Medicare for All

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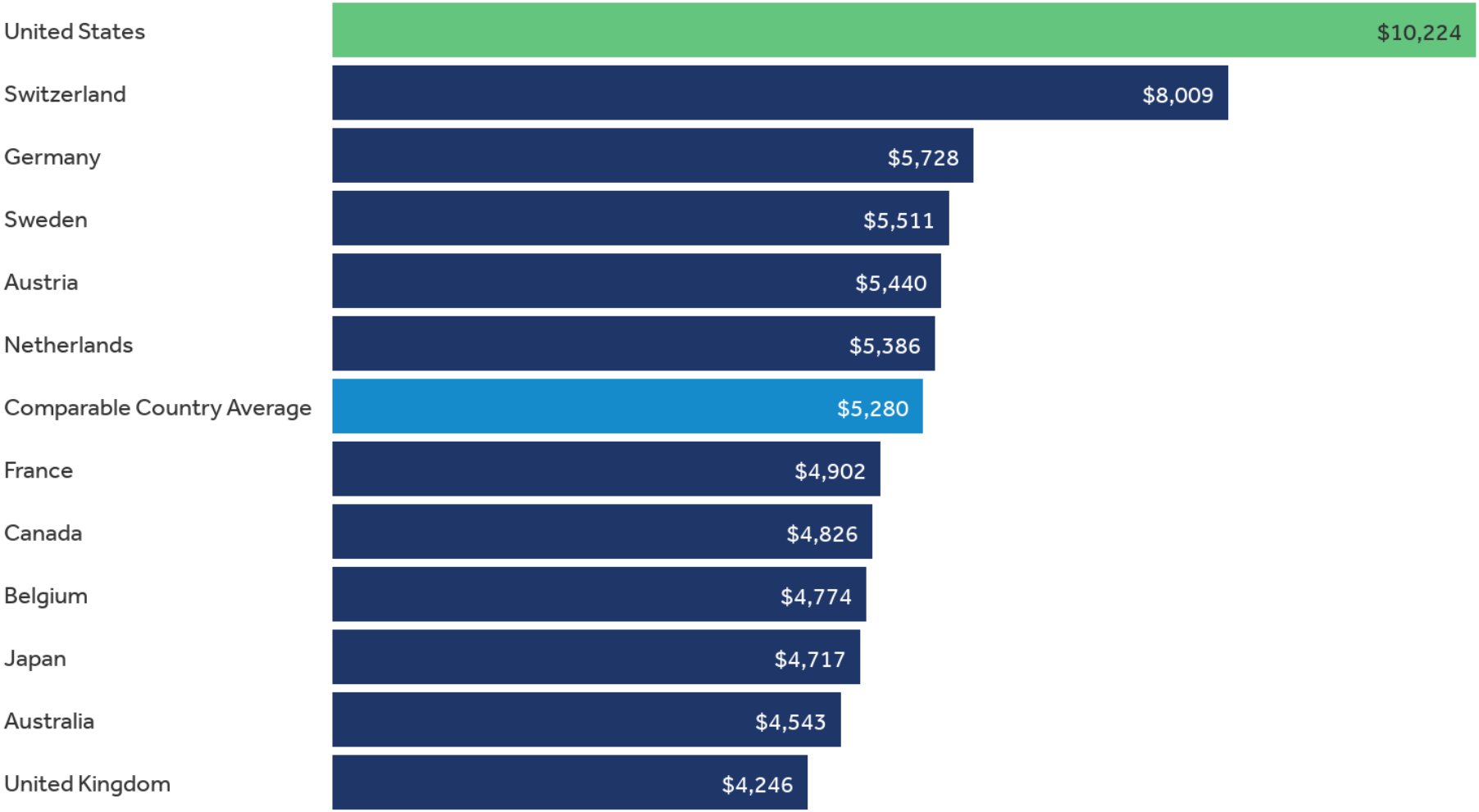
*I borrowed heavily from Ben Scuderi work on this topic

Health consumption expenditures per capita, U.S. dollars, PPP adjusted, 2017



Notes: U.S. value obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data • Get the data • PNG

