Debate Brief · Medicare For All
March 2020

Resolved: The United States should adopt Medicare For All, thus instituting a single-payer system of healthcare.

"We say to the private health insurance companies: whether you like it or not, the United States will join every other major country on earth and guarantee healthcare to all people as a right. All Americans are entitled to go to the doctor when they're sick and not go bankrupt after staying in the hospital."

—Sen. Bernie Sanders, U.S. Presidential Campaign Website (2019)

"Good health is one of our chief national assets. … Because illness makes us a liability to ourselves, our family and our community, we all have a personal obligation to keep well."

—Calvin Coolidge, Newspaper column, August 9, 1930

ABOUT THE COOLIDGE FOUNDATION

The Calvin Coolidge Presidential Foundation is the official foundation dedicated to preserving and promoting the legacy of America's 30th president, Calvin Coolidge, who served in office from August 1923 to March 1929. These values include civility, bipartisanship, and restraint in government, including wise budgeting. The Foundation was formed in 1960 by a group of Coolidge enthusiasts, including John Coolidge, the president's son. It maintains offices at the president's birthplace in Plymouth Notch, Vermont, and in Washington, D.C. The Foundation seeks to increase Americans' understanding of President Coolidge and the values he promoted.

This debate brief written and compiled by:
Calvin Coolidge Presidential Foundation
P.O. Box 97
Plymouth, VT 05056

BACKGROUND

Few parts of the United States economy are as big and complex as that which is referred to as "healthcare." Consider first the size of healthcare. The conglomeration of goods and services that are subsumed under that term include everything from physicians practicing out of their offices, to teams of clinicians caring for patients in hospitals, to pharmaceutical companies researching and making new drugs, to health insurance companies managing how we pay for everything, and much more. All of this costs Americans approximately **$3.6 trillion** (or $11,172 per person) per year.[1] At roughly **17.7 percent of the nation's Gross Domestic Product**, that means that almost one out of every five dollars spent over the course of a year is spent on something having to do with healthcare.

Healthcare in the United States is also exceedingly complex. Many services are paid for by people other than those who receive them (obfuscating who the real customer is); payment amounts are determined by complicated negotiated contracts rather than transparently posted prices; and myriad state and federal regulations specify what caregivers and patients are allowed to do and how they must do it. There are also inconsistencies in how various goods and services are treated by the law. For instance, health insurance purchased through an employer is tax-exempt, but health insurance purchased on one's own is not. Such complexities push and pull people in different directions as they try to make the best decisions for themselves.

Moreover, healthcare in the United States is not composed of *one* system. Rather, there is a patchwork quilt of at least four distinct systems—and arguably more—which different people use based on who they are, what they have, and what stage of life they are in:

- Americans of working age who buy private health insurance through their employer visit privately employed physicians. They experience something called the **Bismarck Model**, because it is based on the system founded by Otto von Bismarck in Germany.
- Americans who served in the military can receive their care from physicians employed by the Veterans Health Administration. They experience what is called the **Beveridge Model**, because it is similar to the system founded by Lord Beveridge in England.
- Older American who are enrolled in Medicare get care from privately employed physicians who are reimbursed by the government. They experience what is called the **National Health Insurance Model**, which is what everyone experiences in Canada.
- Americans who don't purchase private health insurance and do not qualify for any government programs pay for all of their own healthcare themselves. They experience the so-called **Out-of-Pocket Model**, which is the way healthcare is paid for and delivered in much of the rest of the world, including India, China, and most of Africa.

In the desire to reduce costs, to simplify American healthcare to one system, and to extend coverage to every individual (i.e., achieve "universal coverage"), a movement has emerged

[1] National Health Expenditure Accounts. Centers for Medicare & Medicaid Services. Accessed: December 10, 2019.

calling for "**Medicare For All**." In its purest and most consistent form—the form that we would like for you to consider for the purposes of this research brief—this health reform proposal would replace the current mix of various public and private health insurers with one public payer. That one public payer would work in a way that is similar to (though not *exactly* the same as) the current Medicare system.

Under Medicare For All, private health insurance would cease to exist. Everyone would receive health insurance through a single government program, and nobody would be excluded based on their choice to obtain coverage or their ability to pay. Physicians, nurses, and other clinicians who are currently employed by private hospitals and medical practices could remain employed by those entities, but instead of getting paid by patients or health insurance companies, they would all be paid by the government (which under Medicare For All would become the "single payer"). Prices would be set universally by a process of negotiation.

It is important to clarify that despite the name, Medicare For All does not simply extend eligibility for Medicare to all Americans. Fully implemented, Medicare For All would be a completely new and different program. Whereas current Medicare is actually not a single-payer program—it is a multi-payer program in which enrollees, the government, and even some private entities pay for and deliver different sets of benefits—Medicare For All would be a new **single-payer program**, with one new set of benefits for everyone. This program would be paid for primarily via higher taxes on individuals and businesses.

Almost everyone agrees that healthcare is not working as well it could, but there is substantial disagreement over which way forward is the best. Implementing Medicare For All would represent a major change in the direction of American health policy. Some believe it addresses many or all of our current problems and is exactly what American healthcare needs. Others believe it would make our existing problems worse and is wrong for America. Now you get to weigh the evidence and assess the arguments. **What do *you* think?**

Nota bene: Because there are multiple proposals in circulation by various legislators, advocacy organizations, and political candidates that go by the name "Medicare For All," we encourage debaters to evaluate the general idea of Medicare For All as a single-payer program, and not get too mired in the details of any one proposal. A representative bill, to choose one, is the Medicare for All Act of 2019 by Senator Sanders, bill S. 1129.

The proposal known as "Medicare For All Who Want It," which is most closely associated with Presidential candidate Pete Buttigieg, does not institute a true single-payer program, and so for the purposes of this resolution, we discourage affirmative debaters from building their case around that idea.

