An Analysis of Senator Sanders Single Payer Plan

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Summary

Senator Sanders has proposed eliminating private health insurance and the exchanges created through the Affordable Care Act and replacing it with a universal Medicare program with no cost sharing. The plan would shift virtually all health care spending from private and public sources today onto the federal budget. The campaign estimates his plan would cost an average of $1.38 trillion per year over the next decade. https://berniesanders.com/issues/medicare-for-all/. They outline a variety of payroll and income tax increases, higher taxes for capital gains and dividends, taxes on estates of high income households and eliminate tax breaks that subsidize health insurance. Collectively he claims these taxes fully pay for the costs of the single payer plan. The analysis presented below however estimates that the average annual cost of the plan would be approximately $2.5 trillion per year creating an average of over a $1 trillion per year financing shortfall. To fund the program, payroll and income taxes would have to increase from a combined 8.4 percent in the Sanders plan to 20 percent while also retaining all remaining tax increases on capital gains, increased marginal tax rates, the estate tax and eliminating tax expenditures. The plan would create enormous winners and losers even with the more generous benefits with respect to what households and businesses pay today compared to what they would pay under a single payer plan. Overall, over 70 percent of working privately insured households would pay more under a fully funded single payer plan than they do for health insurance today.

Results

- ***The plan is underfinanced by an average of nearly $1.1 trillion per year.*** The Sanders campaign estimates the average annual financing of the plan at $1.377 trillion per year between 2017 and 2026. Over the same time period, we estimate the average financing requirements of $2.47 trillion per year--about $1.1 trillion more on average per year over the same time period. We present results in table 2 showing the Sanders' financing plan. However we also do an analysis of the additional taxes needed to pay for the $1.1 trillion underfinancing. This would require an increase in the payroll tax from 6.2% to 14.3% and an increase in the income related premium from 2.2% to 5.7% -- a combined 20 percent tax on income. In light of the overall scope of the Sanders' financing proposals, additional marginal tax increases on families over $250,000 seam unrealistic. The results are presented in Table 3 This financing requirement is similar to the tax increases needed to finance the proposed Vermont single payer plan.
- A single payer plan would have dramatic distributional impacts on Medicaid and Medicaid spending, and what individuals and businesses pay compared to current law under the Affordable Care Act. Medicare beneficiaries would no longer pay premiums and face no sharing but would pay higher taxes. In general small businesses that do not offer insurance today with 50 or fewer workers would face a 6.2% payroll tax increase. Low income populations living in poverty receiving Medicaid would pay more through the 2.2% income tax and 6.2 percent reduction in wages.

- On the other hand, average employer contributions toward health insurance today exceed 6.2% so the average employer would spend less on care. Finally, individuals currently enrolled in high deductible health plans, particularly the chronically ill, would receive better health benefits.

Aggregate Financial Impacts

- The single payer plan would reduce household and employer premium payments by $1.2 trillion per year starting in 2017.
- The new tax burden would vary dramatically by income. Low income working families would pay 2.2 percent of taxable income and face a 6.2 percent reduction in wages traced to the employer payroll tax. Individuals and families earning over $250,000 would face over a 40 percent increase in taxes to finance the plan and pay for most of the new costs of the plan.

Impacts on Medicare ($2.45 trillion of additional spending over ten years)

- Medicare pays for inpatient hospital care at about 89 percent of costs. A national blended payment rate of 105% of costs would increase Medicare spending by $240 billion over ten years

- More generous cost sharing for the 10-15 percent of beneficiaries that do not have supplemental benefits would increase total Medicare spending. Estimates from a recent NBER study among others indicate that Medicare spending rises by 30 to 45 cents for each $1 reduction in Medicare cost sharing. We use a lower figure of 25% in the analysis resulting in increased Medicare spending of $285 billion between 2017 and 2027. In addition, cost sharing in the program would be eliminated. Medicare has an actuarial value of 80 percent so Medicare spending would rise by over 20%. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7768-02.pdf.
Buying out Medicare cost sharing would cost approximately $1.9 trillion over ten years.