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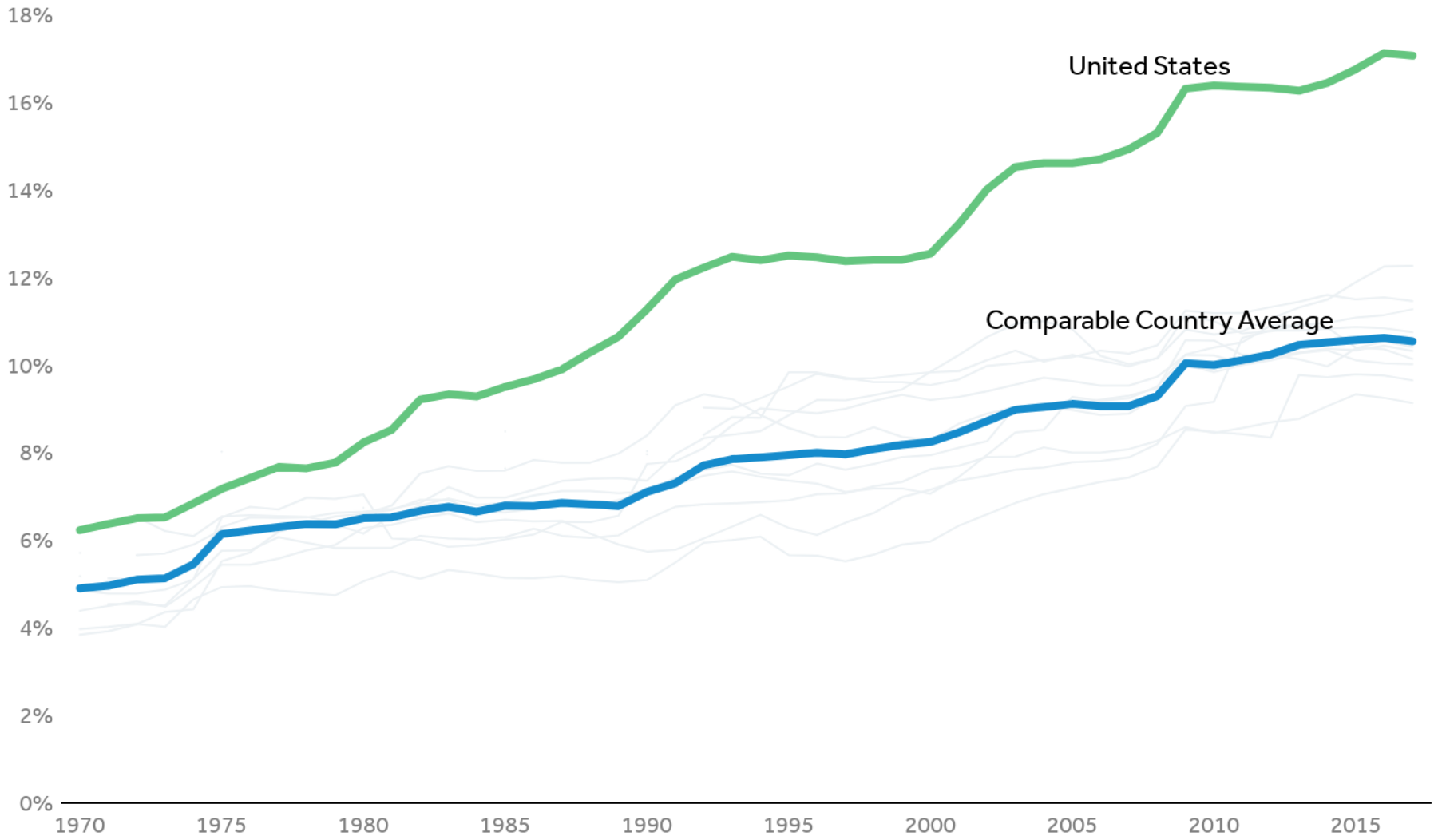
Health consumption expenditures as percent of GDP, 1970 - 2017



Notes: U.S. value obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data • Get the data • PNG

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Percent of total population covered by private and/or public health insurance, 2016 or nearest year

Note: 2016 data shown for the U.S., Australia, Canada, France, and Sweden.

