



The Unanswered Questions of Medicare for All

By Charles Blahous

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The single-payer health insurance proposal known widely as Medicare for All (M4A) cannot be enacted without first answering certain questions. Foremost among these is whether the public would support shifting more than \$32 trillion in M4A's first 10 years from private health spending, over which consumers retain some discretion, to federal health spending, over which consumers do not. A related open question is whether the federal government can adequately finance this amount of spending without triggering significant adverse economic effects. Other unanswered questions include M4A's effects on health providers, the prescription drug market, and private health insurance. M4A would add further to national health cost growth unless provider reimbursements are cut more sharply than lawmakers have been willing to do historically. Yet the consequences of enacting such payment cuts simultaneously with a substantial increase in health service demand are unpredictable.

The Medicare for All (M4A) cost estimate I published with the Mercatus Center last year (Blahous 2018) intensified an already vigorous national debate on whether to replace current US health insurance with a single-payer system. The study achieved its central informational goal, in that hardly an article about single-payer health care now appears without noting that such a system would cost at least \$32.6 trillion in new federal spending over its first 10 years (Alonso-Zaldivar 2018). Yet without my intending it, the study ended up revealing much more. Policy advocates' diverse reactions to the cost analysis illuminated a striking lack of national consensus on fundamental value judgments that must be made in the course of crafting future health care policy.

While rhetorical slogans such as "Medicare for All!" can be voiced without confronting any difficult trade-offs, legislating health care policy nevertheless

requires making such trade-offs. Americans approach these trade-offs differently, as the widely divergent reactions to the study make clear. To enact M4A, or indeed any other fundamental change to national health policy, legislators must find common ground on answers to certain critical policy questions.

Costs and Consequences

First and foremost among these considerations is the unavoidable issue of cost. The aim of my research was purposely narrow: not to opine on the merits or demerits of single-payer health care itself, but to estimate its effect on the federal budget. Apart from the many other important policy considerations in play, knowing this budget impact is essential because it largely determines Congress' legislative procedures. Any legislation

with such far-reaching fiscal consequences will require a Congressional Budget Office (CBO) cost estimate in order to be considered. Both skeptics and proponents of M4A need to know its federal budget effects, yet no up-to-date, official score existed.

My study calculated a lower bound for additional federal costs under M4A of \$32.6 trillion over the first 10 years, ranging up to \$38.8 trillion depending on assumptions about provider payment rates and drug prices. Importantly, these figures do not represent the total cost of M4A, merely its incremental addition to federal spending above current federal programs such as Medicare, Medicaid, the Affordable Care Act (ACA), and the tax preference for employer-provided health insurance. M4A's total costs over its first 10 years would be much higher, in the range of \$54.6–\$60.7 trillion. Dollar amounts so large are difficult to place in any familiar context. As my study noted, financing even the lower-bound cost estimate of \$32.6 trillion would require more additional federal revenues than could be collected by doubling all currently projected individual and corporate income taxes.

Cost is M4A's existential issue, because if federal lawmakers are not willing to impose M4A's cost on taxpayers, no other aspect of the framework will enable its enactment. Americans therefore face a fundamental threshold value judgment as to whether it is acceptable for the federal government to expand to the extent required to deliver M4A.

We simply have no instructive experience with permanent government expansions of that magnitude. M4A's additional federal costs start somewhere in the range of 10.7–12.3 percent of gross domestic product (GDP), rising within the first decade to 12.7–15.1 percent of GDP. For context, consider that the net deficit impact of the 2017 tax cuts, decried by many as fiscally irresponsible, amounted to less than 1 percent of GDP per year. In other words, the fiscal impact of M4A would be over 15 times that of the 2017 tax cuts. For comparison, Social Security, the largest existing federal program, will have taken more than 80 years to grow to 5 percent of GDP by 2020. Congress has simply never seriously considered enacting legislation with such transformative effects as M4A would have on the economy and the size of government.

