**Statement of Charles P. Blahous[1]**

**Before the U.S. Senate Committee on the Budget**

**May 12, 2022**

Thank you, Chairman Sanders, Ranking Member Graham, and all of the members of the committee. I appreciate this opportunity to testify on the federal budget costs of enacting Medicare for All (M4A).

My testimony is based largely on research I published in 2018 to estimate the federal cost of enacting Medicare for All. Let me begin with a few caveats before summarizing these estimates and the assumptions that underlay them. The first caveat is that while there are many similarities between various bills to enact M4A, there are also important differences between them, and thus any estimates developed for one particular bill will not apply exactly to a different one. My 2018 study analyzed one specific bill introduced by Chairman Sanders in 2017, which differed in several important particulars from subsequently introduced M4A bills. That study represents the only comprehensive cost estimate I have developed, and thus I can offer only approximate guidance as to the likely budgetary effects of legislation introduced more recently.

Second, the narrow purpose of my research was to estimate the federal budget costs of enacting M4A. It was not to opine on whether M4A would be good or bad policy, nor did it engage various important value judgments or difficult health policy calls that must be made in the course of any comprehensive healthcare legislation. While the study (as well as this testimony) does describe possible effects of various policy decisions associated with implementing M4A, it does so only to illuminate how the budgetary estimates might be affected by them, and not to presume particular value judgments that are appropriately the prerogative of lawmakers.

Third, although various incarnations of these proposals have titles that include the phrase "Medicare for All," the federal healthcare systems they would establish differ from current Medicare in fundamental ways. Instead of extending the current Medicare program to the population as a whole, these bills would move all Americans, including seniors currently on Medicare, into a new system offering different (mostly more generous) benefits, while doing away with many of Medicare's current financing mechanisms such as patient deductibles and copays. I have not attempted to analyze an expansion of eligibility for traditional Medicare. Nor have I analyzed any of the various proposals to allow new participants to buy into the current Medicare program.

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Fourth, a number of things have changed since my study was performed. Other bills have subsequently been introduced that differ in important particulars from the provisions I analyzed. Other legislation has subsequently been enacted that would directly affect my estimates if I were to redo them. Baseline projections for national health expenditures have also changed, as they always do. And importantly, we now have the benefit of other important published analyses, including work by the Congressional Budget Office (CBO), which models certain important effects that I could not. Later in my testimony, I will attempt to summarize how this newer information might affect a future recalculation of my estimates.

*Cost Estimates*

Let me first summarize the findings of my 2018 study before proceeding to discuss how its results differ from what an updated study might find. My study found that the additional federal costs of enacting Medicare for All would likely be somewhere in the range of $32.6-$38.8 trillion over its first ten years of full implementation, which at the time the study was conducted would have been 2022-2031. The $32.6 trillion projection was presented in the paper as a lower-bound estimate, representing an unlikely scenario in which the provisions of M4A that are intended to lower costs all produced the full amount of their potential savings, without regard for any accompanying adverse effects this might have on healthcare access, timeliness or quality. Alternatively, if after M4A's enactment, historical patterns of federal government behavior remained more consistent with past practice, the new federal costs would be closer to $38.8 trillion over the first ten years.

We have no experience with enacting permanent federal cost increases of this magnitude, which renders these numbers especially difficult for many people to conceptualize. To provide context, the study translated them into a share of GDP. The $32.6 trillion estimate equated to an addition to federal budget costs of roughly 10.7% of GDP in 2022, gradually increasing to 12.7% of GDP in 2031, and growing further afterward. If instead, new federal costs were $38.8 trillion over ten years, federal obligations would be increased by 12.6% in 2022 and by 15.1% in 2031, also growing larger over subsequent time. To illustrate the qualitative size of the cost increase, the study noted that even under the lower-bound estimate of $32.6 trillion, a doubling of all currently projected federal individual and corporate income taxes would be insufficient to finance the added federal costs of enacting M4A.

