



RESEARCH REPORT

The Sanders Single-Payer Health Care Plan

The Effect on National Health Expenditures and Federal and Private Spending

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The Sanders Single-Payer Health Care Plan

Presidential candidate Senator Bernie Sanders has called for adopting a single-payer health care system in the United States.¹ He proposes replacing the programs established under the Affordable Care Act (ACA), as well as preexisting public programs such as Medicaid and Medicare, with the new system. Under his approach, all individuals in the United States would be covered by a single insurance program. Sanders's plan would eliminate all private spending and replace all private and public coverage programs, except Veterans Health Insurance and the Indian Health Service. Benefits provided under the insurance plan would cover all medically necessary services, and cost sharing would be eliminated entirely. Coverage would include both acute and long-term care.

We analyze the effects of Sanders's approach on spending by governments, households, and employers, using information publicly provided by the campaign and making our assumptions explicit where detailed information is not available. In companion work, the Urban-Brookings Tax Policy Center estimated the revenue effects of the same proposal (Sammartino et al. 2016). Highlights from the revenue analysis, available in its entirety separately, are referenced here.

We estimate the impact of the Sanders plan on federal health expenditures and national personal health expenditures. We use three approaches, separately estimating the following changes:

- Changes in acute care spending for the nonelderly who would not have Medicare under current law (for simplicity, referred to as “the nonelderly”). This is by far the largest component of the analysis and is estimated using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).
- Changes in acute care spending on those otherwise enrolled in Medicare. Enhancements to Medicare are estimated using a spreadsheet model and assumptions about the different effects of the proposal.
- Changes in spending on long-term services and supports. We use the Urban Institute's Dynamic Simulation of Income Model (DYNASIM) to estimate the cost of a fully federally financed comprehensive long-term care plan.

The overall results are shown in table 1. The underlying assumptions and more detailed results are presented in the following sections.

Our central findings of the effects of the Sanders approach are shown in table 1 and include the following:

- All American residents would be automatically enrolled in acute care coverage, increasing insurance coverage by an estimated 28.3 million people in 2017, from an uninsurance rate for nonelderly adults of 10.4 percent under current law in 2017. In 2026, the Sanders plan would decrease the number of nonelderly uninsured by 30.9 million, or 11.0 percent of the population, relative to current law. (The uninsurance rate under current law in 2026 is projected to be larger than the rate in 2017 as a result of demographic changes and a slight decrease in the rate of employer-sponsored insurance.) Although the intent is unspecified in the campaign's materials, this finding assumes that the plan would cover the undocumented population as well as citizens and other legal residents.
- National health expenditures for acute care for the nonelderly would increase by \$412.0 billion (22.9 percent) in 2017. Aggregate spending on acute care services for those otherwise enrolled in Medicare would increase by \$38.5 billion (3.8 percent) in 2017. Long-term service and support expenditures would increase by \$68.4 billion (28.6 percent) in 2017.
- Together, national health expenditures would increase by a total of \$518.9 billion (16.9 percent) in 2017, and by 6.6 trillion (16.6 percent) between 2017 and 2026.
- The increase in federal expenditures would be considerably larger than the increase in national health expenditures because substantial spending borne by states, employers, and households under current law would shift to the federal government under the Sanders plan. Federal expenditures in 2017 would increase by \$1.9 trillion for acute care for the nonelderly, by \$465.9 billion for those otherwise enrolled in Medicare, and by \$212.1 billion for long-term services and supports.
- In total, federal spending would increase by about \$2.5 trillion (257.6 percent) in 2017. Federal expenditures would increase by about \$32.0 trillion (232.7 percent) between 2017 and 2026. The increase in federal spending is so large because the federal government would absorb a substantial amount of current spending by state and local governments, employers, and households. In addition, federal spending would be needed for newly covered individuals, expanded benefits and the elimination of cost sharing for those insured under current law, and the new long-term support and services program.

- State and local governments could save \$319.8 billion in 2017 and \$4.1 trillion between 2017 and 2026 as the federal government absorbs these costs under the Sanders plan (not shown in table 1). A maintenance-of-effort requirement could make state and local funds available to help pay for the plan, but the legality of such a requirement is in question.
- Private health care spending by households and employers would drop as the federal government would absorb their spending under current law. Private sector expenditures for these groups would decrease by \$1.7 trillion in 2017 and by \$21.9 trillion between 2017 and 2026. These considerable savings would partially offset the impact on the private sector of new taxes required to pay for the Sanders plan.
- Analysis by the Tax Policy Center indicates that Sanders's revenue proposals, intended to finance all new health and nonhealth spending, would raise \$15.3 trillion in revenue over 2017 to 2026. This amount is approximately \$16.6 trillion less than the increased federal cost of his health care plan estimated here. The discrepancy suggests that to fully finance the Sanders approach, additional sources of revenue would have to be identified; that is, the proposed taxes are much too low to fully finance the plan.

TABLE 1

The Sanders Plan: The Impact on National Health Expenditures and Federal Spending, 2017 and 2017–2026

	2017	2017–2026
ACUTE CARE SPENDING FOR THE NONELDERLY UNDER SANDERS PLAN COMPARED TO CURRENT LAW^a		
Increase in acute care spending (\$ billions)	\$412.0	\$4,996.1
Percent increase	22.9%	22.1%
Increase in federal acute care spending (\$ billions)	\$1,858.0	\$23,227.8
Percent increase	523.4%	531.4%
ACUTE CARE SPENDING UNDER SANDERS PLAN FOR THOSE OTHERWISE COVERED BY MEDICARE COMPARED TO CURRENT LAW^a		
Increase in acute care spending (\$ billions)	\$38.5	\$507.5
Percent increase	3.8%	3.6%
Increase in federal acute care spending (\$ billions)	\$465.9	\$5,838.6
Percent increase	77.9%	71.4%
SPENDING ON LTSS UNDER SANDERS PLAN COMPARED TO CURRENT LAW		
Increase in LTSS spending (\$ billions)	\$68.4	\$1,093.8
Percent increase	28.6%	35.9%
Increase in federal LTSS spending (\$ billions)	\$212.1	\$2,937.2
Percent increase	221.4%	244.3%
TOTAL INCREASE IN SPENDING UNDER SANDERS PLAN COMPARED TO CURRENT LAW		
Increase in national health spending (\$ billions)	\$518.9	\$6,597.4
Percent increase	16.9%	16.6%
Increase in federal spending (\$ billions)	\$2,536.0	\$32,003.5
Percent increase	257.6%	232.7%
DECREASE IN PRIVATE HEALTH SPENDING (HOUSEHOLDS, EMPLOYERS) UNDER SANDERS PLAN COMPARED TO CURRENT LAW		
Decrease in private health spending ^b (\$ billions)	\$1,679.7	\$21,850.8
Decrease in acute care spending for the nonelderly ^a	\$1,240.0	\$15,617.5
Decrease in acute care spending for those otherwise covered by Medicare ^a	\$369.0	\$5,050.4
Decrease in spending for LTSS	\$70.7	\$1,183.0
DECREASE IN UNINSURED UNDER SANDERS PLAN COMPARED TO CURRENT LAW		
	2017	2026
Decrease in uninsured	28.3 million	30.9 million
Uninsurance rate under current law	10.4%	11.0%

Source: Urban Institute analysis.

Notes: LTSS = long-term services and supports.

^a Here, “acute care” includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

^b Private health spending in this table includes spending by households and employers; it does not include spending by other sources, such as providers.

Background: The Sanders Proposal and Prior Estimates

The core of the Sanders proposal is comprehensive first-dollar government-financed health insurance for all Americans, with no benefit limits. Available materials do not specify whether the plan would provide coverage to undocumented immigrants, whether other provisions would be made for financing their care, or whether no such provisions would be made. According to campaign materials, benefits would range from “inpatient to outpatient care, preventive to emergency care, primary care to specialty care, including long-term care and palliative care, vision, hearing, and oral health care, mental and substance abuse services as well prescription medications, medical equipment and supplies, diagnostics and treatment.”² The impact of the coverage and benefit expansions on expenditures would be partially offset by the government’s use of its bargaining power to lower provider payment rates and, in turn, overall health care spending. Administrative costs would also be lower because of the efficiencies resulting from a number of sources, including no private insurance companies, uniform payment rates, and automatic enrollment (i.e., savings on marketing costs). Statements made by the Sanders campaign seem to suggest that he assumes a dramatic reduction in provider payment rates would be largely immediate; the growth rate of health spending would also be lower.