COOLIDGE CONNECTION

In health policy, the term "single-payer" is a relatively recent invention.[2] Calvin Coolidge, who was President from 1923-1929, would not have had any familiarity the modern single-payer (i.e., "Medicare For All") idea, but he did encounter proposals for various forms of government-funded healthcare in his career. In 1915 Coolidge ran for Lieutenant Governor of Massachusetts alongside Samuel McCall, who was running for Governor. The two won their respective elections, and in McCall's inaugural address in January 1916, McCall voiced support for a comprehensive health insurance program for the state.[3] He said:

> *"I am strongly of the opinion that there is no form of social insurance that is more humane, sounder in principle, and that would confer greater benefit upon large groups of our population and upon the commonwealth as a whole than health insurance."*

Privately, Coolidge was apprehensive of such a plan, but publicly he supported McCall, noting that his primary duty was to back up the administration, and that the people could oppose the proposal if they so chose.[4] (The McCall-Coolidge administration did not institute this program.)

Later, as President, Coolidge spoke supportively of addressing the health-related needs of various populations. In his first Annual Message to Congress on December 6, 1923, Coolidge called for the government to attend to military veterans:

> *"No more important duty falls on the Government of the United States than the adequate care of its veterans. Those suffering disabilities incurred in the service must have sufficient hospital relief and compensation…. At present there are 9,500 vacant beds in Government hospitals, I recommend that all hospitals be authorized at once to receive and care for, without hospital pay, the veterans of all wars needing such care, whenever there are vacant beds, and that immediate steps be taken to enlarge and build new hospitals to serve all such cases."*

Likewise, in his Sixth Annual Message to Congress on December 4, 1928, Coolidge supported the continuation of the Sheppard-Towner Act, a public health act that provided federal funding for maternity and child care:

> *"The Federal Government should continue its solicitous care for the 8,500,000 women wage earners and its efforts in behalf of public health, which is reducing infant mortality and improving the bodily and mental condition of our citizens."*

---

[2] Liu, J, and Brook, R. "What is single-payer health care? A review of definitions and proposals in the U.S. Journal of General Internal Medicine." J Gen Intern Med. (2017). 32(7), 822-831.
[3] Sobel, Robert. *Coolidge: An American Enigma*. Washington, D.C.: Regnery, 1998.
[4] Ibid.

Thus Coolidge did not *ignore* healthcare issues, yet it is difficult to imagine that he would have been enthusiastic about any proposal as large and sweeping as the proposals for single-payer healthcare that we hear about today.

Coolidge believed that government worked best and most efficiently when it was small and specific in its functions—not large and generalized. Aid and assistance for particular groups in particular situations, he often could support. The appointment of government to a role that other institutions could better satisfy, he could not. His views on the relationship of the private sector to the public sector were captured in many speeches, including one delivered to the Chamber of Commerce of the State of New York in November, 1925:

> *"When government enters the field of business with great resources, it has a tendency to extravagance and inefficiency, but, having the power to crush all competitors, likewise closes the door of opportunity and results in monopoly."*

Moreover, Coolidge likely would have been stunned by the sheer cost associated with having the government pay for all medical bills, the revenue for which would have had to have been collected through substantially higher taxation. Coolidges disapproving views toward taxes—even for well-intentioned purposes—are legendary:

> *"Realizing the power to tax is the power to destroy, and that the power to take a certain amount of property or of income is only another way of saying that for a certain proportion of his time a citizen must work for the government, the authority to impose a tax upon the people must be carefully guarded."*[5]

Perhaps a fair speculation would be to say that, presented with the equivalent of a modern day proposal for single-payer healthcare, Coolidge might have been sympathetic to certain ends, yet skeptical of the government-led means of getting there.

[5] Presidential Remarks to the Business Organization of the Government, Washington, D.C. June 30, 1924

KEY TERMS

Medicare – Medicare is a national health insurance program that was started in 1966 and is administered by the Centers for Medicare and Medicaid Services, commonly abbreviated as CMS. Medicare is paid for partly through payroll taxes (see "FICA" below) and partly through premiums paid by the people who are enrolled in Medicare. Medicare primarily covers people who are aged 65 or older, although there are some notable exceptions (e.g., people of any age who are disabled, or have end stage renal disease or amyotrophic lateral sclerosis).

Medicare Part A – The sub-part of Medicare that covers care provided in hospitals. The details of what services are covered are determined by the government.

Medicare Part B – The sub-part of Medicare that covers care provided by physicians. The details of what services are covered are determined by the government.

Medicare Part C – An alternative to enrolling in Parts A and B is to enroll in Medicare Part C, commonly called "Medicare Advantage." Instead of the details of what services are covered being determined by the government, they are determined by a private company. The private company has to work within guidelines set by CMS, but they are given the flexibility to offer slightly different choices. Many Medicare Advantage plans include prescription drug coverage, so it is not necessary for people with Medicare Advantage to also enroll in Medicare Part D.

Medicare Part D – The sub-part of Medicare that covers prescription drugs. The details of what services are covered are determined by the government.

"Original Medicare" – This term simply refers to enrolling in Medicare Parts A and B, as opposed to choosing the privately administered Medicare Advantage program.

Medicare For All – Also known as single-payer national health insurance, "Medicare For All" is a proposed system in which a single public agency (i.e., the government) would pay for all medical care. Under most proposals this includes all medically necessary services, such as doctor visits, hospital stays, preventive care, long-term care, prescription drugs, dental care, vision care, and possibly more. Under this system, the people who deliver medical care (e.g., physicians, nurses, and other professionals) may still work for private companies, but the government (in contrast to patients or insurers) pays these individuals for their services.

