition to nonprofit status, another source of the system’s savings.

Over the past several decades, more than two dozen independent analyses of federal and state single-payer legislation by agencies such as the Congressional Budget Office, the General Accountability Office, the Lewin Group, and Mathematica Policy Research Group have found that the administrative savings and other efficiencies of a single-payer program would provide more than enough resources to provide first-dollar coverage to everyone in the country with no increase in overall U.S. health spending.