Source: KFF analysis of OECD and U.S. Census data • Get the data • PNG

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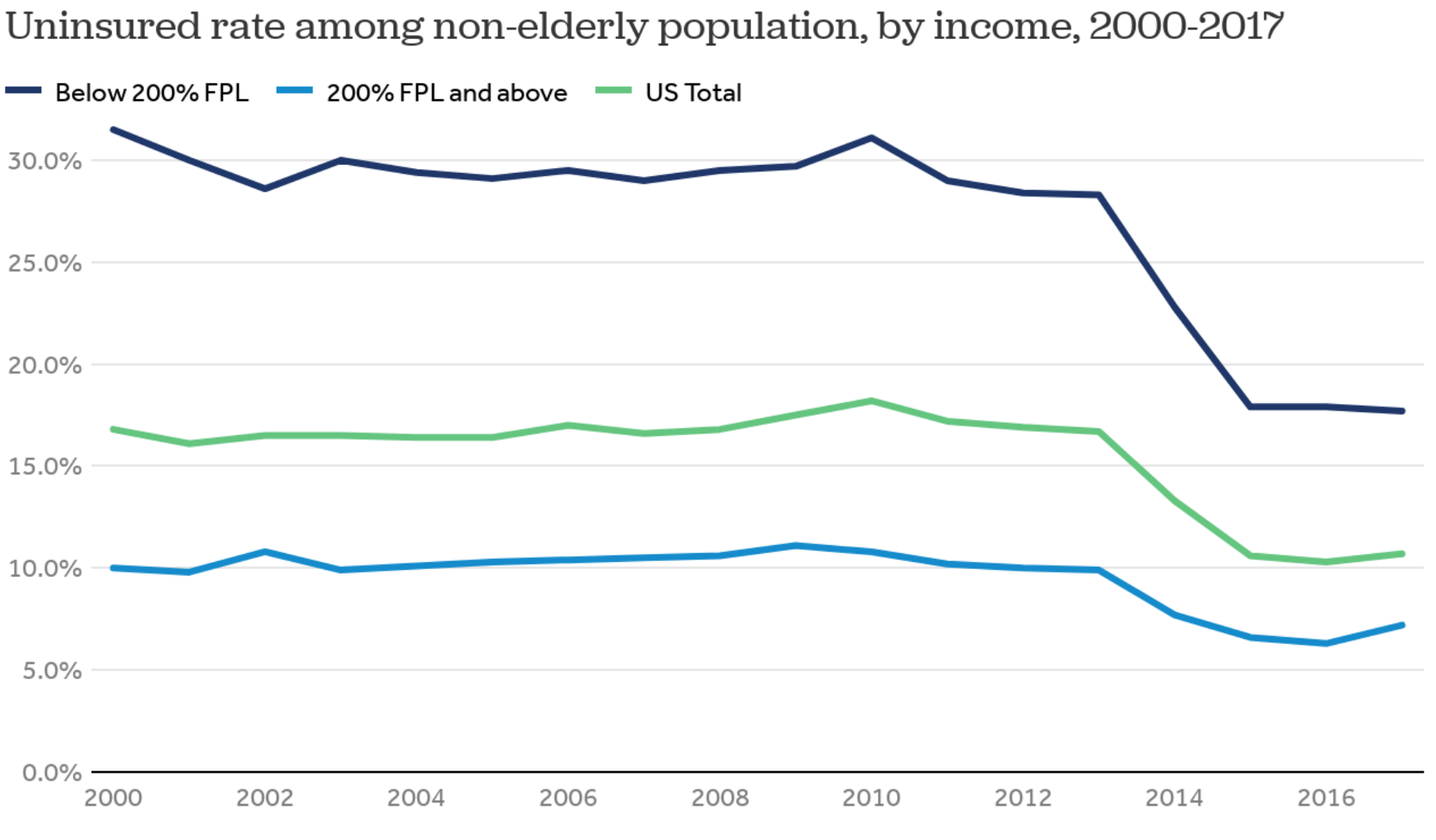
Uninsured



Source: KFF analysis of the National Health Interview Survey • Get the data • PNG