Administrative Savings – Money that is saved by making the *operational* component of a healthcare payment system simpler or more streamlined. Under the status quo, for instance, a physician practice might accept several payments from several different insurance companies. Since each insurance company has their own rules and ways of doing business, it requires extra time and resources to learn and do all the different types of paperwork. Dealing with one payer is simpler, and therefore offers the opportunity for administrative savings.

Monopsony – A market condition in which there is only one buyer of goods and services. The one buyer is called the monopsonist. A monopsonist has great power to drive prices down because by definition there are no other entities for the sellers to sell their goods and services to at a better (i.e., higher for the seller) price.

Premium – The "subscription" price that one pays in order to have a health insurance plan. When reading about premiums, make sure you know whether you are looking at a monthly figure or an annual figure. Most premiums are paid monthly, but when they are discussed in policy circles, people will often compare plans based on what the annual premium is. (The annual premium is simply the monthly premium multiplied by 12.)

Deductible – The amount of money that a patient has to pay before his or her insurance will start covering that person's expenses. If a person has health insurance with a $1,000 deductible, then they have to pay for the first $1,000 of healthcare expenses (e.g., hospital care, physician care, prescriptions drugs) themselves before their insurance starts paying. Deductibles can be high (in the thousands of dollars) or low (in the hundreds of dollars). All else equal, a health insurance plan with a high deductible will have a lower premium.

Out-of-Pocket Costs – Costs that you pay on your own (i.e., directly out of your own pocket) because your health insurance does not cover them. For instance, if you do not enroll in a plan that covers prescription drugs, then you will have to pay for any drugs you need out-of-pocket.

Copay – An amount that you are required to pay to cover part of the cost of a service, such as a visit to a physician or to fill a prescription for a medication. The main purpose of copays is to provide a disincentive for using that service unnecessarily. (If you had no copay at all, then you might see a doctor for every little concern, because it would cost nothing to you directly.)

Third-Party Payer – An entity (e.g., an insurance company or the government) that pays for one party to receive a service from another party. In this nomenclature, the first party is the entity who receives the service; the second party is the entity who provides the service; and the third party is the entity who pays for the service.

Means-test – A test of whether someone is eligible for a government benefit, based upon whether that person possesses the means to do without that help (usually done by income).

Medicaid – A program, run jointly by the federal government and states, that offers health insurance primarily to low-income individuals who are under the age of 65 years old. This program is different from Medicare. Depending on a person's circumstances and age, it is possible for people to be enrolled in one, the other, or both. Medicaid is not the main focus of this brief, but you might encounter it in your research.

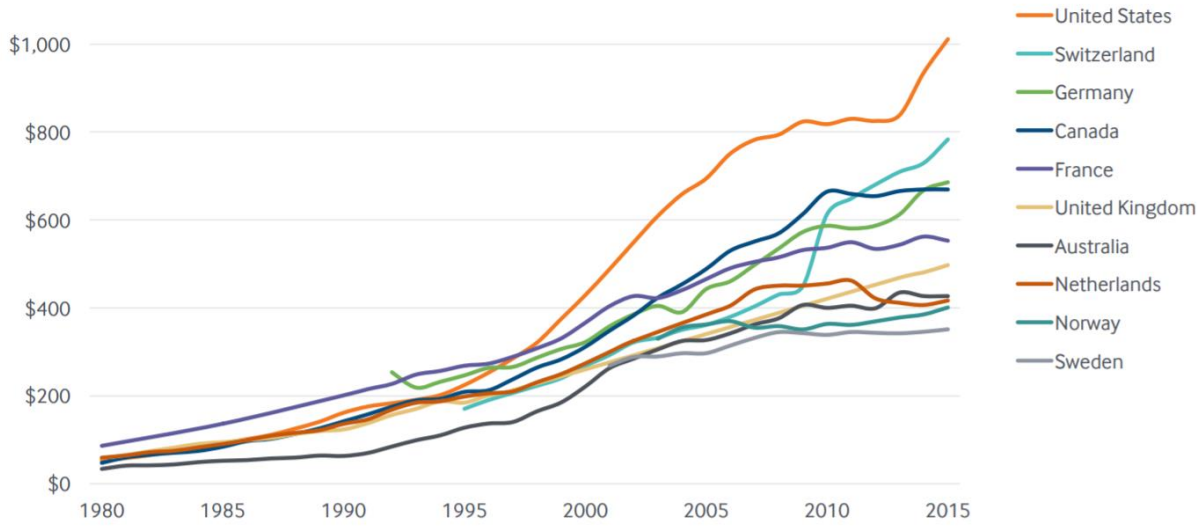
AFFIRMATIVE ARGUMENTS

1. As the sole buyer of healthcare, the government would be able to negotiate better prices with doctors, hospitals, and drug companies.

A major reason why healthcare is so expensive in the United States is that doctors, hospitals, and drug companies have a great amount of leverage over patients and health insurance companies when it comes to setting prices. Individual patients do not have the buying power to demand lower prices. Nor do large insurers, since their customers are spread out over many states, each of which operate as separate markets. However, if the government serves as the sole purchaser of healthcare-related goods and services, it could command monopsonist-level control over the prices offered to those who provide healthcare goods and services, saving the country many billions of dollars.

Hospital care, for example, accounts for approximately 35% of the $3.5 trillion spent annually on healthcare.[6] Using size as leverage, the current Medicare program pays hospitals less than private insurance does for many of the same services. On average, Medicare pays hospitals 86.8% of hospitals' estimated average costs, while private insurance pays hospitals 144.8% of hospitals' average costs. If all of healthcare were paid at the lower rate, total healthcare expenditures would be lower.[7] Hospitals would be pressured to accept these lower prices because under a single-payer healthcare system, there are no other payers to do business with.

Figure 1. National Trends in Per Capita Pharmaceutical Spending, 1980-2015



Source: D.O. Sarnak, D. Squires, and G. Kuzmak. "Paying for Prescription Drugs Around the World: Why Is the U.S. an Outlier?" The Commonwealth Fund, October 2017.