Federal government costs would increase substantially, but direct spending by employers who currently provide coverage and individuals who pay premiums and incur out-of-pocket costs would decrease considerably. The additional government costs would be financed by various taxes, described below. It is not clear whether the Sanders plan would allow individuals to purchase private insurance. Although the plan does not envision a need for coverage for supplemental benefits because no benefits would be excluded from the government coverage, some countries with single-payer systems do allow individuals to purchase private coverage to obtain care from providers with shorter wait times for services, usually in separate facilities. It also is not clear whether the Sanders plan would allow the continued operation of integrated health systems, such as Kaiser or Geisinger, entities that combine the direct provision of medical care with the insurers’ role of managing the efficient provision and use of care. Also unclear is what would happen to Medicare Advantage.

The Sanders campaign estimates that their health program would lead to new public expenditures of \$13.8 trillion from 2017 to 2026. This figure incorporates the campaign’s estimate of the costs of coverage for the remaining uninsured, the universal expansion of benefits, the elimination of deductibles and copayments, the introduction of long-term care coverage, savings from lower administrative costs and provider payment rates, and the impact of provider supply constraints. After subtracting \$3.1 trillion in reduced tax expenditures resulting largely from the elimination of the

current tax exclusion for employer-sponsored insurance, the campaign estimates that \$10.7 trillion of new revenues would be needed. They propose a 2.2 percent income-based premium on households, a 6.2 percent payroll tax imposed on employers, additional revenues from revisions to the estate tax, increases in taxes on capital gains and dividends, new limits on deductions for high-income taxpayers, and increases in income taxes that largely affect high-income people. They anticipate that low-income individuals would save because the amounts they would be required to pay in new taxes would be less than what they are required to pay today in premiums, cost sharing, and other tax payments.

Similarly, employers that now provide coverage would pay less because their obligations under the proposed approach would be limited to the 6.2 percent payroll tax paid by employers. In contrast, across all employers (i.e., including those who offer health insurance and those who do not), employer-paid premiums for health insurance benefits currently average 8.3 percent of total compensation.³ Higher-income individuals would be expected to pay considerably more toward health expenses than they do today.

Emory University professor and health economist Kenneth Thorpe (2016) independently estimates the cost of the Sanders plan at \$1.8 trillion in 2017 and \$24.7 trillion over the 10-year period beginning in 2017. These costs are based on current expenditures, making separate adjustments for current law Medicare enrollees, Medicaid enrollees, the privately insured, and the uninsured. For all populations, he assumes provider payment rates under Sanders would be set to 105 percent of health care costs (in other words, increasing such rates for Medicare and Medicaid enrollees and decreasing them for the privately insured) and that administrative costs of the program would be 4.7 percent of spending on health care services.

He assumes higher health care utilization under the Sanders proposal for current law Medicare enrollees without Medicaid and Medigap coverage, because the proposal would eliminate their deductibles and copayments. He also includes estimates for additional benefits such as dental care, vision, and hearing that are not provided under Medicare but would be covered by Sanders. Thorpe also assumes that states would be required to make ongoing maintenance-of-effort payments for their prior spending on the Medicaid and the Children's Health Insurance Program, with these payments offsetting federal costs of the reform.

Thorpe estimates that the Sanders approach would increase spending on the uninsured 70 percent over current spending levels, an estimate he considers low. Further, Thorpe estimates that spending on the currently insured would increase 10 percent, taking into account the greater generosity of coverage provided under the Sanders proposal. Finally, he assumes that the rate of growth in health care

spending would be 0.5 percentage points below current projections. He does not estimate long-term care benefits other than incorporating current Medicaid long-term care expenditures (which are currently financed by federal, state, and local governments) as fully federal spending under the Sanders plan.

Our approach differs from Thorpe's in several ways, and our methods are described in detail in the sections below. However, there are some central differences:

- We start with different data and modeling assumptions, leading to differences in population, coverage, and spending projections. Our nonelderly population and coverage estimates use simulation modeling based on the American Community Survey, which supports greater detail such as estimates related to undocumented immigrants. Our population and spending estimates for the Medicare population are based on the most recent Congressional Budget Office Medicare baseline.⁴
- We make different assumptions about key factors, including payment rates (for hospitals, physicians, and prescription drugs), administrative costs, induced demand, supply constraints, spending growth rates, and state maintenance-of-effort requirements.
- We include estimated spending for universal long-term services and supports.

Detailed Methods and Results

Acute Health Care for the Nonelderly

METHODS

Our estimates of the cost of the Sanders plan for acute care⁵ for the nonelderly (excluding the nonelderly who would otherwise be enrolled in Medicare) are based on HIPSM, a microsimulation model of the cost and coverage effects of health care reforms (Buettgens 2011). We assume that all US residents, including the undocumented population, would be automatically enrolled in coverage, leading to universal insurance coverage. Although the Sanders campaign does not specify their intended treatment of the undocumented population, we assume they would be included because all government programs that currently help finance uncompensated care (e.g., Medicare and Medicaid disproportionate-share hospital payments) would be eliminated. (Spending related to those otherwise

enrolled in Medicare, both elderly and nonelderly, are estimated in the “Acute Health Care for Those Otherwise with Medicare Coverage” section.)

In the HIPSM model, current law health care coverage and costs are based upon reported insurance status, but the model also computes hypothetical costs for each individual under each possible health insurance status (i.e., enrollment in employer coverage, private nongroup coverage, Medicaid, or uninsurance). These hypothetical health care costs are used if a simulation indicates the individual would change his or her health insurance status. In estimating the Sanders proposal for first-dollar coverage for broadly comprehensive benefits without benefit caps or limits, we build off HIPSM’s estimates of health care costs as if all individuals age 64 and younger were enrolled in Medicaid (as Medicaid benefits most closely resemble those promised under Sanders’s plan). We increase the universal Medicaid spending estimates to account for our assumption that the federal government would pay considerably higher provider payment rates under the Sanders plan than states do under the average Medicaid plan.

By building off estimated Medicaid expenditures, we have the advantage of starting with a spending base that reflects a 100 percent actuarial value plan, that is, full benefits with no cost sharing. Using Medicaid also incorporates supply constraints into our estimates. That is, the Sanders plan would increase demand for health services by eliminating individuals’ direct contributions to care (i.e., by eliminating deductibles, copayments, and coinsurance), but not all increased demand could be met because provider capacity would be insufficient.⁶ By basing our estimates on spending within a universal Medicaid program, we implicitly incorporate the provider supply constraints faced by current Medicaid enrollees, applying to all US residents the health care utilization decreasing effect of the program’s low rates of provider participation. This approach produces lower health care cost estimates than if we had assumed that all increased demand would be met. We do not adjust these estimated Medicaid costs upward to account for the fact that some state Medicaid programs impose benefit or service limits under current law. If we had done so, our cost estimates would have been somewhat higher than shown here. If supply constraints under the Sanders approach end up being lower than in the current-law Medicaid program, that is another source of underestimation of new costs in our analysis.

We inflate our estimated Medicaid costs to account for higher provider reimbursement rates. We assume that the Sanders plan would pay physicians and other providers at Medicare rates for all enrollees. The main exception is hospital payment rates, which we increase to 100 percent of costs because Medicare hospital payment rates are estimated to be 89 percent of costs, on average (American Hospital Association 2015). We also increase estimated Medicaid spending for prescription

drugs by a factor of 1.5 to account for our assumptions that the Sanders formularies would be less restrictive than Medicaid's and that the payment rates would be higher than Medicaid's.⁷ This assumed increase over current-law Medicaid prescription drug payment rates is still equivalent to payment rates 25 percent below Medicare's prescription drug payment rates. It simply does not seem plausible to assume that the current Medicaid prescription drug rebates of about 50 percent could be applied to all individuals. This would be far too great a financial blow to the existing pharmaceutical and medical device industries, even assuming it would be possible to enact such proposals into law. We also assume a lower rate of growth in all health expenditures, 0.5 percentage points below current estimates each year, reflecting the potential impact of a large government monopsony payer.