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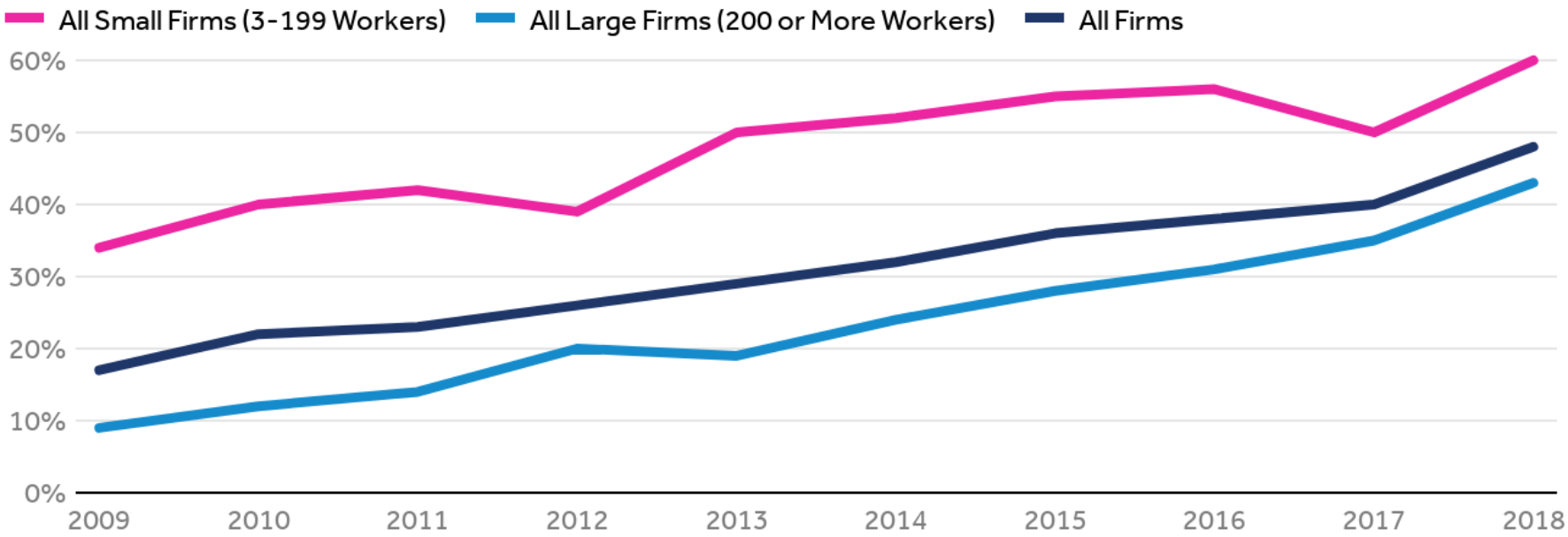
Under-Insured

Percentage of covered workers enrolled in a plan with a general annual deductible of $1,000 or more for single coverage, reduced by any HRA/HSA contributions, by firm size, 2009-2018



Note: Estimate is statistically different from estimate for the previous year shown ($p < .05$) for all firms in 2010 and 2018, all small firms in 2013 and 2018, and all large firms in 2012, 2014, and 2018. These estimates include workers enrolled in HDHP/SO and other plan types. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required to acutally transfer funds until an employee incurs expenses. General annual deductibles are for in-network providers.