Impacts on former Medicaid patients (over $210 billion additional spending over ten years)

- Overall spending will increase for the federal government since payment rates to providers would increase among those formerly covered by Medicaid. Medicaid pays providers approximately 88 percent of costs so spending on behalf of former Medicaid patients would rise by $210 billion over ten years

Impacts of Households and Business

- There would be substantial distributional impacts (large number of households and businesses that pay substantially more and less) of any plan that has to raise a total of 20% of total compensation relative to current law. The new taxes and savings would differ dramatically by income and by small and large employers.
- Most employers that offer coverage today would pay less under a 6.2 percent payroll tax. Over two-thirds of workers are employed in firms whose employer pays over 10% of payroll for health benefits.

- On the other hand, small employers that currently do not offer insurance (390,000 between 10 and 25 and 3.1 million under 10) would see substantial initial increases in taxes to finance the plan through the 6.2 percent payroll tax. This tax would be passed along to workers in the form of lower wages and other benefits.
- Over the ten year period, the plan would require $25 trillion worth of new federal funding. Households and businesses would save nearly $15 billion in premium and out of pocket payments

Table 1 Federal Financing Required Under Sanders Style Plan, 2016-2024 (Trillions of Dollars)

	Revenue and Expense To Finance Single Payer
2017	1.9
2018	2.0
2019	2.1
2020	2.3
2021	2.4
2022 2023 2024 2025 2026 2017-26 Total Average	2.5 2.6 2.8 2.9 3.1 $24.7 $2.47

At Risk Populations

While more generous benefits will help chronically ill patients enrolled in high deductible plans, there are populations at risk with the financing plan designed to pay for a single payer. The following table examines the number of health insurance units (individuals covered under the same health insurance policy) who pay more and less comparing the 8.4 percent combined tax, the increased income tax on households over $250,000, taxing capital gains and dividends at the same rate as taxable income and limiting deductions to high income households compared to what they and their employer pay for health insurance plus the dollar value of enhanced benefits. We increase total premiums paid by employers and families by an average of 25 percent to reflect the more generous benefits envisioned under the single payer plan. We assume that the single payer benefits facing a family are the reduction in their (enhanced) insurance spending as well as their employers' contribution (these employer savings would go to workers in higher wages and other benefits). Medicare beneficiaries would no longer pay any Medicare premiums and would receive approximately a 20 percent increase in benefits to reflect the elimination of cost sharing. We use income and payroll data as well as employee and employer health insurance premium data from the Current Population Survey.

Table 2 Number of Health Insurance Units Paying More and Less for Health Care under Single Payer Compared to Current Law (Millions)

Population	Total	Pay More Under Single Payer	Pay Less Under Single Payer
Medicare workers	6.2	2.6 42%	3.6 58%
Medicaid workers	**8.2**	**5.9 72%**	**2.3 28%**
Young adult workers	**10.1**	**4.8 48%**	**5.3 52%**
Workers in firms under 50	**33.1**	**9.7 30%**	**23.4 70%**
Total working families	**68.3**	**18.9 28%**	**49.4 72%**

SOURCE: Simulations from the Current Population Survey.

Many workers would pay more and many less under the Sanders financing plan. For instance, 42 percent of working Medicare beneficiaries would pay more under the single payer plan while 58 percent would receive additional benefits that exceed their new contribution. Over 70 percent of low income working Medicaid households would pay more for a single payer plan. Nearly half of young adult workers would also pay more in new taxes than benefits

received. Overall, 28 percent of working households with private insurance today would pay more under a single payer plan.

Table 3. **Number of Health Insurance Units Paying More and Less for Health Care under Single Payer Compared to Current Law (Millions) When Plan in Fully Financed**

Population	Total	Pay More Under Single Payer		Pay Less Under Single Payer	
Medicare Workers	6.2	4.1	66%	2.1	34%
Medicaid Workers	8.2	7.0	85%	1.2	15%
Young adult workers	10.1	6.5	65%	3.6	35%
Workers in firms under 50	33.1	18.6	57%	14.5	43%
Total working households with Private Insurance	68.3	48.7	71%	19.6	29%

We also examine the distributional impacts of the plan when fully financed. On average, the plan is underfinanced by over a trillion dollars per year. We calculate the total payroll tax and income related premium needed to fully fund the program. We inflated our 2014 income and payroll data from the CPS (which is aligned to the Bureau of Labor Statistics payroll data https://research.stlouisfed.org/fred2/series/A576RC1A027NBEA using CBO projections of income and payroll growth https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51129-2016Outlook_OneCol.pdf to reflect 2021 income and payroll.