[6] Centers for Medicare & Medicaid Services. National health care expenditure data. Accessed February 2, 2019.
[7] Schulman KA, Milstein A. "The Implications of 'Medicare for All' for US Hospitals." JAMA. 2019.

Likewise, a Medicare For All program could use its size to negotiate better prices for pharmaceuticals. Figure 1 above shows the difference in per capital pharmaceutical spending by country, over the past three and a half decades. At present, Americans pay relatively high prices for their prescription drugs because as unorganized purchasers they cannot effectively band together to demand lower prices from monopolistic (i.e., single-seller) drug companies. In countries with single-payer healthcare systems, however, governments can offer a take-it-or-leave-it price. Drug companies that refuse to accept this price forego all sales in that country.[8]

2. Simplifying the healthcare payment system would result in substantial administrative savings.

The complex nature of the status quo is extremely inefficient. Currently hospitals and physician offices that wish to accept payment from patients' health insurance companies must develop and maintain the capability to handle many different sets of paperwork, each with their own idiosyncratic rules and procedures. Even small physician offices often need to hire multiple office workers to handle all of the different types of paperwork. One study found that roughly 0.7 full-time equivalent (FTE) office workers per physician were required to handle the billing and insurance functions in the average medical office.[9] This administrative complexity adds an estimated $265 billion per year in wasteful, unnecessary costs to the system.[10]

> "A national health insurance program could save approximately $150 billion on paperwork alone. Because of the administrative complexities in our current system, over 25% of every health care dollar goes to marketing, billing, utilization review, and other forms of waste. A single-payer system could reduce administrative costs greatly."
>
> Source: "Single-Payer Myths; Single-Payer Facts" Physicians for a National Health Program. Accessed December 2, 2019.

Under Medicare For All, hospitals and medical offices would not need so many workers to handle so many different systems of claims administration paperwork because with only one payer, there would just be one consolidated system of paperwork. Many of the various functions that are inherent in private health insurance would simply not be necessary, including advertising costs, sales commissions, premium determination, and outrageous CEO pay.[11] Office workers would not be needed to address claims denials or adjudicate prior authorization

[8] Robinson, James C., Patricia Ex, and Dimitra Panteli. "Single-Payer Drug Pricing In A Multipayer Health System: Does Germany Offer A Model For The US?." Health Affairs Blog. March 22 (2019).
[9] Sakowski, et al. "Peering Into The Black Box: Billing And Insurance Activities In A Medical Group" Health Affairs. 2009.
[10] Bauchner H, Fontanarosa PB. Waste in the US Health Care System. JAMA. 2019;322(15):1463–1464. doi:10.1001/jama.2019.15353
[11] Blumberg and Holahan. "The Pros and Cons of Single-Payer Health Plans" The Urban Institute. March 2019.

requests. Middlemen such as prescription benefit managers could also be eliminated.[12] Finally, the Medicare For All program would not need to make a "profit," so even more money could remain in the pockets of consumers.

Current Medicare has lower administrative costs than the private sector (3% compared with 17%).[13] Figure 2 shows administrative costs by category of activity. Costs range from 13 minutes of time and roughly $20 in administration for a simple primary care visit, to upwards of 100 minutes of time and over $215 spent for every inpatient surgery.

Figure 2. Estimated Billing and Insurance-Related Administrative Costs by Activity

Costs and Processing Time	Primary Care Visit	Emergency Department Visit[b]	General Inpatient Stay[c]	Ambulatory Surgery	Inpatient Surgery
Total processing time, min	13	32	73	75	100
Total cost, $ (%)	20.49 (100)	61.54 (100)	124.26 (100)	170.40 (100)	215.10 (100)
Cost breakdown by activity, $ (%)					
Pre- and intraencounter costs					
Registration and preregistration	3.82 (19)	5.58 (9)	16.48 (13)	16.48 (10)	16.48 (8)
Physician time	6.36 (31)	10.97 (18)	13.29 (11)	51.20 (30)	51.20 (24)
Postencounter costs					
Professional billing	4.22 (21)	11.72 (19)	4.22 (3)	45.55 (27)	45.55 (21)
Hospital billing		13.70 (22)	44.43 (36)	17.44 (10)	44.43 (21)
Overhead	6.10 (30)	19.57 (32)	45.84 (37)	39.72 (23)	57.43 (27)

[a] Percentages may not sum to 100 because of rounding.

[b] Emergency department visit without hospital admission.

[c] For a general medicine inpatient stay, the billing and insurance-related cost of physician time assumes that autopopulation of the electronic health record after the first inpatient day occurs correctly without subsequent need for physician time or alterations. The cost of professional billing assumes that the incremental cost of additional inpatient days is minimal with respect to the first inpatient day and that physicians are timely with their billing responsibilities, such that all inpatient professional rounding charges are processed and submitted to payers concurrently.

Source: Tseng, Phillip, et al. "Administrative costs associated with physician billing and insurance-related activities at an academic health care system." JAMA. 2018.

3. Guaranteeing that everyone has health coverage finally fulfills our duty to make healthcare a human right for all Americans.

Prior to the enactment of the Affordable Care Act (a.k.a. Obamacare) in 2010, roughly 46.5 million Americans, or 16% of the population, did not have health insurance.[14] While that set of reforms did manage to bring the number of uninsured down to roughly 28 million Americans, that is still a far cry from true universal coverage—the goal of *everyone* having coverage.

> In 1946 the World Health Organization (WHO) declared in its Constitution that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being."
>
> Source: World Health Organization Constitution. (Adopted 1946)

[12] Ibid.
[13] Ibid.
[14] Tolbert, et al. "Key Facts about the Uninsured Population" Kaiser Family Foundation. December 13, 2019.