Source: KFF Employer Health Benefits Survey, 2009-2018 • Get the data • PNG

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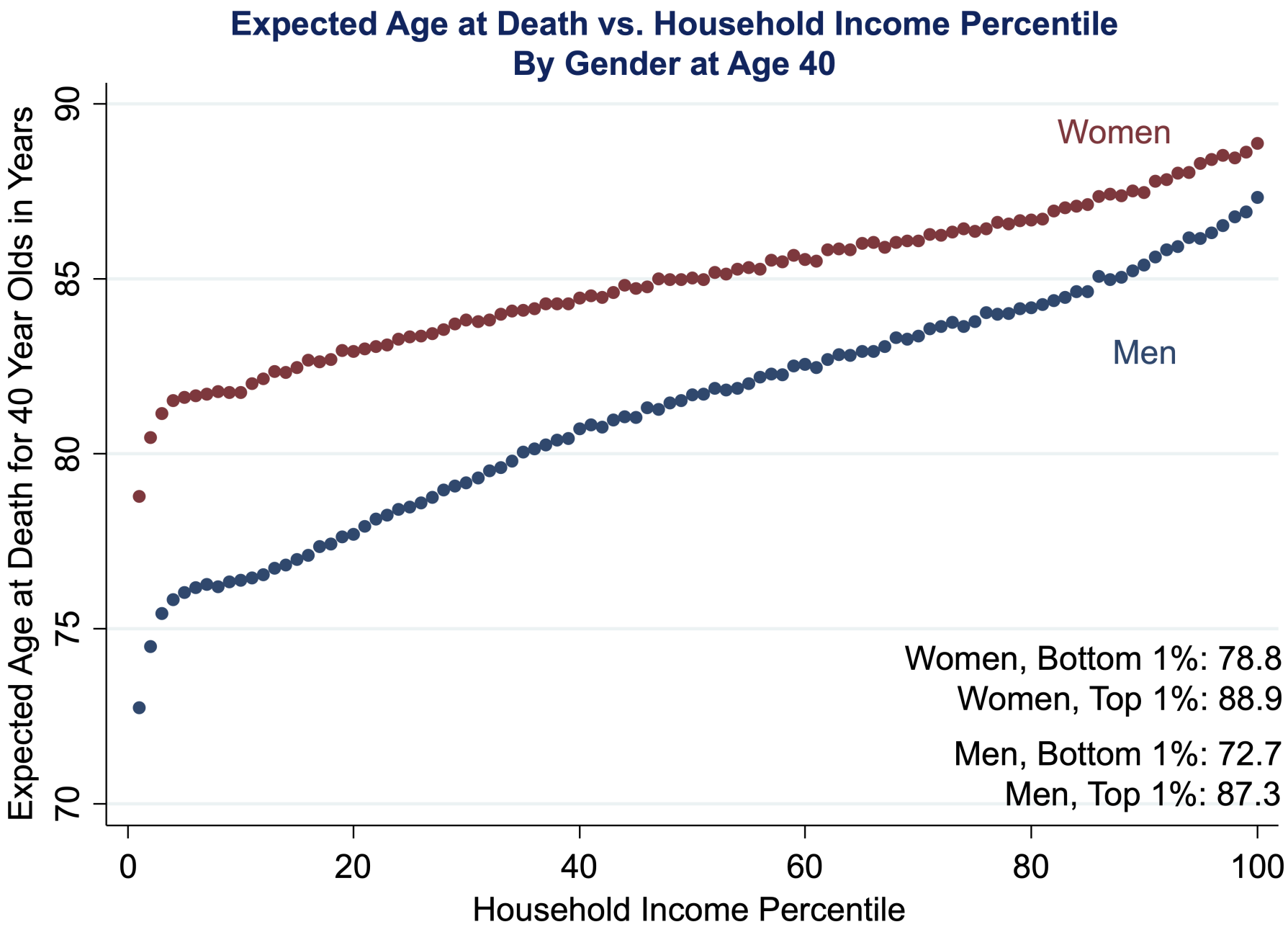
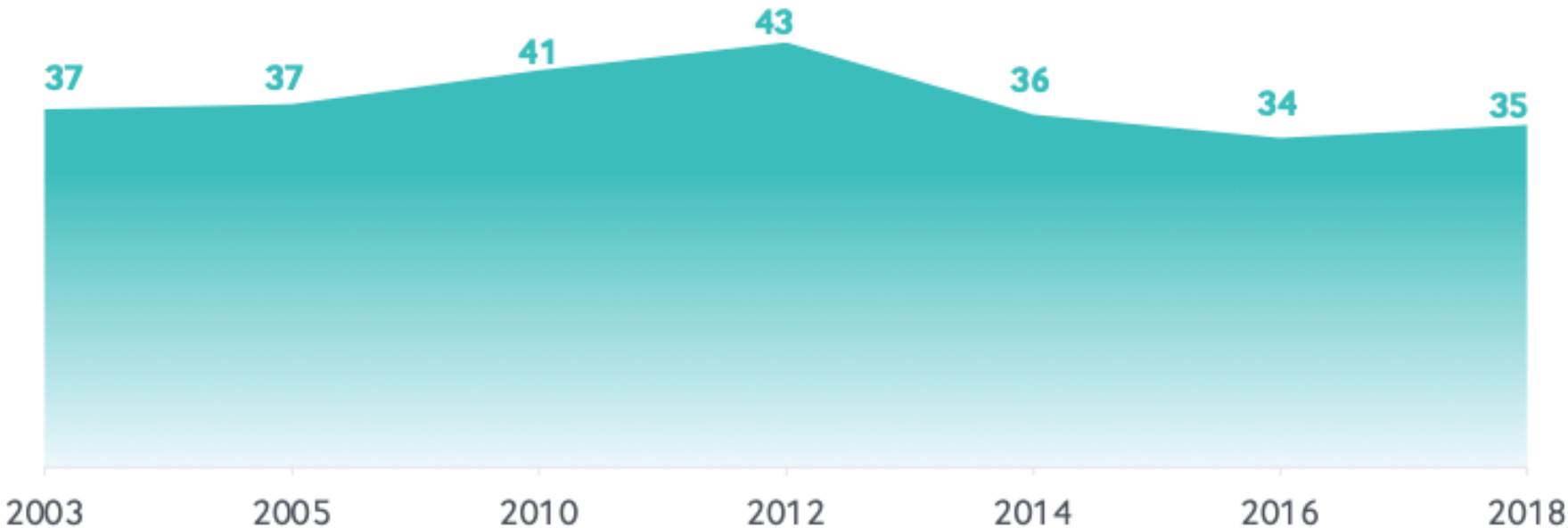