We assume administrative costs of 6 percent of claims, based on the Centers for Medicare & Medicaid Services measure of Medicare's administrative expenditures in the National Health Expenditure Accounts. This is the appropriate figure for estimating proposals that build upon the entire Medicare program, not just traditional Medicare (Sullivan 2013). Although managed care providers, such as Kaiser, Geisinger, and others, are not specified in the Sanders materials, we assume they would be permitted because they provide valuable utilization management and quality control functions. In addition, 6 percent is plausible in this scenario because that is slightly below average for large firms' administrative costs. We do not believe that administrative costs can fall far below this level; far too many administrative functions must be conducted. One such function is rate setting for a wide array of providers, including both fee-for-service and any capitated providers that would remain—the latter would require separate payment negotiations. In the fee-for-service world, a considerable amount of care management and utilization control would be required, as would oversight and enforcement activities that prevent financial abuses by providers and ensure sufficient quality of care.

Because the HIPSM model includes detailed characteristics of each nonelderly individual, we can calculate their health expenditures under current law from 2017 to 2026 and how much of the expenditures are paid by the individuals themselves, public programs, employers, or health care providers.⁸ Then, we use the model to estimate expenditures for all nonelderly people under the Sanders plan for those 10 years and compare that with current-law projections. We are then able to estimate the changes in health care spending for individuals with various characteristics. However, our estimates do not include the increased tax burden that has been estimated independently by the Urban-Brookings Tax Policy Center (Sammartino et al. 2016).

RESULTS

We estimate that under current law, 28.3 million people under age 65 will be uninsured in 2017. The Sanders plan would provide automatic coverage to all these individuals, eliminating the uninsured. Providing comprehensive health coverage for acute care without cost sharing, as specified in Sanders’s proposal, to the nonelderly population—an estimated 272 million people—would cost \$2.2 trillion in 2017. This is a 22.9 percent increase in personal national health expenditures over current levels for this population, reflecting the expansion of coverage to all Americans, the elimination of cost sharing, and the more comprehensive benefits relative to private coverage under current law (table 2). Acute care for the nonelderly would cost \$27.6 trillion from 2017 to 2026, an increase of \$5.0 trillion, or 22.1 percent relative to current law. Under current law, the federal government would spend \$355.0 billion on acute care for the nonelderly in 2017 and \$4.4 trillion from 2017 to 2026. Thus, there would be \$1.9 trillion in additional federal spending in 2017 and \$23.2 trillion in additional federal spending from 2017 to 2026.

TABLE 2

Acute Health Care Spending for the Nonelderly: Sanders Plan versus Current Law, 2017 and 2017–2026

	2017				2017–2026			
	Sanders plan (\$ billions)	Current law (\$ billions)	DIFFERENCE		Sanders plan (\$ billions)	Current law (\$ billions)	DIFFERENCE	
			(\$ billions)	%			(\$ billions)	%
Total acute health care spending for the nonelderly	\$2,213.0	\$1,801.0	\$412.0	22.9%	\$27,599.0	\$22,602.9	\$4,996.1	22.1%
Federal acute health care spending for the nonelderly	\$2,213.0	\$355.0	\$1,858.0	523.4%	\$27,599.0	\$4,371.3	\$23,227.8	531.4%

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2016.

Note: Here, the term “acute care” includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

Current spending for nonelderly acute care is shared among federal, state, and local governments; employers; households; and in-kind payments by providers. If existing costs were federalized, spending by state and local governments would be eliminated (a decrease in spending of \$188.5 billion), as would

spending by employers (\$749.8 billion), households (\$490.3 billion), and providers (\$17.6 billion in in-kind contributions; table 3). Thus, although federal spending on nonelderly acute care would increase by \$1.9 trillion in 2017 under the Sanders plan, the savings for other payers would be considerable and would partially offset the financial burden of new taxes required to pay for the reform.

TABLE 3

Acute Health Care Spending for the Nonelderly under Current Law, 2017, by Source of Spending
(\$ billions)

	Total	Federal government	State/local government	Employers	Households	Providers
Acute health care spending for the nonelderly (public and private)	\$1,801.0	\$354.9	\$188.5	\$749.8	\$490.3	\$17.6

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2016.

Note: Here, the term “acute care” includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

The greatest increases in health care spending under the Sanders plan compared with current law occur on behalf of those with the lowest incomes, because the currently uninsured and underinsured are now concentrated in those income groups (table 4). Spending on behalf of those with incomes below the federal poverty level (FPL) would increase 47.9 percent, and spending on behalf of those with incomes between 100 and 200 percent of FPL would increase 32.9 percent. Even those with higher incomes would consume more health care services, however, because their current out-of-pocket spending would be eliminated, increasing their use of care. Spending on behalf of those with incomes above 400 percent of FPL would increase 6.1 percent in aggregate.

Of the \$2.2 trillion in total acute care spending for the nonelderly that we estimate would occur in 2017 under the Sanders proposal, we estimate that \$77.0 billion would be spent on health care for undocumented immigrants (table 5). Another \$166.0 billion would be spent on those who would be uninsured under current law. Health care spending for the otherwise uninsured would increase 169.5 percent. The remaining \$2.0 trillion would be spent on those who currently have health insurance. Their spending would increase 15.5 percent; they would receive more comprehensive benefits on average, and the elimination of cost sharing would lead to greater use of care.

TABLE 4

Acute Health Care Spending for the Nonelderly: Sanders Plan versus Current Law, 2017

	Sanders plan (\$ billions)	Current law (\$ billions)	DIFFERENCE	
			(\$ billions)	%
Total acute health care spending for the nonelderly	\$2,213.0	\$1,801.0	\$412.0	22.9%
Income by federal poverty level				
< 100%	\$562.0	\$380.0	\$182.0	47.9%
100–200%	\$392.0	\$295.0	\$97.0	32.9%
201–300%	\$322.0	\$263.0	\$59.0	22.4%
301–400%	\$261.0	\$226.0	\$35.0	15.5%
> 400%	\$676.0	\$637.0	\$39.0	6.1%

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2016.

Note: Here, the term “acute care” includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

TABLE 5

Acute Health Care Spending for the Nonelderly: Sanders Plan versus Current Law, 2017, by Current Coverage

	Sanders plan (\$billions)	Current law (\$ billions)	DIFFERENCE	
			(\$ billions)	%
Total acute health care spending for the nonelderly (public and private)	\$2,213.0	\$1,801.0	\$412.0	22.9%
Coverage under the current law				
Insured	\$1,970.0	\$1,705.0	\$265.0	15.5%
Uninsured	\$166.0	\$61.6	\$104.4	169.5%
Undocumented immigrants	\$77.0	\$34.4	\$42.6	124.0%

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2016.

Note: Here, the term “acute care” includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

Acute Health Care for Those with Medicare Coverage under Current Law

METHODS

This section describes our estimates of the cost of the Sanders plan for those who would be enrolled in Medicare under current law. The HIPSM model estimates above do not include spending for those enrolled in Medicare or spending on long-term services and supports, regardless of age; we address the latter in the “Long-Term Services and Supports” section. The estimates in this section include acute care costs for elderly and nonelderly individuals who would be enrolled in Medicare under current law (including nonelderly people with disabilities).⁹ These estimates include spending on postacute stays in nursing facilities or postacute home care that Medicare would cover under current law.