The additional federal costs of enacting M4A, unlike the initial costs of establishing Social Security,

must be borne on top of the federal government's obligations to Social Security, Medicare, Medicaid, and its other preexisting spending commitments. The federal government currently lacks a viable plan to finance these obligations even before considering M4A's costs (CBO 2018). It remains an open question whether all who are favorably disposed to M4A in a conceptual sense would also favor expanding the federal government and increasing their tax burdens to the unprecedented levels required to bring M4A into existence.

One of the more interesting divides exposed by the study is a wide divergence in attitudes about the significance of replacing so much private health spending with federal spending. Some M4A advocates have suggested that the federal cost increase is not the pertinent metric, focusing instead on M4A's potential effects on total national—including current federal, state, and private—health spending (Scott 2018). Specifically, these advocates believe M4A to be a good policy choice if it achieves universal health coverage while containing national health spending, irrespective of the new federal cost obligations it would create.

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M4A supporters are correct to observe that Americans already pay for the vast majority of health spending that would occur under M4A and that most of M4A's costs are therefore not “new” to the national economy. Specifically, my study projected that M4A would not qualitatively change total national health spending. Instead, national health spending under M4A would be somewhere within the range of 96–107 percent of current projections by 2031, depending on the specific assumptions. Yet this does not necessarily imply that it is trivial or benign to shift all or even most private health spending to federal spending. After all, Americans spend vast amounts of money on

many things, including health care, housing, food, and state and local government services. This does not suggest that it would be simple or uncontroversial for the federal government to assume responsibility for providing these various goods or services to every person in America.

Two of the most important facets of such a shift are its vast magnitude and the transfer of decision-making from individuals and businesses to the federal government. Depending on the specific assumptions, the initial additional federal obligations would be in the ballpark of \$10,000 annually per person. Even if M4A fully liberated Americans from all their current personal health care expenses, including all spending by employers and deducted from workers' wages, a family of four might still strongly object to having to send an additional \$40,000 to Washington each year on top of their current tax burdens. The sheer magnitude of this resource transfer and the difficulty of crafting an equitable means of allocating the costs might be a bridge too far for many Americans.

Then, too, the factors of personal choice and control cannot be summarily dismissed as irrelevancies. Many Americans are satisfied with employer-sponsored insurance and prefer to continue with it. Beyond that, not all Americans will want to yield their purchasing decisions involving health care, food, or any other deeply personal expenditure to the federal government—even if they are already spending that amount of money and the government promises to lower the total tab by a few percentage points. Instead, these Americans may place significant value on being able to choose whether and how to allocate those resources. Moreover, they might not trust the government to produce the promised cost savings or maintain the full range of existing purchasing choices, while worrying about potential consequences of the government's cost-containment methods.

In sum, we cannot assume that Americans generally regard federal spending as functionally equivalent and interchangeable with their own personal spending. We therefore cannot assume Americans will broadly support shouldering M4A's costs through their federal taxes, even if it relieves them of all the other ways they currently pay for health care.

How the federal government would finance this enormous cost expansion is an especially important variable. US health care is currently financed via a wide variety of methods, including premiums paid by individuals and their employers, individual payments out of pocket, and spending at various levels of government. If nearly all this spending is shifted to the federal ledger, the federal government would need to decide how to collect the revenue necessary to finance it. These decisions are central to the economic consequences and the political viability of a single-payer health care system.

Marc Goldwein has noted that “it would be almost impossible to raise \$32 trillion of taxes (or finance it with extra borrowing) and not create some negative GDP effects and deadweight loss.” Goldwein guesses that US economic losses could “easily exceed \$2 trillion over a decade” (Goldwein 2018)—in other words, more than the M4A's realistic potential to lower US health care costs. Economic losses of this magnitude under M4A seem virtually certain. Even given all the inefficiencies that currently exist in private health insurance, current premium payments create fewer deadweight losses than the possibilities on the table for financing M4A.