Expected Age at Death vs. Household Income Percentile
By Gender at Age 40
Expected Age at Death for 40 Year Olds in Years
70
75
80
85
90
Women
Men
Women, Bottom 1%: 78.8
Women, Top 1%: 88.9
Men, Bottom 1%: 72.7
Men, Top 1%: 87.3
0
20
40
60
80
100
Household Income Percentile

Percent of adults ages 19–64 who reported any of the following cost-related access problems in the past year:

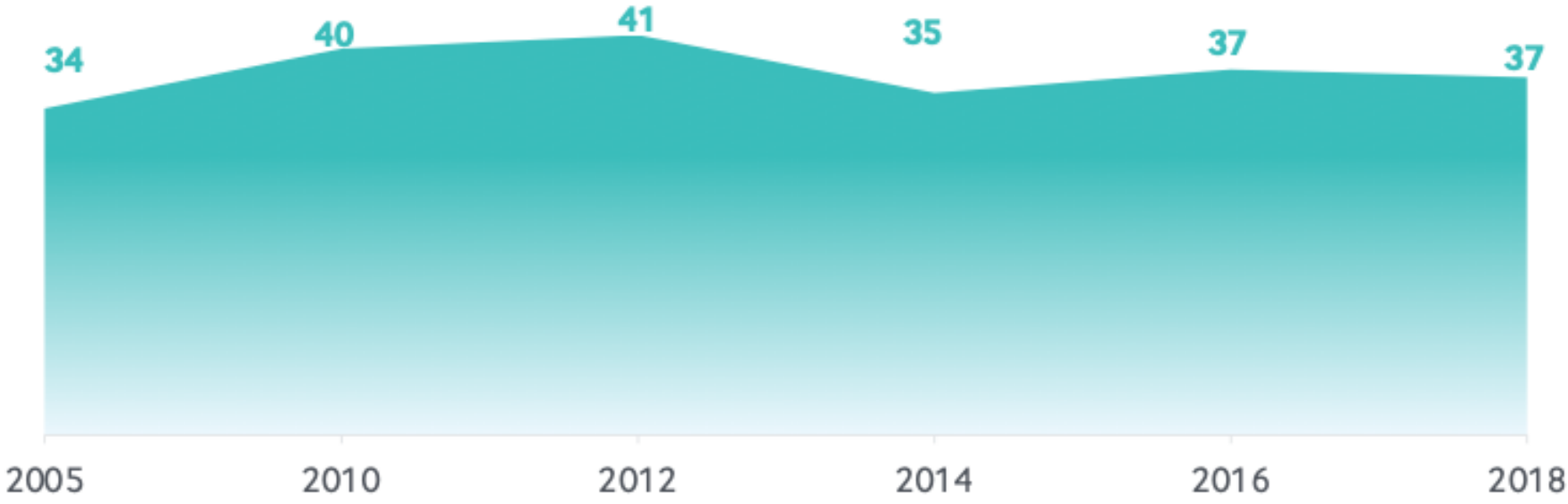
- *Had a medical problem but did not visit doctor or clinic*
- *Did not fill a prescription*
- *Skipped recommended test, treatment, or follow-up*
- *Did not get needed specialist care*



Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).