For those otherwise enrolled in Medicare, we estimate the cost of the Sanders plan to be equal to the sum of current-law Medicare spending (Congressional Budget Office 2016), Medigap expenditures,¹⁰ out-of-pocket spending for Medicare-covered services,¹¹ out-of-pocket spending for services not covered under Medicare (Nonnemaker and Sinclair 2009), Medicaid spending on Medicare coinsurance and premiums (Centers for Medicare & Medicaid Services 2013), estimated Medicaid acute care spending for those enrolled in Medicare,¹² and spending by employers and employees on retiree and employee coverage for those also enrolled in Medicare (McArdle, Neuman, and Huang 2014; Mercer 2013). We then assume additional spending that would be induced by the elimination of deductibles, copayments, and coinsurance for current-law Medicare beneficiaries who do not have supplemental coverage such as Medigap or Medicaid to wrap around their Medicare benefits. We estimate a smaller increase in spending for those who would otherwise face cost sharing under supplemental Medicare coverage, including Medigap, Medicare Advantage, or employer coverage, and we assume an increase in spending for current-law Medicare enrollees who do not have prescription drug coverage.

We also assume additional costs because the Medicare benefit package is not as comprehensive as what would be provided under Sanders, namely coverage of dental, vision, and hearing services.¹³ We increase hospital payment rates to 100 percent of costs for Medicare hospital payments.¹⁴ Physicians and other providers are assumed to be paid at Medicare rates. We reduce current-law Medicare drug spending 25 percent, assuming the federal government would begin direct price negotiations with pharmaceutical companies under the Sanders approach, and this adjustment is partly based on price comparisons in a recent report of the Office of the Inspector General (Levinson 2015). We subtract the administrative cost related to current benefit spending in Medicare and replace it with the common 6 percent administrative cost assumption that we make for the Sanders program as a whole.

Increased spending on the Medicare population attributable to the elimination of cost sharing is estimated based on published induction factors (US Department of Health and Human Services 2013). For spending increases related to those who currently have Medicare and no supplemental insurance, such as Medigap or employer-sponsored insurance, we apply a 4 percent induction factor; for those with supplemental insurance, we apply a 3.5 percent induction factor.¹⁵

RESULTS

Under the current system, an estimated \$1.0 trillion in health care spending for those enrolled in Medicare in 2017 is spread across several payers (table 6). These payers are the federal government (\$597.8 billion), state and local governments (\$58.4 billion), employers (\$43.1 billion) and households (\$325.9 billion). Overall, acute care spending on those otherwise enrolled in Medicare would amount to \$1,063.7 billion under the Sanders plan in 2017 compared with \$1,025.2 billion under current law, a difference of \$38.5 billion and a relative increase of 3.8 percent (table 7). The increase in federal spending on acute care for those otherwise enrolled in Medicare under the Sanders plan is projected to be \$465.9 billion, a 77.9 percent increase in federal spending relative to current law for this population. Additional detail on spending for those otherwise enrolled in Medicare under current law and under the Sanders plan is provided in tables 6 and 7, respectively.

Under current law, spending by the federal government on Medicare enrollees (net of spending offsets from state and local government and household spending on premiums, cost sharing, and direct provision of acute care) is attributable to spending that falls under the Medicare program (\$533.6 billion) and spending that falls under the Medicaid program (\$64.2 billion; table 6).¹⁶ Under current law, spending by state and local governments on Medicare enrollees includes Medicare Part D payments by states (\$10.0 billion), state and local Medicaid funding of acute care spending for those with Medicare (\$41.1 billion), and state and local Medicaid funding of Medicaid-covered Medicare premiums and cost sharing (\$7.3 billion).

Individuals with Medicare coverage supplement Medicare benefits through spending in several categories: Medicare premiums collected for Parts A, B, and D (\$92.0 billion); Medigap premiums for Medicare-covered services (\$33.2 billion); out-of-pocket spending for Medicare-covered benefits (\$117.9 billion); out-of-pocket spending for benefits not covered by Medicare (\$24.5 billion); and employees' and retirees' premium contributions for employer-sponsored health insurance (\$58.3 billion).¹⁷ Employers spend on health care for those enrolled in Medicare through employer-based insurance and retiree premium contributions (\$43.1 billion).

TABLE 6

Acute Health Care Spending under Current Law for Those with Medicare, 2017

	Spending under current law (\$ billions)
Total acute care spending under current law for those with Medicare	\$1,025.2
Federal spending	\$597.8
Federal Medicare ^a	\$533.6
Federal Medicaid (for those with Medicare)	\$64.2
State and local spending	\$58.4
Medicare Part D payments by states	\$10.0
State/local Medicaid funding of acute care spending for those with Medicare	\$41.1
State/local Medicaid funding of Medicaid-covered Medicare premiums and cost sharing	\$7.3
Employer spending	\$43.1
Employer share of employee and retiree premium contributions for health insurance sponsored by employer	\$43.1
Household spending for those with Medicare	\$325.9
Medicare premiums collected for Parts A, B, and D	\$92.0
Estimated Medigap premiums for covered services	\$33.2
Estimated out-of-pocket costs for Medicare-covered benefits	\$117.9
Estimated out-of-pocket costs for benefits not covered by Medicare	\$24.5
Employee and retiree share of premium contributions for health insurance sponsored by employer	\$58.3

Sources: Urban Institute analysis of data and estimates from American Hospital Association (2015); Centers for Medicare & Medicaid Services (2013); Congressional Budget Office (2016); Cubanski et al. (2014); Garfield et al. (2015); Jacobson, Huang, and Neuman (2014); Levinson (2015); McArdle, Neuman, and Huang (2014); Mercer (2013); Nonnemaker and Sinclair (2009); Sullivan (2013); and US Department of Health and Human Services (2013).

Note: Here, the term “acute care” includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

^a The federal Medicare amount is net of spending offsets from state and local government and household spending on premiums, cost sharing, and acute care. The Medicare benefit spending amount includes an estimated 6 percent administrative cost.

Spending for acute care under the Sanders plan for those otherwise enrolled in Medicare (\$1,063.7 billion) would entail fully federalizing existing Medicare spending and spending related to the additional benefits being provided, plus the elimination of beneficiary cost sharing. This includes federalizing current-law state and local spending (\$58.4 billion), current-law employer spending (\$43.1 billion), and current-law household spending (\$325.9 billion).

TABLE 7

Federal Acute Health Care Spending under Sanders Plan for Those Otherwise Covered by Medicare, 2017

	Spending under Sanders plan for those otherwise covered by Medicare, 2017
Total acute care spending under Sanders plan for those otherwise covered by Medicare (\$ billions)	\$1,063.7
Current law spending (\$ billions)	\$1,025.2
Current law federal spending	\$597.8
Federalization of current law state/local spending	\$58.4
Federalization of current law employer spending	\$43.1
Federalization of current law household spending	\$325.9
Additional federal spending and savings (\$ billions)	\$38.5
Decrease in Medicare prescription drug spending from payment rate adjustment	-\$24.9
Additional prescription drug costs for Medicare enrollees who do not currently have prescription drug coverage	\$17.0
Additional Medicare hospital spending from payment rate adjustment	\$25.3
Additional Medicare spending of Medicare enrollees who have cost sharing under current law due to lack of supplemental coverage or cost sharing under various supplemental coverage arrangements	\$21.1
Increase in total acute care spending under Sanders plan compared to current law for those otherwise covered by Medicare (\$ billions)	\$38.5
Percent increase	3.8%
Increase in federal acute care spending under Sanders plan compared to current law for those otherwise covered by Medicare (\$ billions)	\$465.9
Percent increase	77.9%

Sources: Urban Institute analysis of data and estimates from American Hospital Association (2015); Centers for Medicare & Medicaid Services (2013); Congressional Budget Office (2016); Cubanski et al. (2014); Garfield et al. (2015); Jacobson, Huang, and Neuman (2014); Levinson (2015); McArdle, Neuman, and Huang (2014); Mercer (2013); Nonnemaker and Sinclair (2009); Sullivan (2013); and US Department of Health and Human Services (2013).

Note: Here, the term “acute care” includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

Spending on this population would increase under the Sanders plan in three ways: the provision of drug coverage to current-law Medicare enrollees who do not have it (\$17.0 billion); increased payment rates for hospital care, bringing payments up to 100 percent of costs (\$25.3 billion); and additional spending induced by the elimination of cost-sharing requirements (\$21.1 billion).¹⁸ Spending on those otherwise covered by Medicare would decrease under the Sanders plan because of savings related to a prescription drug payment-rate adjustment (-\$24.9 billion); this is netted out of the new spending of \$38.5 billion.