When the plan is fully financed through a 14.3 percent payroll tax and 5.7 percent income related premium two-thirds of working families on Medicare would pay more in a single payer tax than they would receive in additional benefits . Some 85 percent of low income working populations on Medicaid would also pay more in taxes and reduced wage growth compared to any additional single payer benefits. Nearly 60 percent of workers in small firms would pay more in single payer taxes and reduced wage growth. Overall 71 percent of workers and their families with private insurance would pay more for the single payer tax compared to the additional insurance benefits.

Assumptions

- Both the Affordable Care Act and a single payer plan are designed to achieve universal coverage. The main difference is the ACA is dramatically less disruptive while a single payer plan would create enormous financial winners and losers among households and businesses.

- ➢ The single payer plan is federally financed and would replace coverage in the Affordable Care Act.
- ➢ The plan would eliminate private health insurance and cost sharing.
- ➢ Medicare cost sharing would be eliminated. The plan would also buy out Medicare premium contributions for Parts A, B and D of the program.
- ➢ We assume other federal and state funding for worksite health care, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health remain in place.
- ➢ State spending on their share of Medicaid and CHIP is not likely to continue fully for programs that no longer exist. However is likely that some state financing would remain in place. There is a precedent here with the Medicare Modernization Act with Part D of Medicare. When passed, Medicare assumed responsibility for financing the drug costs of dual Medicare- Medicaid eligibles. However, each state faced a "clawback" which started at 90 percent of what they would have spent on dual eligible drug expenses and phased down to 75 percent in 2015. We make a similar assumption for state MOE financing of the costs of former Medicaid and CHIP patients. If there were no state MOE, financing requirements for the single payer plan would increase by an average of $450 billion per year—an additional $4.5 trillion over ten years.
- ➢ Since private insurance pays providers above treatment costs and Medicare and Medicaid pay below we assume that a blended payment rate would be at 105% of costs. This will increase Medicare spending and spending to care for those formerly covered by Medicaid.
- ➢ We assume that administrative savings would be similar to those estimated by the state of Vermont, about 4.7 percent of total health care spending. This is built into the financing requirements in Table 1 as a savings. https://umassme ed.edu/uploadedFiles/CWM_CHLE/About/Vermont%20Health%20Care%20Financing%20Plan%202017%20-%20Act%2048%20-%20FINAL%20REPORT.pdf. However, these potential savings would be more than offset by the reduction in cost sharing and expanded set of benefits.
- ➢ We take private insurance and out of pocket spending (which is folded into single payer insurance spending) and make several adjustments to develop a single payer funding estimate. First we increase it by 10 percent to reflect the increased total health care spending that results from a reduction in out of pocket payments. Second we adjust downward by 20% to reflect the lower blended payment and finally we reduced the total by 4.7 percent to reflect potential administrative costs savings. Finally we add in the new spending among the previously uninsured.
- ➢ Reduced cost sharing in Medicare would increase Medicare spending among the 15% of beneficiaries that currently do not have another form of supplemental coverage. Studies have shown that supplemental coverage increases Medicare spending by 10-25 percent depending on the source of coverage.

- ➢ The plan would cover approximately 265 million Americans previously with private insurance, other federal and state programs, Medicaid and the uninsured and another 50.5 million through Medicare
- ➢ We assume that the plan would ultimately reduce the growth in per capita spending through price and payment controls on health care providers
- ➢ We assume employers pay a 6.2 percent payroll tax and individuals pay a 2.2 percent tax on taxable income as well as the increased marginal tax rates and taxation levels of capital gains and dividends. Most economists assume that workers bear the incidence of the employer payroll tax. We also consider a tax structure discussed below that would be fully funded http://www.taxpolicycenter.org/taxtopics/currentdistribution.cfm

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[1] Findings in the study are solely the responsibility of the author and do not reflect the views of Emory University