Table 1: Projected Federal Cost Increases under M4A

| **Scenario** | **New Federal Costs, 2022-31 ($T)** | **New Federal Costs, 2022 (% of GDP)** | **New Federal Costs, 2031 (% of GDP)** |
|---|---|---|---|
| Lower-bound estimate | $32.6 T | 10.7% | 12.7% |
| Estimate assuming continuity in provider + drug payments | $38.8 T | 12.6% | 15.1% |

The estimates in the preceding table do not reflect the total federal costs of M4A, but rather just its addition to federal costs above and beyond currently projected federal healthcare spending and tax subsidies, which include Medicare, Medicaid, the tax subsidy for employer-sponsored health insurance, Affordable Care Act exchange subsidies, and other health programs. Total projected health cost obligations under M4A were estimated to be substantially higher than the net cost increases shown in Table 1, somewhere within the range of $54.6 trillion and $60.7 trillion over the first ten years. Under the lower-bound estimate, federal spending on M4A alone would be 20.8% of GDP by 2031. For reference, 20.8% of GDP is more than all federal spending as a percentage of GDP as recently as 2018.[2] Further, these figures did not account for all national health-related spending under M4A, as for example they excluded long-term care spending that would remain the responsibilities of individuals and state governments.

*Factors Affecting the Cost Estimates*

The vast majority of new federal costs under M4A would result from the federal government's assuming responsibility for most national health spending currently financed by other entities, including private insurance, state and local governments, and individuals. By itself, and before considering possible offsetting savings, M4A's expansion of coverage combined with shifting from privately-financed to federally-financed insurance would not only cause federal budget obligations to increase, but national health expenditures as well. This increase occurs partially because of increased expenditures on health services for the currently uninsured, and partially because of M4A's coverage of some services not now covered by traditional Medicare, such as dental, vision and hearing benefits. Additional expenditure increases would also occur because M4A would offer first-dollar coverage of individuals' health services, unlike traditional Medicare and most current private insurance. It is well established in the economics literature that the more of an individual's health services that are covered by insurance, the more they tend to consume, irrespective of the services' efficacy or value. M4A's first-dollar coverage of health services would therefore fuel substantial additional demand.

M4A seeks to offset these additional costs through various means. One is through the replacement of private health insurance by a federally-administered system that sponsors intend to have lower administrative costs. My study adopted an aggressive assumption that over half of the administrative costs currently borne by private insurance would be eliminated. These assumed administrative cost savings would offset roughly 4% of the additional federal costs arising from the federal government's becoming the financier of nearly all US healthcare. For another comparison, these assumed administrative cost savings would offset roughly 28% of the additional national health spending expected to arise from increased health service demand under M4A. In other words, health insurance administrative costs would be lowered, but these savings would offset only a fraction of the additional national health expenditures projected as a result of M4A's expanded and enhanced coverage.

[2] Congressional Budget Office, "Historical Budget Data," Feb. 2021, https://www.cbo.gov/data/budget-economic-data#2

Another means by which the M4A legislation I analyzed would attempt to contain costs is by having the Secretary of Health and Human Services negotiate drug prices with a particular emphasis on replacing brand-name medications with less expensive generics. To understand how cost projections are affected by such features, it is important to distinguish between potential savings and likely savings. There are hard limits on the potential savings that can arise from such a provision because prescription drugs accounted (at the time of my study) for just 10 percent of total national health expenditures, and generics already made up 85 percent of all prescription drugs sold. Nevertheless, my lower-bound estimates employed aggressive assumptions for prescription drug cost savings, specifically an immediate 12 percent reduction in prescription drug expenditures, without attempting to model potential adverse effects of this reduction on the pharmaceutical industry or the pace of innovation.