Consistent with our assumptions regarding acute care for the nonelderly, we assume that acute health care spending on behalf of those otherwise enrolled in Medicare would grow 0.5 percentage points more slowly under the Sanders plan than under current law.¹⁹ Still, under the Sanders plan, federal spending on acute care for those otherwise enrolled in Medicare would be \$14.0 trillion from 2017 to 2026 compared with \$8.2 trillion under current law. This difference of \$5.8 trillion represents a relative increase in spending of 71.4 percent (table 8).

TABLE 8

Federal Acute Health Care Spending for Medicare Beneficiaries under Current Law and under Sanders Plan in 2017 and 2017–2026

		2017		2017–2026			
		DIFFERENCE				DIFFERENCE	
Sanders plan (\$ billions)	Federal spending under current law (\$ billions)	(\$ billions)	%	Sanders plan (\$ billions)	Federal spending under current law (\$ billions)	(\$ billions)	%
\$1,063.7	\$597.8	\$465.9	77.9%	\$14,020.4	\$8,181.9	\$5,838.6	71.4%

Sources: Urban Institute analysis of data and estimates from American Hospital Association (2015); Centers for Medicare & Medicaid Services (2013); Congressional Budget Office (2016); Cubanski et al. (2014); Garfield et al. (2015); Jacobson, Huang, and Neuman (2014); Levinson (2015); McArdle, Neuman, and Huang (2014); Mercer (2013); Nonnemaker and Sinclair (2009); Sullivan (2013); and US Department of Health and Human Services (2013).

Notes: The spending growth factor applied to the Sanders plan is 1.060, while the growth factor applied to federal spending under current law is 1.065. Here, “acute care” includes short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.

Long-Term Services and Supports

METHODS

Because the Sanders plan has limited detail related to its proposal to provide universal long-term services and supports (LTSS), we focus on capturing its stated intention: to cover costs for LTSS for those with high-level LTSS needs.²⁰ For many, LTSS needs are not now covered by government programs or private insurance. We make a series of assumptions that we believe captures the spirit of the proposal. Our estimates are generated using DYNASIM, the Urban Institute’s simulation model designed to analyze the distributional consequences of retirement and aging issues, including projections of needs and expenditures for LTSS.²¹

We focus here on assumptions specific to estimating costs for the Sanders proposal. DYNASIM's baseline LTSS assumptions about disability prevalence and service use have been documented elsewhere (Favreault, Gleckman, and Johnson 2015). Because DYNASIM's LTSS model focuses on the population age 65 and older, we use simplifying assumptions derived from literature about the nonelderly LTSS population²² to scale DYNASIM's estimates for the full age distribution, taking service-use mix into account to approximate total plan costs.

As Medicare acute-care-covered services are accounted for elsewhere in these analyses, our estimates of LTSS benefits under the Sanders proposal do not include postacute stays in nursing facilities or postacute home care that Medicare would cover under current law; these costs are included in the "Acute Health Care for Those with Medicare Coverage under Current Law" section.

We make the following assumptions, which in general we believe to be conservative:

1. The daily benefit rate for the new program would vary by state and type of service (nursing home, home care, or residential care). Program rates for nursing homes are set at 115 percent of recently observed current-law Medicaid rates.²³ We set the rates modestly above the Medicaid rate because existing rates are estimated to fall short of costs of care in some states (Eljay, LLC and Hansen Hunter & Company 2015); further, press accounts suggest that Medicaid beneficiaries can have difficulties finding placements, given some nursing homes' preference for Medicare and other patients that pay higher rates.²⁴ Nursing home rates are adjusted annually thereafter for wage inflation using the intermediate assumptions of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds (2014). Program rates for home care are assumed to vary both across and within states and to average about 100 percent of current law private payment rates. Home care rates are adjusted annually thereafter for the average of wage and price inflation using the intermediate assumptions of the board of trustees' report. We assume wages grow roughly uniformly for all workers (both LTSS providers and others) and across states.²⁵
2. The program would impose some limits on home care use, given that states generally set limits under Medicaid. We currently assume that the maximum daily home care benefit equals half the maximum daily benefit for nursing home care and that benefits are delivered at most five out of seven days per week.²⁶ Fewer than 10 percent of home care beneficiaries use the maximum amount of care in a given year. More typically, home care beneficiaries use about half the maximum benefit.
3. The new program would pay for home care services related to activities of daily living delivered in homes or residential care facilities (i.e., assisted living facilities), but it would not contribute

toward room and board. This is consistent with most states' treatment of residential care under Medicaid (Caffrey et al. 2012; Mollica 2009). Many people in residential care facilities would receive the maximum annual home care benefit under these assumptions.

4. The cost sharing that Medicaid now requires from some LTSS beneficiaries (e.g., nearly all income excluding a personal needs allowance for those in nursing homes) would no longer be required under the option, consistent with the Sanders campaign's statements about eliminating copayments and deductibles.
5. Only individuals whose disabilities meet the definition in the Health Insurance Portability and Accountability Act (HIPAA)²⁷ would qualify for LTSS benefits under the new program. We assume that the program would cover virtually all US residents, should they reach this disability threshold at some point in their lives. This would include individuals who do not qualify for Medicare or Social Security benefits under current law, many of whom now receive Supplemental Security Income and Medicaid. It would also include long-duration unauthorized immigrants, consistent with the intent to cover everyone.
6. We assume the benefits under the Sanders plan would begin 14 days after a determination of disability, with disability defined consistently with HIPAA. (Other proposals define deductibles using dollars spent on LTSS or days using formal services.) This assumption decreases the cost of the Sanders plan relative to a shorter waiting period but increases the cost relative to a longer waiting period. Waiting periods in which covered benefits are not provided (also known as elimination or deductible periods) are common in the private long-term care insurance market and in incremental proposals to modify LTSS financing. Given that many LTSS spells are short, this choice has cost and distributional implications.²⁸
7. The new program would provide a service reimbursement benefit, not a cash benefit. This would likely affect benefit take-up. Some who would use a cash benefit for home modifications or to support care by friends or family may be less comfortable having formal providers in their homes regularly and instead continue to rely predominantly on family caregivers. (Most analysts suggest assuming effectively universal take-up of cash benefits.) Nonetheless, the new LTSS benefit could substantially increase formal service use relative to current financing arrangements. The potential increase could be large because family caregivers currently provide a large share of LTSS informally.²⁹ Because of likely limits in supply of formal caregivers and nursing home beds in many regions, we gradually phase in the demand for new services rather than assuming large shares of unmet need would be immediately met and the maximum amount of informal care would immediately be supplemented by formal care.

8. We assume administrative costs of 6 percent of benefit payments, consistent with the cost estimates of the Sanders proposal described above. This is higher than the costs for administering the Social Security Disability Insurance program but far lower than administrative loads in the private long-term care insurance market (Giese and Schmitz 2015).
9. The role of the private long-term insurance market (which we already assume will decline in terms of the share of the population paying premiums and receiving benefits on an age-specific basis) would be extremely limited. A small share of those who have policies may keep part of their insurance in order to be covered for services the new LTSS program would not cover (e.g., the room and board component of residential care, a higher-quality nursing home, or a greater quantity or quality of home care). However, significant transition issues would likely arise for those who have paid large amounts to policies that would mostly duplicate—and in some cases, could be less generous than³⁰—the program’s new benefit. These may require private insurance companies to offer enrollees or the federal government rebates from reserve funds in exchange for the government absorbing the duplicative liabilities. We ignore transition issues in the present analyses and focus on likely changes to family cash flows in the short run.
10. The Veterans Administration would continue to provide LTSS, and the new Sanders program would not replace those benefits for that population. Home care services provided by the Administration on Aging under the Older Americans Act would be replaced by the Sanders plan.