Access to healthcare is mediated by insurance.[15] To secure healthcare as a right, we need to make sure that every person has health insurance coverage. Medicare For All achieves that goal with certainty and immediacy. Other approaches, such as relying on the free market to reduce costs, even if they are mostly successful, could still leave some people uninsured. Only a single-payer-style Medicare For All system provides full assurance and security to everyone for nearly all of their healthcare needs. As Senator Bernie Sanders (D-VT) describes in a bill summary on his website:[16]

> *The Medicare for All Act will provide comprehensive health care to every man, woman and child in our country—without out-of-pocket expenses. No more insurance premiums, deductibles or co-payments. Further, this bill improves Medicare coverage to include dental, hearing and vision care. In other words, this plan would do exactly what should be done in a civilized and democratic society. It would allow all Americans, regardless of their income, to get the health care they need when they need it.*

With the security of knowing that one has health insurance comes freedom. In a modern society where healthcare is high-tech and expensive, is needed to help Americans live happier, healthier and more fulfilling lives.

4. Under Medicare For All, insurance coverage wouldn't be tied to employment.

> "Under a single-payer system… [c]overage would be portable–e.g. no longer tied to employment or to an insurer's network of providers–and truly universal."
>
> Source: "What is Single-Payer?" Physicians for a National Health Program. Accessed Jan. 14, 2020

One of the most distortionary things about the status quo in healthcare is that due to the way it is treated by the tax code, most people who purchase private health insurance do so through their employer. Currently, about 156 million people (49% of the U.S. population) receive their health insurance their employer.[17] Although it is good that they have access to insurance, this arrangement can also create an undesirable situation known as "job lock" in which people feel that they cannot leave their job (to seek out a better job, or start a new business, or temporarily leave the work force to start a family, etc.) because they will risk losing their insurance. The Sanders website:

> *Employers would be free to focus on running their business rather than spending countless hours figuring out how to provide health insurance to their employees. Working Americans wouldn't have to choose between bargaining for higher wages or better health insurance.*

---

[15] Maruthappu, Mahiben et al. "Is Health Care a Right? Health Reforms in the USA and their Impact Upon the Concept of Care." Annals of medicine and surgery (2012) vol. 2,1 15-7. 5.
[16] "The Medicare For All Act of 2019" Official Website: Sen. Bernie Sanders. (Accessed January 11, 2020.)
[17] "Health Insurance Coverage of the Total Population" Kaiser Family Foundation. (Accessed January 11, 2020.)

Because Medicare For All would be administered through the government, it would eliminate the phenomenon of job lock. Individuals would no longer be limited to the health insurance options that their employer pick for them. Additionally, it would be good for American businesses, as they would no longer be with responsibility of contracting with health plans.

NEGATIVE ARGUMENTS

1. Medicare For All will cost too much.

According to economic analyses of Senator Sanders's proposed Medicare For All legislation, adopting Medicare For All would commit the federal government to approximately $32 trillion in spending over the first 10 years of the program. At that price tag, this health reform proposal is too expensive for the nation to afford.[18],[19]

> "[Medicare For All] would add approximately $32.6 trillion to federal budget commitments during the first 10 years of its implementation (2022–2031)."
>
> "This projected increase in federal healthcare commitments would equal approximately 10.7 percent of GDP in 2022. This amount would rise to nearly 12.7 percent of GDP in 2031 and continue to rise thereafter."
>
> Source: Blahous, Charles. "The Costs of a National Single-Payer Healthcare System." Mercatus Center at George Mason University, Arlington, VA. July 2018.

Advocates of Medicare For All concede that we would have to raise taxes in order to pay for the program, but they fail to appreciate how large the increases would be. According to one study that explored different options for financing Medicare For All, the government would have to raise payroll taxes by 32 percent on workers and businesses, or levy a 25 percent income surtax, or institute a new 42 percent value-added tax (VAT) on consumption, or charge each person a "mandatory public premium" averaging $7,500 per capita.[20] Looked at another way by the Blahous study from Mercatus, if all currently projected federal individual and corporate income tax collections were *doubled*, it would still be insufficient to pay for the program.[21]

Not only is the projected cost of switching the entire country's health payments over to Medicare For All extremely high, it is uncertain and risky. In the interest of being as fair as possible to the proposal, the $32-trillion figure is an estimate that generously assumes that there *will* be some significant savings from administrative costs and drug costs. In fact, the model used in the study to come up with the overall cost figure assumes that reimbursements (i.e., payments) to doctors will be roughly 40 percent lower than they are today. If anything, since it is far from certain that these savings will materialize as predicted, current estimates represent a *best* case scenario that *understates* the cost of the program. Given the precarious fiscal state that the United States is already in with a $22.2 trillion national debt and the federal government running chronic budget deficits, we simply cannot afford Medicare For All.

---

[18] Blahous, Charles. "The Costs of a National Single-Payer Healthcare System." Mercatus Center at George Mason University, Arlington, VA. July 2018.
[19] John Holahan et al. "The Sanders Single-Payer Healthcare Plan: The Effect on National Health Expenditures and Federal and Private Spending." The Urban Institute. 2016. Tables 1 and 9.
[20] "Choices in Financing Medicare For All: Preliminary Analysis." Committee for a Responsible Federal Budget, October 28, 2019
[21] Blahous, Charles. "The Costs of a National Single-Payer Healthcare System." Mercatus Center at George Mason University, Arlington, VA. July 2018.

2. Using monopsony power to dictate lower prices will cause physicians, hospitals, and drug companies will cause them to provide fewer goods and services, and will stifle innovation.

In normal markets, when buyers and sellers negotiate with each other to arrive at mutually-agreeable prices, it is a good thing for the economy. Both parties win. But when there is only one buyer (a monopsonist) and that buyer demands a price for goods or services that the seller considers too low, economic theory dictates that the seller will offer fewer of those goods or services—and might even decide to close its business or produce something else instead. Under Medicare For All, the federal government would have monopsony power over physicians, hospitals, and drug companies.