History provides reason for skepticism that this level of savings would be achieved. Historically the federal government has tended to prioritize health benefits for those dependent on federal programs over the interests of taxpayers in restraining cost growth. Though it is theoretically possible that under M4A the federal government would switch its emphasis from allowing patients full access to the fruits of pharmaceutical and other healthcare innovation, to protecting the interests of taxpayers through cost containment, the political economy incentives under M4A make this unlikely. Under M4A, the lack of deductibles, copayments and cost-sharing would largely eliminate consumer (and thus voter) direct sensitivity to healthcare prices, including drug prices. Moreover, the established national tendency to favor access to pharmaceutical innovation and development over cost containment has likely become even more entrenched during the ongoing pandemic. Dramatic drug price savings under M4A should therefore be considered an aspirational goal rather than the basis for an intermediate cost projection. This is one of multiple reasons why my study found that actual costs under M4A would likely exceed the lower-bound projection scenario.

The most significant variable affecting M4A cost projections is that of provider payment rates. The study's lower-bound projection assumed that all provider payment rates would immediately be set to Medicare rates, which for inpatient hospital services were roughly 40% lower than private insurance rates over the time window in the study. Several earlier studies had assumed higher payment rates than this would be required, because Medicare payment rates were substantially below providers' reported costs of providing services. The CMS Medicare actuary, for example, projected at the time of the study that 80% of hospitals would experience negative margins in the near term when treating Medicare patients, a situation M4A would extend to the population as a whole. See Figures 1 and 2, reproduced from a memorandum from the CMS Medicare actuary's office.[3]

[3] The figures shown here are reproduced from CMS Office of the Actuary, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2018TRAlternativeScenario.pdf. These figures from the 2018 memorandum were chosen for inclusion in this testimony because they illustrate data cited in the study. CMS has more recently

Figure 1: CMS Medicare Actuary Comparisons of Inpatient Hospital Payment Rates

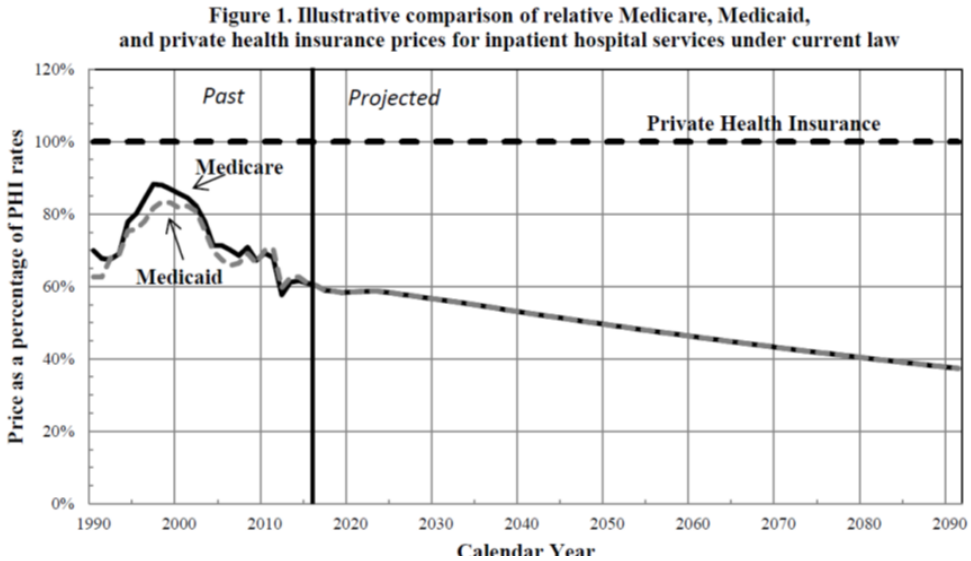
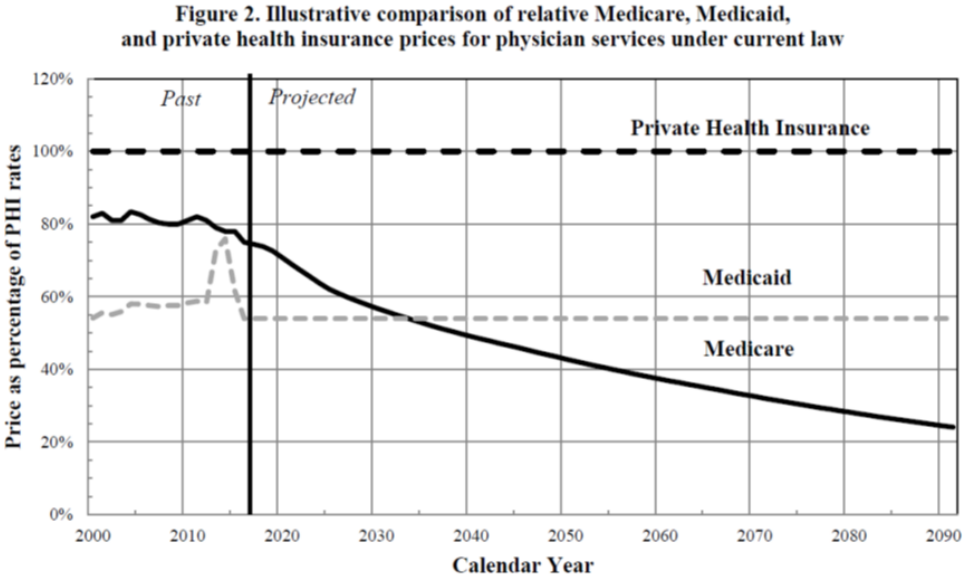