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Specifically, with M4A adding roughly \$10,000 per American in additional annual federal costs, the federal government is unlikely to find it politically feasible to require every American, rich or poor, young or old, to fully pay for their own per capita share of the federal cost increase. Legislators would more likely seek to finance M4A with assessments that are at least proportional to the payer's income and more likely via proportionally higher assessments on higher-income households. Indeed, the financing mechanisms suggested by M4A proponents—such as increased estate taxes, income taxes, and “wealth” taxes—would together still not be adequate to

finance its full costs, and they confirm that sponsors intend to rely on progressive taxes that would significantly reduce total US economic output (Sanders 2017).

In sum, national health spending under M4A is more likely to rise than to fall, but even if it falls slightly, deadweight loss would likely more than offset any potential savings, leaving Americans poorer on average. It is far from clear that Americans would be willing to pay the massive additional federal taxes required only to produce this problematic combination of outcomes.

How and What Would Providers Be Paid?

Another threshold question concerning M4A is how and what health care providers—including hospitals, physicians, nurses, and others—would be paid. The M4A bill introduced by Sen. Bernie Sanders (I-VT) specifies that providers would be paid at current-law Medicare reimbursement rates, which are substantially lower than those paid by private insurance (S. 1804, §611). The proposed cuts to providers now working through private insurance would be severe. According to data from the Centers for Medicare and Medicaid Services (CMS) actuary, payment cuts for these treatments would start at roughly 40 percent for hospitals, growing gradually larger over time. For physicians, the cuts for treating those currently with private insurance would be closer to 30 percent in the first year of full implementation, but per current-law Medicare payment schedules the cuts would quickly grow larger—to 42 percent within the first 10 years and becoming much more severe after that.

Before the Sanders bill was introduced, experts generally assumed that provider cuts of this magnitude could not and would not be imposed under M4A. A widely cited Urban Institute analysis preceding the bill's introduction noted that Medicare payment rates were well below hospitals' reported costs; therefore, assumed M4A hospital payment rates would be set higher than current Medicare rates to enable hospitals to break even and thereby continue operating (Holahan et al. 2016). An analysis by Emory University Professor Ken Thorpe also assumed higher M4A hospital payment rates (5 percent

higher than the Urban team's assumptions) (Thorpe 2016).

Three critical questions about M4A provider payment rates necessitate answers: *Would* provider cuts similar to those in the Sanders bill actually be implemented? *Should* they be implemented? And what would be the *consequences* if they were implemented? It is important to distinguish among these questions. An analytical conclusion that such cuts are unlikely to be implemented does not necessarily imply that they should not be. Similarly, a policy opinion that such cuts should occur does not equate to a projection that they actually will.

Would Proposed Provider Payment Cuts Be Implemented? Whether M4A would successfully implement provider payment reductions on the order of the Sanders bill is a critical question for several reasons, including the fundamental one of costs. Without such provider cuts, M4A's coverage expansion would drive national health spending higher than currently projected, undoing a foundational premise of the case for M4A (Blahous 2018). But there are strong reasons for skepticism that such cuts would actually take effect. One of them is Congress' legislative track record on provider cuts of comparable or lesser magnitude.

The cuts in the Sanders M4A bill would sharply reduce provider reimbursements for treatments now covered by private insurance, which represent a substantially greater (more than 50 percent larger) share of national health spending than does Medicare. Federal lawmakers have historically proved unwilling to uphold many smaller payment cuts affecting relatively fewer Medicare treatments. For example, lawmakers repeatedly overrode Medicare physician payment reductions specified under the previous statutory Sustainable Growth Rate (SGR) formula, overriding those cuts when they would have been just 4–5 percent, continuing when they had accumulated to more than 25 percent, and finally repealing the formula altogether (Hahn 2014, 6–7). For comparison, the provider cuts in the Sanders bill would start at about 30 percent for physicians and 40 percent for hospitals and would apply to the more numerous treatments now covered by private insurance. In other words, the provider cuts required to keep M4A from exacerbating our national health

cost problem are far steeper than statutory reductions that federal lawmakers persistently balked at implementing.