> "The classic problem of monopsony buying power [is] underprovision of services. The medical market is no exception. This problem manifested in Medicaid years ago–as states started to clamp down on payments, providers exited the market, leaving us with the patchwork system we have today. Could the same happen to Medicare?"
>
> "We are already hearing reports of doctors who do not take Medicare patients. In a 2010 survey of 9,000 physicians, the American Medical Association reported that 17 percent of doctors restricted the number of Medicare patients; among primary care physicians, a whopping 31 percent did. With universal Medicare, is the population really going to accept, and would Congress really allow, the continued reductions in prices?"
>
> Source: Blumberg and Holahan. "The Pros and Cons of Single-Payer Health Plans" The Urban Institute. March 2019.

If the federal government *does not* use its buying power to negotiate lower prices, then the case for Medicare For All to lower health expenditures is weakened. On the other hand, if the federal government *does* use its buying power, it risks setting prices to low for those who produce healthcare goods and services, which again weakens the case. Physicians will stop taking new patients. Hospitals will stop scheduling needed surgeries. Drug companies will stop investing in research and development. We cannot risk that the government, acting as sole buyer, will know exactly the "right" price to offer for everything such that taxpayers do not overpay for what they get, yet physicians, hospitals, and drug companies still have enough incentive to stay in business. Only markets can achieve such a precise and delicate balance.

3. The potential for administrative savings under Medicare For All is overstated.

Advocates for Medicare For All are fond of pointing out how expensive and inefficient it is for physician practices and hospitals to handle the paperwork and administrative processes associated with dealing with multiple private insurance companies. Some of those activities are indeed wasteful, but some actually serve valuable purposes.

Consider two examples: *prior authorization* and *fraud prevention*. Prior authorization is an administrative process that requires physicians to call and obtain permission from a health insurance company before ordering certain tests or procedures. The insurance company

reviews the request to make sure that it is necessary and that does not duplicate some other test or procedure that was recently done for that patient by another doctor. This process helps to keep costs down by avoiding unnecessary duplication. Most Medicare For All proposals, like the current traditional Medicare program, would not have prior authorization. Not having prior authorization might make healthcare more convenient for patients, but it diminishes the claim that Medicare For All will be cheaper due to administrative savings.

Fraud Prevention is another administrative process that is underappreciated by Medicare For All advocates. Private insurance companies spend much more on protecting against fraud (e.g., physicians and hospitals billing for services they did not deliver, or scammers posing as legitimate healthcare providers and getting paid for phony bills) than the government does. In 2018, the Centers for Medicare & Medicaid Services spent just two-tenths of one percent of its budget on combating waste, fraud, and abuse.[22] When a private insurance company spends money to prevent fraud, it is recorded as an administrative expense. By contrast, when a government program—such as the current Medicare program—fails to spend money on fraud prevention, it *looks* as though it has low administrative costs when in reality it is losing money to scammers and cheaters.

Table 1. Estimated Improper Payment Rates and Improper Payments (in Billions)

Program	2018 Improper Payments		2019 Improper Payments	
	Rate	Amount	Rate	Amount
Medicare Parts A & B	8.12%	$31.62	7.25%	$28.91
Medicare Part C	8.10%	$15.55	7.87%	$16.73
Medicare Part D	1.66%	$1.32	0.75%	$0.61

Source: Centers for Medicare & Medicaid Services. November 18, 2019.

Although it is difficult to know the precise amount of undetected waste, fraud, and abuse, the government's own Office of Management and Budget (OMB) puts the figure in the tens of billions of dollars per year. Table 1 above shows the estimated improper Medicare payments for the fiscal years of 2018 and 2019.

[22] Author's calculation based on figures published in the 2018 CMS Program Integrity Budget Overview and CMS Budget Overview. Numerator: $2.103 billion. Denominator: $1.021 trillion.

4. Under a government system such as Medicare For All, having *health insurance coverage* is no guarantee that one will actually receive the *care* that one needs.

Advocates for Medicare For All treat universal coverage as if it is one and the same with providing true health security. It is not. Simply carrying around a health insurance card in one's wallet does not guarantee that a doctor, hospital, or drug company will be there when one needs care or the right medication.

> As of October 2019, 33,200 patients in England had been waiting six weeks or more for one of 15 core diagnostic tests. That is in a country of 56 million people—roughly the number of people in Florida, New York, and Pennsylvania combined. Imagine how many people would be waiting for healthcare if England had a population as large as the entire United States?
>
> Source: NHS Diagnostic Waiting Times and Activity Data: October 2019 Monthly Report.

This is a critical distinction because the very structural changes that must be made in order to grant health care as a "right" to everyone also serve to diminish the likelihood that care will be supplied when needed. Under Medicare For All, millions more Americans will be able to say that they have health coverage, but with more patients trying to see the same number of doctors, waiting times for everyone will have to increase. In Canada, where all citizens have coverage under their National Health Insurance model, patients on average wait 4.3 weeks for a computed tomography (CT) scan, 10.6 weeks for a magnetic resonance imaging (MRI) scan, and 3.9 weeks for an ultrasound.[23] In England, another country with universal coverage, instead of reporting average wait times for diagnostic services such as MRI scans and CT scans, their National Health Service reports the *number of patients forced to wait six weeks or more*. As of the end of October 2019, the total number of patients in England who had been waiting six weeks or more for one of 15 common diagnostic tests was 33,200.[24]