Figure 2: CMS Medicare Actuary Comparisons of Physician Payment Rates




We do not know how providers would respond to payment reductions of this magnitude for treatments now covered by private insurance, concurrent with a simultaneous increase in patient demand for health services under M4A. It was clearly likely that there would be some disruptions in the availability, timeliness and quality of healthcare services, but my 2018 study did not attempt to model the extent to which the supply of healthcare services may be insufficient to meet expanded demand under M4A.

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published updates of these figures that are qualitatively similar. See https://www.cms.gov/files/document/illustrative-alternative-scenario-2021.pdf.

The study's lower-bound estimates assumed the universal and immediate application of Medicare payment rates. Throughout recent history, lawmakers have repeatedly balked at applying payment reductions that are far smaller, less sudden, and applicable to a lesser number of payments, than this assumption. For example, lawmakers began annual overrides of the Medicare physician payment Sustainable Growth Rate formula when the pending cuts were just 4-5% and applied only to Medicare treatments. By contrast, inpatient hospital service payment cuts M4A would start at over 40% in the lower-bound projection scenario and apply to the larger number of treatments now covered by private insurance.

Table 2 summarizes how the 2018 M4A cost estimates were affected by these various assumptions.

Table 2: Effect of Various Assumptions upon M4A Cost Projections

| **Scenario** | **Additional Federal Costs, 2022-2031 ($T)** |
|---|---|
| = Added federal costs from coverage increase | = $40.368 T |
| - Administrative cost savings | - $1.572 T |
| = Estimate assuming administrative savings | = $38.797 T |
| - Potential drug cost savings | - $0.846 T |
| = Estimate assuming drug and admin. savings | = $37.950 T |
| - Lowering provider payments to Medicare rates | - $5.307 T |
| = Lower-bound estimate | = $32.644 T |

*Other Contemporaneous Perspectives on Federal Costs*

An occasional question about such estimates is whether they reflect a particular policy viewpoint or instead reflect broader agreement among experts as to the likely costs of M4A. The answer is that cost estimates produced by experts from a wide range of policy perspectives and affiliations arrived at roughly the same results as my study, after adjusting for different years estimated, as well as assumptions regarding provider payment rates, drug prices, and whether long-term services and supports (LTSS) are included. The following table translates my 2018 estimates into what they would have been for M4A's implementation during 2017-2026, as assumed in studies published by the Urban Institute, the Center for Health and Economy, and Emory University professor Ken Thorpe.