Even if lawmakers were willing to gradually lower private insurance provider payments by 40 percent cumulatively, they are still highly unlikely to do so all at once and thereby risk sudden disruptions in health service supply. In 2015, federal lawmakers replaced the SGR physician payment schedule with the Medicare Access and CHIP Reauthorization Act (MACRA) schedule, which also aims to constrain payment levels, but on a more delayed schedule. Furthermore, the ACA's current Medicare provider payment constraints are devised to produce substantial savings over the long run, but only gradually (accumulating 1.1 percent per year) (Boards of Trustees 2018, 6). As a general rule, whenever belt-tightening has been deemed too sudden, even its authors have been unwilling to implement it. Other examples include the various Obama administration waivers and postponements of the ACA's Medicare Advantage cuts and coverage mandate penalties (Blahous 2016).

Indeed, it remains an open question whether even the ACA's current and relatively gradual Medicare payment growth constraints will be sustained, irrespective of whether M4A is enacted. The CMS Office of the Actuary issues an annual memorandum questioning whether Medicare's physician payment schedule under MACRA, or the ACA's provider payment constraints, will be maintained in future decades (Shatto and Clemens 2018). CMS's alternative projection scenario assumes that the ACA's Medicare payment constraints will be phased out starting in 2028, based on the actuary's finding that to do otherwise would render most hospitals' finances untenable (Heffler et al. 2018). None of these highly uncertain aspects of current law are nearly as severe as the more dramatic provider payment reductions in proposed M4A legislation.

All these considerations feed into the question of whether M4A would deliver on its advocates' hopes for bringing national health spending growth under control. Unless lawmakers are willing to impose far more sudden and potentially disruptive provider payment reductions than they have historically been willing to implement, M4A's coverage expansion should be expected to further increase national health spending growth.

Should Proposed Provider Payment Cuts Be Implemented? The preceding evidence, however, tells us only that M4A is unlikely to dramatically reduce provider payments. It does not answer an equally important question: How *should* provider payment levels be set?

In a well-functioning market, policymakers are generally excused from making value judgments about how much a seller of services should be paid. Prices arise from the intersection of what consumers are willing to pay and what sellers are willing to accept for their services. The accepted role of government is not generally to impose a price structure, but to ensure that the market operates fairly and transparently.

Few seem willing to contend that our current patchwork system of paying for health care efficiently or transparently determines provider payment levels. There is widespread belief that various health goods and services cost more than they should and more than they would cost in a well-functioning market. A study by Jeffrey Clemens and Joshua Gottlieb found that, whenever Medicare overpays for health services, the effects spread throughout the health market by fueling even larger price increases in private insurance (Clemens and Gottlieb 2013; Whoriskey and Keating 2013). Anecdotal horror stories abound, for example, of hospitals charging upward of \$25 for a single aspirin (Alkire 2012).

Analysts and advocates, however, derive different conclusions from current US health care market dysfunction. Some experts point to government's role in distorting the health market, fueling excess cost growth by subsidizing millions of Americans' health insurance and with the federal tax preference for employer-provided health benefits over other forms of worker compensation (Finkelstein 2005). From this vantage point, solutions lie in the direction of corralling these drivers of excess cost growth. Single-payer represents a diametrically opposed approach: harnessing the full power of government to control health costs and prices, irrespective of where a well-functioning market might set them.

Both market advocates and single-payer advocates might agree that health care services are overpriced, even as they disagree on the causes of and solutions to the problem. But of these opposing perspectives, only the single-payer approach forces lawmakers to

make normative judgments on how to set provider payment rates.