Results

We estimate that providing a comprehensive LTSS benefit to all US residents without cost sharing as specified in Sanders’s proposal would cost \$307.9 billion in 2017; this is a 28.6 percent increase in national health expenditures on LTSS over current levels (table 9). The cost of these new benefits would offset current-law state Medicaid spending on long-term care (\$73.0 billion) and current-law federal Medicaid spending (\$95.8 billion). In addition, households’ current out-of-pocket expenses, direct payments to providers, and cost sharing under Medicaid would be eliminated (\$62.5 billion). Households would also be relieved of payment for private long-term care insurance (\$8.3 billion). Finally, we estimate that health care spending on LTSS services would increase by \$68.4 billion under the Sanders plan. This takes into account the additional services individuals would choose to receive and that the market could supply in this time frame. This is not an estimate of the current-law family caregiver burden but reflects only new services that would be received; we anticipate that family

caregiving would remain an important component of LTSS. Increased costs to the federal government, after accounting for federal Medicaid savings, would be \$212.1 billion in 2017.

TABLE 9

Estimated Costs and Cost Offsets for LTSS under the Sanders Plan, 2017, 2026, and 2017–2026

Estimated costs and cost offsets for LTSS under the Sanders plan	2017	2026	Total, 2017–2026
New LTSS benefit payments, including administrative expenses (\$ billions)	\$307.9	\$560.3	\$4,139.6
Total state Medicaid savings	\$73.0	\$109.7	\$881.7
Total federal Medicaid savings	\$95.8	\$155.0	\$1,202.4
Savings to families (reduced out-of-pocket expenses)	\$62.5	\$119.2	\$872.6
Potential private long-term care insurance offsets (household savings)	\$8.3	\$10.5	\$89.2
Costs for new services that address unmet needs or reduce family caregiver burdens	\$68.4	\$166.0	\$1,093.8
Increased costs to the federal government, after accounting for federal Medicaid savings (\$ billions)	\$212.1	\$405.3	\$2,937.2
Percent increase	221.4%	261.5%	244.3%

Source: Authors' calculations from the Dynamic Simulation of Income Model (runid 919).

Note: LTSS = long-term services and supports.

From 2017 to 2026, additional LTSS services under the Sanders plan would cost approximately \$1.1 trillion, an increase of 35.9 percent over current-law total national LTSS spending (percentage increase not shown). Federal spending for LTSS over the period would be \$4.1 trillion compared to \$1.2 trillion in federal spending under current law, a difference of \$2.9 trillion, or 244.3 percent of current-law federal spending.

CAVEATS

These estimates focus on annual cash flows over the short run. Thus, we have not addressed the LTSS program's long-range sustainability as analysts typically would do for a social insurance program such as Social Security (which has accrued reserves through the Old-Age, Survivors, and Disability Insurance Trust Fund) or for a private long-term care insurance program that also attempts to fully prefund benefits. After this 10-year window, we would anticipate that costs would grow faster than in previous years as baby boomers reach age 80 and older, when rates of severe disability and LTSS use are much higher. Revenues would correspondingly need to grow rapidly over the ensuing 20 years (roughly 2027–2046).

Discussion

We estimate that the Sanders plan would increase current national health care spending on acute and long-term care by about \$518.9 billion (16.9 percent) in 2017 and would increase federal government spending about \$2.5 trillion (257.6 percent) in 2017 and \$32.0 trillion (232.7 percent) from 2017 to 2026. Our 10-year federal cost estimates are higher than those published earlier this year by Kenneth Thorpe (2016). He estimated total new federal costs of \$24.3 trillion over 2017 to 2026. As is the case whenever one projects the costs of new programs, there is uncertainty around these estimates. There are several reasons why components of these estimates may be too low and some reasons why others may be too high.

The following assumptions may tend to underestimate the costs of the program:

- Setting provider payment rates for acute care services at levels consistent with the current law Medicare program may be too restrictive. Payment rates may in fact have to be higher, at least initially and perhaps indefinitely, to be acceptable to providers.
- Setting provider payment rates for long-term care services at only 15 percent above current Medicaid levels may also be inadequate to induce an expansion of provider supply necessary to meet a significant share of the expanded demand that would result from the new program.
- Our assumptions about reductions in drug prices are particularly aggressive and may fall well short of political feasibility.
- We have assumed that supply constraints in the provision of acute care for the nonelderly would be consistent with those inherent in the current law Medicaid program; however, it is possible that the constraints would not be that severe. If that is the case, more demand for medical services would be met and expenditures would be higher, both in term of total national health expenditures and federal costs.
- We do not adjust estimated costs upward to account for the fact that some Medicaid programs impose benefit and service limits under current law, but there would be no such limits under the Sanders plan. Consequently, use of these benefits and services would be higher under the Sanders plan than we have estimated here.
- We did not include a cost estimate for increased utilization of services associated with the move from current or no coverage to first-dollar coverage of new benefits (e.g., dental, vision and hearing, as well as prescription drugs for some beneficiaries) in Medicare.

- We assume that most long-term care services would be provided in the home rather than in more expensive nursing homes and that many people would continue to rely on family members for services rather than taking full advantage of the formal care services that Sanders would make available at no cost. If there is more of a shift from informal to formal care than we have assumed, costs would be higher.
- The elimination of cost sharing for LTSS could lead to a much greater increase in demand than we have assumed.

The following assumptions may tend to overestimate costs:

- Our estimates include costs associated with providing undocumented immigrants with acute care services for the nonelderly and long-term care services equivalent to that of citizens and documented residents (we were not able to estimate costs for providing coverage to elderly undocumented immigrants). If the new program excludes this population, those costs would be subtracted and government spending on uncompensated care would be added.
- Our assumed reduction in the growth of healthcare spending of 0.5 percentage points below current projected growth rates may be too pessimistic. A government-run system may be able to do better. However, large cuts in provider payment rates and even further reductions in annual growth rates would necessarily be politically challenging because of both providers and the supply constraints such cuts likely would create. Some might argue that our estimate of 6 percent administrative costs is too high. For reasons discussed below, we do not believe this to be the case.
- Our estimates would also be lower if we assumed a less generous home care benefit or assumed a longer waiting period for long-term care services. Costs would also be lower if individuals were required to use more of their own resources to finance institutional care as they do today. However, such assumptions seem inconsistent with the broad intent of the proposal.
- We do not assume that some segment of the high-income population would opt out of the single-payer system and finance their care with the purchase of private insurance. It is difficult to know what would happen in such a case—whether individuals would solely rely on private insurance or use a mix of privately and publicly covered services. Both paying higher taxes and purchasing private insurance may not be affordable for many, even among those with high

incomes. But to the extent it would be permitted and occurred, such a shift could increase national health expenditures and private spending while reducing federal spending.

The Sanders plan would have significant benefits for the poor and others with low incomes. They would receive considerably more in health services than they do today, with no out-of-pocket costs. Their employers, however, would pay a payroll tax of 6.2 percent on their earnings. This would ultimately be shifted back onto employees—including low-income employees—in the form of lower wages. Thus, low-income workers, like other workers, would in fact bear some of the costs of financing the plan. Employer contributions to health insurance premiums would also be offset, and presumably those contributions to compensation would be turned into wages or other benefits (Blumberg 1999; Blumberg et al. 2012). Those in need of long-term care services, often a very sick population with high needs, would receive important new benefits.

The 2.2 percent income surtax on taxable income would also affect many low-income people, but upper-middle-income and high-income individuals would bear most of the brunt of financing this plan through large tax increases (Sammartino et al. 2016). Higher-income people, too, would receive the benefits of comprehensive insurance coverage with no cost-sharing requirements and would no longer have to pay premiums for private coverage. However, their benefit improvements would be more modest given their current coverage, and they may find it harder to access providers because of supply constraints.

Some of the new federal costs would be offset by lower tax expenditures related to health insurance. In particular, offsetting employer-sponsored insurance and employers passing that savings back to workers in the form of increased wages would mean that income and payroll tax revenues would increase because insurance contributions are tax exempt but wages are not. Given these changes with the medical expense deduction and other health-related tax preferences, revenues would be expected to increase by \$251.2 billion in 2017 and \$4.0 trillion between 2017 and 2026.³¹

Analysis by the Urban-Brookings Tax Policy Center indicates that Sanders's revenue proposals, intended to finance all new health and nonhealth spending, would raise \$15.3 trillion in revenue from 2017 to 2026 (Sammartino et al. 2016). This amount includes the increased revenue that would be produced by eliminating the tax exclusion for employer-based health insurance discussed above. The total \$15.3 trillion that would be raised is approximately \$16.6 trillion less than the increased federal cost of his health care plan estimated here, suggesting that fully financing the Sanders approach would require additional sources of revenue be identified, that is, the proposed taxes appear to be too low to fully finance the plan.