Table 3: Alternative Estimates for Added Federal Costs under M4A, if Effective 2017-2026

| **Estimate** | **New Federal Costs over 2017-2026 ($T)** |
|---|---|
| Center for Health and Economy, Alternative Estimate | $40.2 |
| Blahous (w/o provider cuts or drug savings) | $29.5 |
| Urban Institute (w/o LTSS benefit) | $29.1 |
| Blahous (w/drug savings, w/o provider cuts) | $28.9 |
| Center for Health and Economy, Primary Estimate | $27.3 |
| Blahous (w/provider cuts & drug savings) | $25.2 |
| Thorpe | $24.7 |

As Table 3 shows, my 2018 estimates are generally within the range of those produced by other experts, the differences between them largely attributable to differences in key assumptions. The Urban Institute study produced an estimate of $32.0 trillion, which included LTSS coverage. Adjusting for the fact that the 2017 bill I studied did not include this coverage brings the Urban Institute's estimate down within the range of my own. My lower-bound estimate was generally smaller than those of other experts because it assumed the immediate imposition of Medicare provider payment rates, which are lower than the payment rates the other studies all assumed would be the minimum necessary. The Thorpe study estimated higher total national health spending than mine, while mine assumed the federal government would pay for a higher percentage of the whole. In general, however, the estimates are qualitatively similar regardless of who made them, providing the same general picture of the scale of federal government expansion M4A would bring about.

*How Future Estimates Might Change in Light of Recent Information*

As noted earlier, I have not performed a comprehensive cost re-estimate since my 2018 study was performed. However, there are multiple reasons why an updated version of my study would likely produce somewhat different estimates. We now have additional information that was not available to me at the time of my study, including a comprehensive report from CBO in December of 2020.

The CBO report modeled five options for creating a national single-payer healthcare system along the lines of M4A, projecting the new federal costs of each option in a single year (2030). Only one of these options, option 5, resembled current proposals for M4A, which generally include LTSS coverage. CBO found that option 5 would increase federal costs by $3.00 trillion in 2030 alone, as well as increasing national health expenditures (NHE). CBO's options 1 and 2 are less relevant to the M4A discussion because they are for models with significant patient cost-sharing, at cross purposes with the stated policy goals of most M4A advocates and sponsors. Options 3 and 4 also differ from current M4A proposals in omitting long-term care benefits, but are nevertheless useful for predicting how my own previous estimates (which also omitted long-term care costs) might

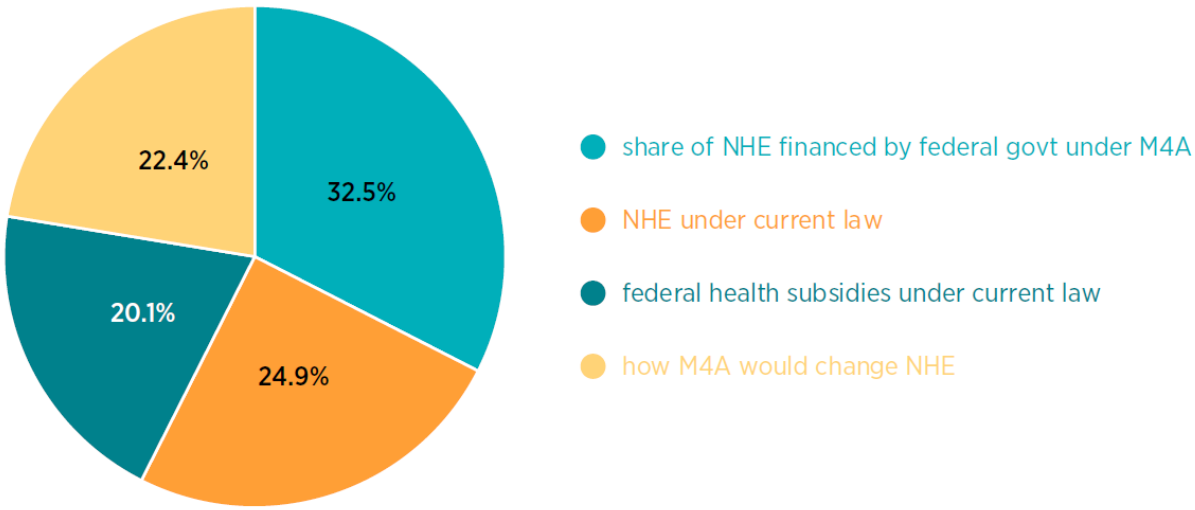
change in light of more recent information. Table 4 compares key assumptions and results from CBO's options 3 and 4 to my own.