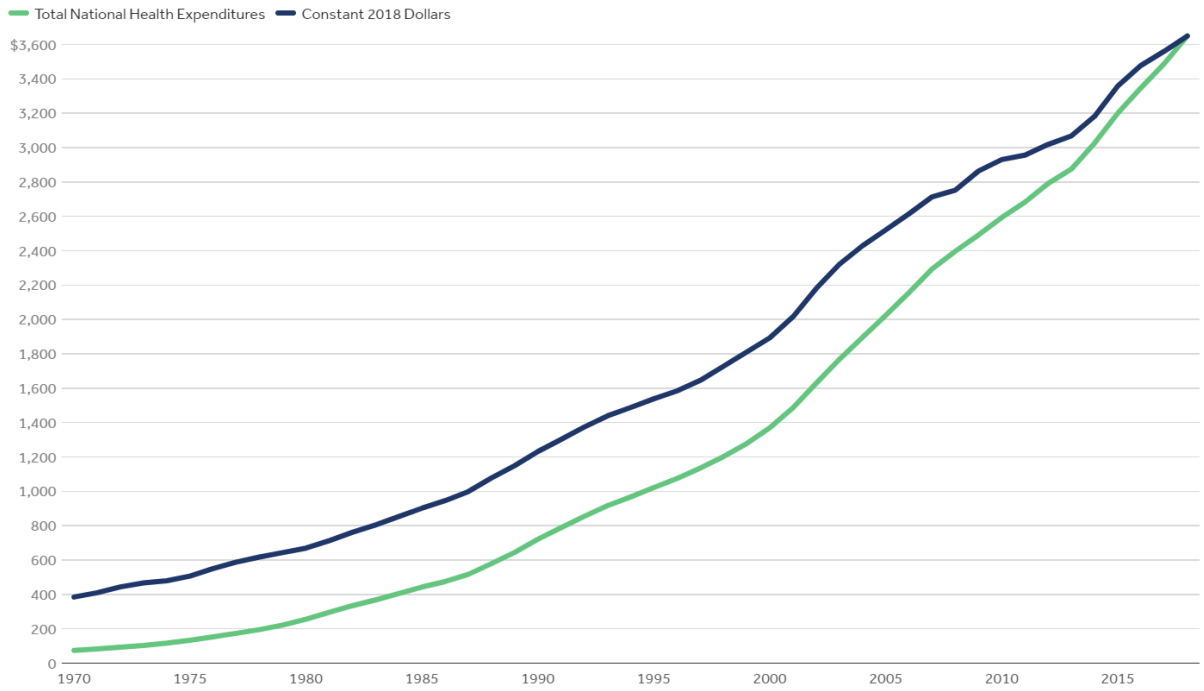
Simply extending health coverage to millions of additional people without addressing the incentive structures and resources needed—doctors, nurses, hospitals, and so forth—to deliver care to that many people is not a good way to fix healthcare. Rather than declaring everyone covered through a government program, we should prefer market-based reforms that introduce more health insurance options to consumers and that bring the cost of health insurance down to levels where everyone can purchase the amount and type of coverage they think is best for themselves and their family.

---

[23] "Waiting Your Turn: Wait Times for Health Care in Canada, 2018 Report" Fraser Institute. December 4, 2018.
[24] NHS Diagnostic Waiting Times and Activity Data: October 2019 Monthly Report. NHS. Published December 2019.

APPENDIX A. Total U.S. Healthcare Expenditures, 1970-2018

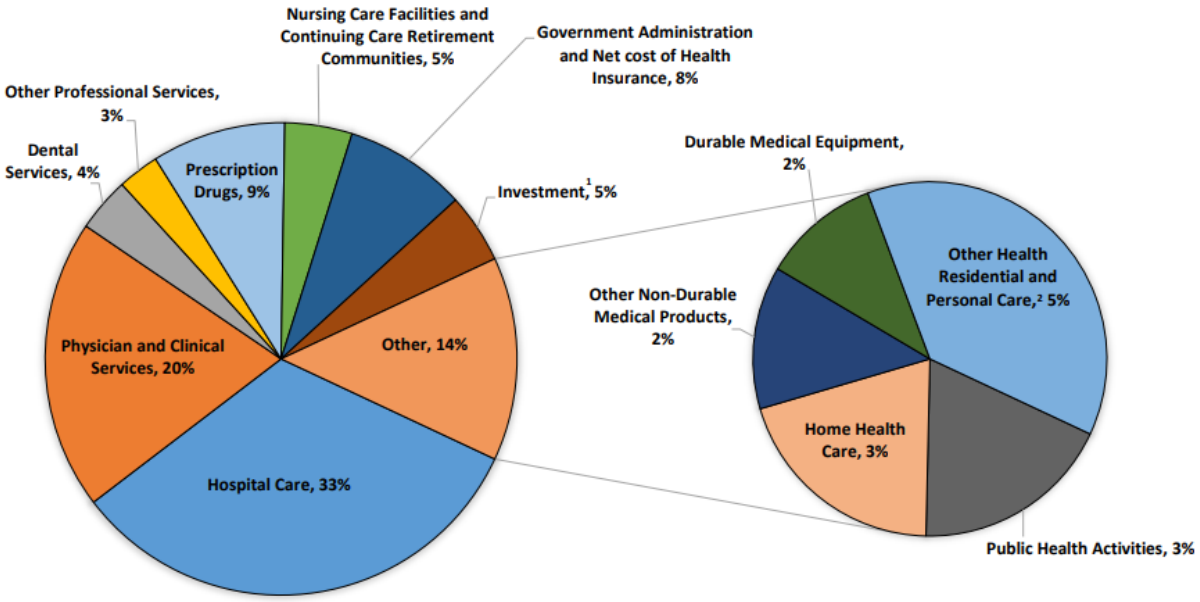
Total national health expenditures have climbed steadily since the 1970s. The rate of growth slowed temporarily after the passage of the Affordable Care Act (a.k.a. Obamacare) in 2010, but then sped up again shortly thereafter. The graph below shows total expenditures in green and an adjusted data series in blue (constant 2018 dollars) to show that the growth is real and not due merely to inflation.