We estimate that current state and local spending will be \$319.8 trillion in 2017 and \$4.1 trillion between 2017 and 2026. Because this would be absorbed by the federal government under the Sanders plan, some might suggest requiring states to pay maintenance-of-effort costs to offset the increased federal acute care and long-term care costs. Some dispute exists about whether maintenance-of-effort requirements are legal, however, given *National Federation of Independent Business v. Sebelius*; that decision may call into question whether such payments amount to coercion.

However, many other issues would be raised by a single-payer system. Providers would be seriously affected. Hospitals would see only small financial effects in the aggregate because payment rates would be increased for those otherwise insured by Medicare and Medicaid and revenue from the otherwise uninsured would increase, but they would receive less revenue for providing care to those who would otherwise be privately insured. Different types of hospitals would be advantaged and disadvantaged, depending upon their patient mix. Growth in revenues over time would be slower than under current law, however. Physician incomes would be squeezed by the new payment rates because such rates would be considerably below what physicians are paid by private insurers. Again, whether providers were financial winners or losers from the reform would depend upon their current payer mix. The pharmaceutical and medical device industries would be squeezed perhaps more than is sustainable. Behavioral responses by the range of health care providers to such a vast change are uncertain. If provider incomes fall, additional federal investment in medical education might be necessary to achieve a sufficient level of supply. Choices would need to be made about the treatment of existing private long-term care insurance contracts and the reserves the companies that issued these policies now hold.

We assume a 6 percent administrative cost across the board; this may be too low given the many functions that would need to be carried out, including a range of care management functions, rate setting, bill paying, and oversight responsibilities for a wide variety of providers across the nation. By eliminating copayments, coinsurance, deductibles, and service limits of all types, the Sanders plan would increase demand for services. We have assumed supply constraints such that not all of the increased demand would be met. But the failure to meet all demand could lead to public outcry. Any remaining role for private health insurance would also have to be determined. If higher-income people purchase private insurance, it could give them faster access to desired providers, increasing their satisfaction with the system. Yet it could also lead to longer queues for those relying on the remaining providers, causing dissatisfaction in other quarters.

Finally, moving to a single-payer system would be highly disruptive in the near term. When the ACA required people to give up private insurance plans that were less costly than those available in the reformed nongroup market, some vocal complaints led to quick administrative action to increase

opportunities for people to keep non-ACA compliant plans longer. The ACA's changes to the health insurance system and the number of people affected by those changes has been small compared to the upheaval that would be brought about by the movement to a single-payer system.

Notes

1. “Medicare for All: Leaving No One Behind,” Bernie 2016, accessed May 6, 2016, <https://berniesanders.com/issues/medicare-for-all/>.
2. Ibid.
3. This estimate is for civilian workers (i.e., those in private industry and state and local government) for December 2015. US Bureau of Labor Statistics, “Employer Costs for Employee Compensation,” March 10, 2016, <http://www.bls.gov/news.release/ecec.nr0.htm>.
4. Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026,” March 2016, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline.pdf>
5. We use the term “acute care” here to include short-term treatment for injury or illness, care provided during recovery from surgery, and medical care provided to treat chronic conditions such as diabetes and heart disease. It excludes long-term care provided in institutional settings and home-based care delivered to those with chronic conditions that affect their ability to perform everyday activities.
6. Such inevitable supply constraints were acknowledged in David Himmelstein and Steffie Woolhandler, “On Kenneth Thorpe’s Analysis of Senator Sanders’ Single-Payer Reform Plan,” *Huffpost Politics* (blog), updated January 29, 2016, http://www.huffingtonpost.com/david-himmelstein/kenneth-thorpe-bernie-sanders-single-payer_b_9113192.html.
7. A study in 2015 by the Office of the Inspector General showed that for selected brand-name drugs, per-unit pharmacy costs under Medicaid were less than half of Medicare’s, largely because of Medicaid’s rebate policies (Levinson 2015).
8. For more information about our estimates of health coverage and costs under current law, see Buettgens and colleagues, “The Cost of ACA Repeal” (forthcoming).
9. Costs for the elderly who are not enrolled in Medicare are not included; this leads to an underestimate of spending.
10. Historical Medigap spending estimates (Jacobson, Huang, and Neuman 2014) were combined with enrollment projections (Congressional Budget Office 2016).
11. Historical out-of-pocket spending estimates based on Cubanski and colleagues (2014) were combined with estimates from Jacobson, Huang, and Neuman (2014) and enrollment projections (Congressional Budget Office 2016).
12. Estimates based on Garfield and colleagues (2015) were combined with Urban Institute analysis of data from the CMS-64 and the Medicaid Statistical Information System. In addition, for all Medicaid spending estimates, we estimate that federal Medicaid payments are 57 percent of total Medicaid spending, and state and local Medicaid payments account for the remaining 43 percent of Medicaid spending.
13. We do not estimate induced spending resulting from first-dollar coverage of these formerly noncovered services; consequently, we recognize that our estimate of spending on dental, vision, and hearing services is low.
14. Estimates based on American Hospital Association (2015) lead to an overall hospital payment rate adjustment of $100/89 = 1.12$.
15. No induction factors are applied to the spending estimates of Medicare enrollees who do not currently have prescription drug coverage and would gain prescription drug coverage under the Sanders plan. This leads to an underestimate of spending in this area.

16. As described in the report, this Medicare benefit-spending estimate includes an estimated 6 percent administrative cost.
17. Our figures may underestimate household spending because they do not capture additional premium payments related to Medicare Advantage and Part D that enrollees pay directly to the plans.
18. For Medicare-covered services, some Medicare enrollees lack supplemental coverage through Medigap or employer coverage (or both), and others face cost sharing under the various supplemental coverage arrangements.
19. The growth rates assumed are based on Congressional Budget Office (2016) estimates over this period. The spending growth factor applied under the Sanders plan is computed based on Congressional Budget Office total Medicare spending on gross outlays and is equal to 1.060; the growth factor applied to federal spending under current law is based on Congressional Budget Office total Medicare spending on net outlays and is set equal to 1.065.
20. The Sanders plan describes coverage of “the entire continuum of health care...including long-term and palliative care.” See Bernie Sanders, “Medicare for All: Leaving No One Behind,” <https://berniesanders.com/issues/medicare-for-all/>.
21. See Favreault, Smith, and Johnson (2015). The analysis presented here projects costs on a cash-flow basis, given the Sanders plan structure.
22. For example, see population-based studies such as Kaye, Harrington, and LaPlante (2010), Medicaid studies such as Eiken and colleagues (2015), and provider studies such as Harris-Kojetin and colleagues (2016).
23. For Medicaid rates, we use composite (often weighted average) rates from the literature (e.g., Eljay, LLC, and Hansen Hunter & Company, PC [2015]), given that prices are often facility-specific within a state.
24. Katie Thomas, “In Race for Medicare Dollars, Nursing Home Care May Lag,” *New York Times*. April 14, 2015.
25. In some previous DYNASIM LTSS projections, we have assumed that home care prices grow at the average of wage and price growth, given stagnation in the wages of less-skilled workers.
26. All the estimates in the model are prorated in the first year of disability and in the year of death to account for the share of the year disabled or dead, respectively.
27. HIPAA requires that a person is unable to perform, without substantial assistance from another individual, at least two activities of daily living for at least 90 days because of a loss of functional capacity, or that the person needs “substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.” The specific activities of daily living in the statute are eating, toileting, transferring, bathing, dressing, and continence.
28. We could shift to a longer elimination period (say, 90 to 100 days) to reflect integration with Medicare’s current-law deductible period or more cost sharing, but we start with a low value given the spirit of limited cost sharing.
29. In unpublished tables from the National Long-Term Care Survey, Brenda Spillman estimates that roughly 82 percent of those age 65 and older meeting the HIPAA criteria (using a definition of severe cognitive impairment) receive some form of care. Over two-thirds receive informal care; only about one-third receive formal care. Many receive both.
30. Some insurance policies have low daily benefits or lack inflation protection.
31. Calculations based on Sammartino and others (2016).