Table 4: Alternative Payment Assumptions and Results

| **Scenario** | **Key Assumptions** | **New Federal Costs in 2030 ($T)** |
|---|---|---|
| Blahous lower-bound | No LTSS benefits, Medicare payment rates, 12% drug price cuts | $3.97 |
| CBO Option 3 | No LTSS benefits, hospitals at 123% of Medicare payment rates, physicians at 111% of Medicare rates, 30% drug price cuts | $1.77 |
| CBO Option 4 | No LTSS benefits, hospitals at 142% of Medicare payment rates, physicians at 120% of Medicare rates, 7% drug price cuts | $2.40 |
| Blahous drug price cuts only | No LTSS benefits, current-law hospital/physician payment rates, 12% drug price cuts | $4.63 |
| Blahous, no provider payment or drug price cuts | No LTSS benefits, current-law hospital/physician payment rates, no drug price cuts | $4.73 |

As Table 4 shows, there are substantial differences between CBO's estimates and mine, even between scenarios (such as CBO's Option 4 and my study's "maintain provider payments" scenario) where key underlying payment rate assumptions are in the same general range. This raises the question as to why CBO's estimates differ so much from mine (and by extension, from those of the Urban Institute, the Center for Health and Economy, and Thorpe). In an effort to answer this question, I grouped the sources of projection differences into four broad categories depicted in Figure 3.

Figure 3: Differences between CBO Option 4 and Blahous Maintain-Provider-Payments Scenario




Note: M4A = Medicare for All; NHE = national health expenditures.
Source: Author's calculations based on data from CBO's Single-Payer Health Care Systems Team, "How CBO Analyzes the Costs," cross-referenced with Blahous, "Costs of a National Single-Payer Health Care System."

As Figure 3 shows, the largest differences between my estimates and CBO's are unrelated to M4A's effect on national health costs. The largest share of difference (32.5%) pertains to different estimates of the share of national healthcare that would be financed by the federal government, instead of continuing to be financed by others, including state and local governments, philanthropies, and individuals out of pocket (for example, on LTSS and prescription drugs). CBO also estimated something I did not; the amount of healthcare services that would continue to be provided by physicians and other providers who opt out of the M4A system. While I believe that some of these various categories of healthcare spending are likely to be absorbed or crowded out by M4A, I also believe CBO is correct to conclude that substantial amounts of this care would continue to be paid for by Americans outside of the M4A system.

The second largest category of difference (24.9%) involves downward movement of the current-law baseline projections for NHE. After my study was published, the Centers for Medicare and Medicaid (CMS) lowered their NHE projections somewhat. Additionally, CBO derived its own estimates for NHE that were somewhat lower than CMS's. Each of these two effects (CMS's downward revisions and CBO's additional adjustments) reduces the cost estimates in roughly equal measure. Hence, were I to repeat my study using CMS projections again, it is reasonable to estimate that I would incorporate roughly half of this category of differences into my revisions.