Percent of adults ages 19–64 who reported any of the following medical bill or debt problems in the past year:

- *Had problems paying or unable to pay medical bills*
- *Contacted by a collection agency for unpaid medical bills*
- *Had to change way of life to pay bills*
- *Medical bills/debt being paid off over time*



Data: Commonwealth Fund Biennial Health Insurance Surveys (2005, 2010, 2012, 2014, 2016, 2018).

Introduction

- America pays more than any other country for health care.
- Despite this, we manage to cover fewer people in our system than comparable countries.
- What are some potential causes for this? Could it be that ...
  - Americans tend to require or demand costlier services?
  - the American system is much less efficient than the systems of other countries?
  - private insurers extract uniquely enormous rents (profit) from the American system?
- Addressing these potential causes while expanding coverage is a fundamental challenge for the next administration.

Medicare for All: Universal, Single-Payer Health Insurance

- **Universal Coverage:** all Americans automatically enrolled.
  - Zero deductibles, co-pays, or surprise bills.
  - Patients choose among providers.
  - Medicare expanded to include hearing, vision, and dental coverage.
  - Private insurers can offer supplemental plans for items not covered.
- **Single Payer:** a single entity, the federal government, reimburses all providers for covered care.
  - Employers no longer responsible for managing care.
  - Providers interact with a single client, reducing duplication.
- Note that M4A does not (directly) affect providers: private entities still provide health care (unlike UK).

M4A and Drivers of Health Costs

- M4A is fundamentally a moral policy choice: will the richest nation on Earth extend basic protections to all of its people?
- However, M4A will also address all three potential causes of massive healthcare costs raised earlier. Specifically, M4A:
  - **Encourages take-up of preventative care:** previously un- or under-insured Americans will be able to access preventative care before more serious and costly conditions develop.
  - **Increases efficiency:** allows the government to negotiate lower drug prices, as in other countries, while reducing administrative costs.
  - **Removes the role of profit:** private insurance is an incredibly profitable business, but that profit comes at the cost of patients who face higher premiums, deductibles, and co-pays and lower quality of care. M4A eliminates profits.

Some Wonkier Benefits of M4A

In addition to the cost benefits, M4A also:

- Improves the **pooling of risk** in the health insurance system: insurance systems are more efficient when they pool a greater range of risk types.
- Eliminates the **job lock** phenomenon: individuals will no longer be tied to jobs in order to preserve coverage. This improves worker welfare and fosters competition among employers.
- Encourages **entrepreneurship**: taking the plunge of starting a business is risky. Universal coverage removes one important barrier for entrepreneurs, giving everyone a fair shot at starting a business.
- And many more...

Big Question 1: Who Pays, and How?

- The political debate around all forms of public health insurance is highly misleading.
- Experts predict that we will spend, on aggregate, $52 trillion on health care over the next ten years under the current system (this includes spending both through public and private insurers).
- Will private, for-profit health insurers act as the financial intermediaries (the status quo), or will the federal government be the intermediary (M4A)?
- To pay for M4A,
  - Taxes replace premiums and out-of-pocket expenses.
  - Cost savings bring the overall bill down.
- Recent research from the Center for Infectious Disease calculates that a single-payer, universal health-care system is likely to lead to a 13% savings in national health-care expenditure, equivalent to more than US$450 billion annually

Tax Changes

- Replace employer health insurance payments with an employer Medicare contribution:
  - Initially calculated relative to current spending at each firm.
  - Projected to cost employers $200 billion less than current system, while raising over 50% of the revenue necessary for M4A.
  - Exemptions for self-employed and small businesses.
- Introduce new taxes:
  - on financial transactions (levied on financial firms),
  - on large corporations (depreciation credits), and
  - on large fortunes (6% wealth tax on wealth above $1 billion).

Cost Savings

M4A is projected to cost less than the current system while covering more people. How?

- Massive reductions in administrative spending:
  - In 2017, private insurers spent 12.2% of total premiums collected on administrative costs, compared to just 2.3% for traditional Medicare.
- Prescription Drug Reform:
  - The House Committee on Ways and Means found that individual drug prices in the U.S. ranged from 70% to 4,833% higher than the combined mean price for that same drug in 11 other similar countries.
  - Through negotiation and production of generics, bring drug prices in line with current Medicare prices.