References

- American Hospital Association. 2015. *Trendwatch Chartbook 2015*. "Table 4.4: Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare." <http://www.aha.org/research/reports/tw/chartbook/2015/table4-4.pdf>.
- Blumberg, Linda J. 1999. "Who Pays for Employer-Sponsored Health Insurance?" *Health Affairs* 18 (6): 58.
- Blumberg, Linda J., Matthew Buettgens, Judith Feder, and John Holahan. 2012. "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act." *Inquiry* 49 (2): 116–26.
- Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. 2014. *2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*. Washington, DC: Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds. <http://www.ssa.gov/OACT/TR/2014/tr2014.pdf>.
- Buettgens, Matthew. 2011. *Health Insurance Policy Simulation Model (HIPSM) Methodology Documentation*. Washington, DC: Urban Institute. <http://www.urban.org/research/publication/health-insurance-policy-simulation-model-hipsm-methodology-documentation>.
- Buettgens, Matthew, Linda J. Blumberg, John Holahan, and Siyabonga Ndwandwe. Forthcoming. "The Cost of ACA Repeal." Washington, DC: Urban Institute.
- Caffrey, Christine, Manisha Sengupta, Eunice Park-Lee, Abigail Moss, Emily Rosenoff, and Lauren Harris-Kojetin. 2012. "Residents Living in Residential Care Facilities: United States, 2010." NCHS Data Brief 91. Hyattsville, MD: National Center for Health Statistics.
- Centers for Medicare & Medicaid Services. 2013. *CMS-64 Quarterly Expense Report, Federal Fiscal Year 2013*. Baltimore, MD: Centers for Medicare & Medicaid Services. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/CMS-64-Quarterly-Expense-Report.html>.
- Congressional Budget Office. 2016. "Congressional Budget Office's March 2016 Medicare Baseline by Fiscal Year." Washington, DC: Congressional Budget Office. <https://www.cbo.gov/sites/default/files/51302-2016-03-Medicare.pdf>.
- Cubanski, Juliette, Christina Swoope, Anthony Damico, and Tricia Neuman. 2014. "How Much Is Enough? Out-of-Pocket Spending among Medicare Beneficiaries: A Chartbook." Menlo Park, CA: Kaiser Family Foundation. <http://kff.org/report-section/how-much-is-enough-out-of-pocket-spending-among-medicare-beneficiaries-section-1/>.
- Eiken, Steve, Kate Sredl, Paul Saucier, and Brian Burwell. 2015. "Medicaid Long-Term Services and Supports Beneficiaries in 2011." Baltimore, MD: Centers for Medicare & Medicaid Services. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-beneficiaries-report-2011.pdf>.
- Eljay, LLC, and Hansen Hunter & Company, PC. 2015. "A Report on Shortfalls in Medicaid Funding for Nursing Center Care." Washington, DC: American Health Care Association. https://www.ahcancal.org/research_data/funding/Documents/2014%20Medicaid%20Underfunding%20for%20Nursing%20Center%20Care%20FINAL.pdf
- Favreault, Melissa M., Howard Gleckman, and Richard W. Johnson. 2015. "Appendix." In "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending." *Health Affairs* 34 (12): 2181–91. <http://content.healthaffairs.org/content/early/2015/11/24/hlthaff.2015.1226/suppl/DC1>.

- Favreault, Melissa M., Karen E. Smith, and Richard W. Johnson. 2015. *The Dynamic Simulation of Income Model (DYNASIM): An Overview*. Washington, DC: Urban Institute.
<http://www.urban.org/research/publication/dynamic-simulation-income-model-dynasim-overview>.
- Garfield, Rachel, Robin Rudowitz, Katherine Young, Laura Snyder, Lisa Clemans-Cope, Emily Lawton, and John Holahan. 2015. "Trends in Medicaid Spending Leading up to ACA Implementation." Menlo Park, CA: Kaiser Family Foundation. <http://files.kff.org/attachment/issue-brief-trends-in-medicaid-spending-leading-up-to-aca-implementation>.
- Giese, Christopher J., and Allen J. Schmitz. 2015. "Premium Estimates for Policy Options to Finance Long-Term Services and Supports." Brookfield, WI: Milliman. <http://www.thescanfoundation.org/ltc-financing-initiative>.
- Harris-Kojetin, Lauren, Manisha Sengupta, Eunice Park-Lee, Roberto Valverde, Christine Caffrey, Vincent Rome, and Jessica Lendon. 2016. "Long-Term Care Providers and Services Users in the United States: Data from the National Study of Long-Term Care Providers, 2013–2014." *Vital and Health Statistics* 3 (38).
- Jacobson, Gretchen, Jennifer Huang, and Tricia Neuman. 2014. "Medigap Reform: Setting the Context for Understanding Recent Proposals." Menlo Park, CA: Kaiser Family Foundation.
<https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8235-02-medigap-reform-setting-the-context-for-understanding-recent-proposals1.pdf>.
- Kaye, H. Stephen, Charlene Harrington, and Mitchell P. LaPlante. 2010. "Long-Term Care: Who Gets It, Who Provides It, Who Pays, And How Much?" *Health Affairs* 29 (1): 11–21.
- Levinson, Daniel R. 2015. "Medicaid Rebates for Brand-Name Drugs Exceeded Part D Rebates by a Substantial Margin." Report OEI-03-13-00650. Washington, DC: US Department of Health and Human Services.
- McArdle, Frank, Tricia Neuman, and Jennifer Huang. 2014. "Retiree Health Benefits at the Crossroads." Menlo Park, CA: Kaiser Family Foundation. <http://kff.org/report-section/retiree-health-benefits-at-the-crossroads-overview-of-health-benefits-for-pre-65-and-medicare-eligible-retirees/>.
- Mercer. 2013. "Mercer National Survey of Employer-Sponsored Health Plans." Power Point Presentation, February 19. http://benefitcommunications.com/upload/downloads/Mercer_Survey_2013.pdf.
- Mollica, Robert L. 2009. "State Medicaid Reimbursement Policies and Practices in Assisted Living." Report Prepared for National Center for Assisted Living. Washington, DC: American Health Care Association.
- Nonnemaker, Lynn, and Shelly Ann Sinclair. 2009. *Medicare Beneficiaries' Out-Of-Pocket Spending for Health Care Services*. Insight on the Issues Brief I30. Washington, DC: AARP Public Policy Institute.
http://assets.aarp.org/rgcenter/health/i30_oop.pdf.
- Sammartino, Frank, James R. Nunns, Leonard E. Burman, Jeffrey Rohaly, and Joseph Rosenberg. 2016. "An Analysis of Senator Bernie Sanders's Tax Proposals." Research Report. Washington, DC: Urban-Brookings Tax Policy Center. <http://www.taxpolicycenter.org/publications/analysis-senator-bernie-sanderss-tax-proposals>.
- Sullivan, Kip. 2013. "How to Think Clearly about Medicare Administrative Costs: Data Sources and Measurement." *Journal of Health Politics, Policy and Law* 38 (3): 479–504.
- Thorpe, Kenneth E. 2016. "An Analysis of Senator Sanders' Single Payer Plan." Unpublished paper, January 27. Atlanta, GA: Emory University. <https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal>.
- US Department of Health and Human Services. 2013. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans—Small Business Health Options Program. Federal Register Table 24. <https://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf>.

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Melissa Favreault is a senior fellow in the Income and Benefits Policy Center at the Urban Institute, where her work focuses on the economic well-being and health status of older Americans and individuals with disabilities. She also analyzes long-term care needs and the distributional effects of Medicare and Medicaid. Her work in this area has focused on how changes in family structure and work/earnings patterns affect economic well-being in retirement, with a special emphasis on effects for women and lower-wage workers. For this research, she has often relied on dynamic microsimulation models. She has helped develop these types of models for both Urban and the Social Security Administration. Favreault earned her BA in political science and Russian from Amherst College, and her MA and PhD in sociology from Cornell University.



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