The smallest category of difference (20.1%) involves alternative calculations of federal healthcare subsidies under current law. A substantial portion of this difference is rooted in legislative events subsequent to the publication of my study, such as the repeal of the so-called "Cadillac plan tax," medical device tax and other health insurance taxes, thereby increasing net federal health subsidies

under current law. Accordingly, if my study were to be updated, a substantial portion of these changes would need to be incorporated.

Perhaps surprisingly, alternative views of the likely effects of M4A on national health spending account for only 22.4% of the difference between my federal cost estimates from CBO's. Though relatively small, these differences are likely to be of strong interest to policy makers, because they pertain to whether M4A decelerates national health spending growth or accelerates it still further, and because they also pertain to whether patients receive the care they seek. CBO's cost estimates here are lower than mine because they a) assume lower administrative costs and b) find that a substantial amount of healthcare sought under M4A would simply be denied.

CBO's report acknowledges that it assumes lower administrative costs under M4A than other studies do, as well as lower than in other U.S. public insurance systems and single payer systems abroad. CBO devotes substantial space to explaining its lower estimates. CBO projects an administrative cost rate for M4A of between 1.5%-1.8%, whereas other studies' estimates have ranged from 4.7%-6.0%, existing single-payer systems internationally generally range from 2%-3%, and current Medicare/Medicaid's are roughly 8%. While I commend CBO for the thoroughness and rigor of their administrative cost derivations, and while M4A has the potential to further reduce administrative costs below my 2018 assumptions, CBO's assumptions go further than I feel comfortable adopting. We must remember important factors in play here, for example that other nations have not generally achieved administrative cost rates that low despite many years of experience, and also that current Medicare serves an older population with higher average healthcare costs than M4A would, meaning that M4A could not achieve administrative cost rates below current Medicare fee-for-service's 2.3 percent unless M4A's administrative costs per capita were dramatically lower.

Perhaps the most striking difference between my study and CBO's is that CBO modeled the amount of care that would be denied under M4A, whereas I lacked the capacity to model this phenomenon and implicitly assumed that the supply of healthcare services would expand to meet additional demand, while cautioning that this might not happen. Our respective estimates of increased healthcare demand in 2030 were remarkably similar ($684 billion in my study vs. $661 billion in CBO's Option 4), but CBO found that $254 billion of this new demand for healthcare would simply go unmet. In its Option 3 (the option that attempts to slow the growth of health spending by more stringently restricting provider payments), CBO found that the majority of additional demand ($319 billion out of $591 billion) would go unmet. In other words, Americans would be promised more healthcare, but the majority of these promises would go unfulfilled.

CBO's assumptions of large administrative cost reductions become especially important in this context. CBO's model assumes that health providers under M4A will be able to dramatically reduce their time spent on administrative tasks, and that this time saved will be converted to additional supply of healthcare. However, the numbers become daunting if we shift our perspective from what I would regard as aggressively optimistic to prudently optimistic.

For example, CBO projects that 80% of the time nurses spend on administrative tasks would be eliminated by M4A. If we simply assume that M4A does half as well – that is, reducing nurses' administrative duties by 40% rather than 80% -- and combine this with assumptions of Medicare-level payment rates, as well as CBO's reasonable and well-studied assumptions regarding the prevalence of opt-outs, provider supply responses to payment cuts, and the ability of health providers and drug manufacturers to expand supply in response to demand – then we find that almost all of the additional health services promised by M4A would fail to materialize. Only $96 billion of a projected $684 billion in healthcare demand increase – or 14% -- would be met, whereas an overwhelming 86% would be denied. Moreover, $81 billion of the supply increase that would occur would consist entirely of prescription drugs: by contrast, over 97% of the additional physician and hospital services sought under M4A wouldn't be delivered. In this scenario, it would be no exaggeration to say that M4A would increase eligibility and demand for additional healthcare, while in practice denying the promised additional access almost completely.