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data.
Published December 2019. Accessed December 20, 2019.

APPENDIX B. How Health Dollars Are Spent in the United States

Nationally, the two largest components of healthcare spending are hospital care (33%) and physician services (20%). The pie chart below identifies the other major sectors of healthcare spending in the U.S. and how much they account for.

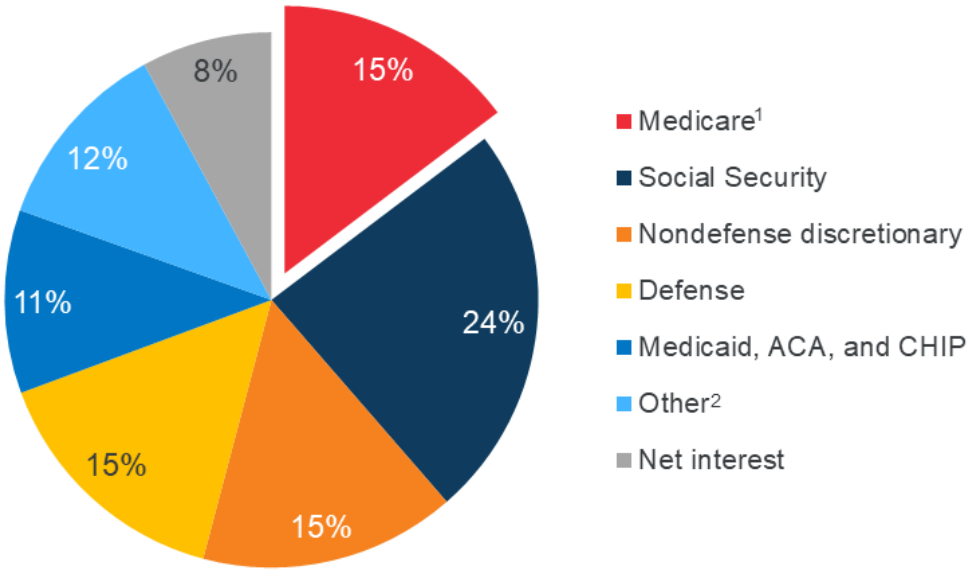


[1] Includes Noncommercial Research and Structures and Equipment.
[2] Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.
Note: Sum of pieces may not equal 100% due to rounding.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. Data for Calendary Year 2018. Accessed January 12, 2020.

APPENDIX C. Medicare As a Share of the Federal Budget

The current Medicare program, which covers about 44 million people (approximately 15% of the U.S. population), comprises about 15% of the federal budget. That is about the same proportion as the military. Under Medicare For All, the proportion would be much higher, as many more individuals would receive coverage under the new program.



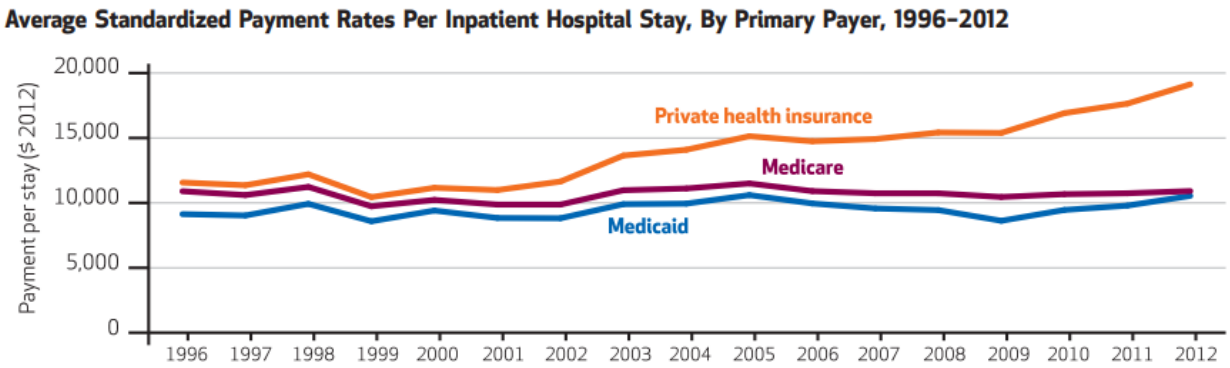
Total Federal Outlays, 2018: $4.1 trillion
Net Federal Medicare Outlays, 2018: $605 billion

NOTE: All amounts are for federal fiscal year 2018.[1] Consists of mandatory Medicare spending minus income from premiums and other offsetting receipts.[2] Includes spending on other mandatory outlays minus income from offsetting receipts. ACA is Affordable Care Act. CHIP is Children's Health Insurance Program.

Source: Kaiser Family Foundation analysis of federal spending from Congressional budget Office, The Budget and Economic Outlook, 2019 to 2029. Published May 2019.

APPENDIX D. What Medicare Pays Compared to Private Insurance

The chart below shows the difference in the average rate per hospital stay for three different payers: Private health insurance, Medicare, and Medicaid. Private health insurance consistently pays hospitals and physicians the most, and Medicaid pays hospitals and physicians the least. Medicare pays hospitals and physicians somewhere in between. This is from a paper in the journal *Health Affairs* and is based on the author's analysis of data from 1996 to 2012 from the Medical Expenditure Panel Survey.



Notes: The average payment rates were computed as if each primary payer paid for all non-maternity adult stays in a given year. Payments were adjusted for inflation and standardized across payers in terms of patient's age, sex, race/ethnicity, geography, household income as a percentage of the federal poverty level, conditions, charges, length-of-stay, and whether or not a surgical procedure was performed. They were not standardized for changes over time in the bundles of treatments and services provided during inpatient stays.

Source: Selden, et al. "The Growing Difference Between Public And Private Payment Rates For Inpatient Hospital Care." *Health Affairs*. December 2015.