These findings are not only of concern from a health policy perspective, they carry important implications for the potential costs of M4A. For example, the provider payment rates assumed in my study's lower-bound projection scenario are more clearly unrealistic if they would lead to 97% of the new demand for hospital and physician services under M4A being denied. Lawmakers are highly unlikely to tolerate such a situation after national investment in the promise of universal access to healthcare. The CBO report therefore enables us to say with increased certainty that the higher-payment scenarios in my study are far more probable than my lower-bound projections.

The CBO report also indicates that M4A bills introduced in Congress would almost certainly add to, rather than subtract from, the problem of rising national health expenditures. Option 5, the option that most closely tracks proposed legislation, would increase NHE under CBO's analysis. Option 4, which subtracts the long-term care benefits of existing bills, would also add to NHE even if as little as 11 percent of CBO's projected reduction in administrative costs failed to materialize. These NHE increases would be larger if lawmakers deemed the projected denials of care to be unacceptable, and relaxed scheduled provider payment cuts in an effort to alleviate them.

Although I cannot attach precise numbers to a hypothetical update of my analysis in light of the CBO report, I will try to give a sense of how the numbers might move if such an analysis were attempted. The provider payment rate assumptions in my lower-bound scenario (resulting in a $32.6 trillion federal cost projection over ten years in my 2018 study) have appeared more unrealistic since my study was performed, and this scenario should probably be discarded on the grounds of being too implausible. The payment rate assumptions underlying my $38.8 trillion estimate are more plausible, and an updated estimate could reasonably be fashioned via revisions to them. The largest factor increasing this cost projection would be the inclusion of LTSS benefits contained in current bills to establish M4A. Offsetting this would be factors reducing the projected cost, with the largest factors likely to be, in order: changes in the current-law federal baseline since my study was performed; care projected to be denied under M4A; a larger estimate of private

entities', states', localities', and individuals' continuing roles in financing care; changes in baseline projections for NHE; and lower administrative costs than previously assumed. Taking all these factors in combination, it is reasonable to guess that a revised estimate of the ten-year cost of this scenario would be closer to $31 trillion rather than $39 trillion, if applied to the same hypothetical years as my previous study. If $31 trillion were indeed the number, this would again exceed what could be financed by doubling all currently projected individual and corporate income taxes.

Despite the projected federal cost likely being lower in a hypothetical future study than in my previous study, this projection scenario would still show a net increase in NHE because the expansion of benefits to include LTSS, dental, vision and hearing, as well as the increase in patient demand resulting from more expansive insurance coverage, would together increase costs by more than administrative cost savings and outright denials of care would reduce them. Only if provider payments and drug prices were cut substantially would we expect this projection to produce a net reduction in NHE. Note that these findings would be broadly consistent with CBO estimates for Option 5, which show a net increase in NHE. Although my methods would still feature some differences with CBO's, the incorporation of many of CBO's inputs including updated estimates of federal health subsidies under current law, current-law NHE projections, and modeling of supply limitations, would likely bring my federal cost estimates within 20 percent of CBO's parallel estimates, even before payment rate changes are considered.

My study focused on federal cost projections under M4A, in part because such cost estimates play a key role in Congress's legislative procedures and are thus critical information for lawmakers. Many have correctly noted, as also described earlier in this testimony, that the vast majority of these projected costs are not new to the US economy as a whole, are currently being shouldered by others, and would be shifted to the federal government under M4A. Lawmakers should be cognizant that just as with other major national expenditures such as what Americans spend on food or housing, the fact that we are already bearing most of these costs does not necessarily imply that the federal government would find it easy or even practicable to assume them, nor does it necessarily suggest that the federal government can readily provide these goods and services free of charge to every American while satisfying their diverse needs and preferences. While total national health spending is an important piece of policy information, federal lawmakers considering M4A would not be able to avoid the central question of how to finance its costs to the federal budget.

I hope this information is useful to committee members as Congress considers the various implications of enacting M4A legislation.