Unfortunately, data offer only a murky picture of what optimal provider payment rates would be in a single-payer system. The American Hospital Association reports that Medicare reimburses hospitals at only 87 percent of costs, whereas private insurance reimburses at 145 percent of costs (AHA 2018, Chart 4.4). Taken at face value, this would mean that hospitals currently take Medicare patients despite losing money when treating them and then make up the loss (and then some) by private insurance reimbursing at far more than hospitals' costs.

One interpretation of the data is that hospitals manage their finances based on their overall case mix, which would mean that those with private insurance are subsidizing hospital services for those on Medicare and Medicaid. An alternative interpretation is that hospitals would not take Medicare (or Medicaid) patients if they truly experienced losses whenever they did, thus hospitals' reported costs must be somewhat overstated relative to their true ones. Yet another theory is that hospitals' current excess capacity allows them to make beds available to Medicare and Medicaid patients at below-cost rates. These and other alternative interpretations lead to different conclusions as to how much a single-payer system could reduce provider payments without substantially reducing the quality or timeliness of health care services.

Providers' administrative costs are a particular analytical sticking point: Specifically, how much administrative cost savings potential could a single-payer system offer? Many single-payer advocates cite private insurance profit and administrative overhead as drivers of unnecessarily high health spending (Irwin 2017). But multiple studies, including mine (Blahous 2018) as well as an Urban Institute study (Holahan et al. 2016), found that the potential savings on insurance administration under M4A are not nearly as large as the health spending increases it would induce. In implicit recognition of these realities, some single-payer advocates shift their emphasis to the potential for savings in providers' own administrative costs, beyond savings in the actual costs of insurance.

Some single-payer advocates believe M4A would eliminate the need for much of providers' current administrative expenses, thereby allowing the dramatic reductions in provider payment required to decelerate national health spending under M4A. Hospitals themselves appear to disagree (Leonard 2018). "Many hospitals wouldn't be able to keep their doors open," the president of the Federation of American Hospitals has stated (McCaughy 2019). While hospital associations should naturally be expected to lobby for higher payment rates, they should also be expected to lobby for lower administrative costs and a net improvement in their own financial position. The hospitals' opposition to M4A's provider cuts does not necessarily mean that payments should not be cut, but it is a telling indicator that hospitals are skeptical that their own administrative savings under M4A would offset their revenue losses from lower reimbursements.

What Would Be the Consequences? The biggest unanswered question about provider payment rates—more unpredictable than whether provider payment cuts proposed under M4A would or should be implemented—is what would be the consequences of implementing the cuts. Demand for health services would rise substantially under M4A, not only because of covering the currently uninsured, but also because the currently insured would attempt to consume more services as M4A provides more generous coverage. A substantial body of economics literature demonstrates that the higher the percentage of one's health purchases that are paid by insurance, the more services (both effective and ineffective) one tends to consume. My study estimated that total national demand for health services would rise by roughly 11 percent under M4A (Blahous 2018).

It is unclear whether the supply of US health services would expand under M4A, let alone expand sufficiently to meet this additional demand without causing disruptions to timely access to health care. It is even less clear that supply could fulfill the increased demand if the suppliers of health services are simultaneously subject to substantial reimbursement reductions. While part of that demand increase would be the result of a positive change—that is, giving the previously uninsured greater access to health services—some of the supply crunch would

arise from M4A's more generous coverage incenting additional unnecessary and ineffective care.

Experts have published general warnings that M4A would trigger health access disruptions, but we lack reliable projections of their extent. The CMS actuary projects that this year over 80 percent of hospitals will lose money treating Medicare patients, suggesting that many hospitals will go into the red if payments now made through commercial insurance are reduced to Medicare rates (Heffler 2018). The Urban Institute projects that under single payer "not all increased demand could be met because provider capacity would be insufficient," despite assuming higher provider payment rates than in the Sanders bill (Holahan et al. 2016). The extent of these health care access disruptions and how policymakers would respond are among the largest unanswered questions about M4A. The only near certainty is that the combination of a substantial increase in demand and a sharp diminution in suppliers' reimbursements would cause some such disruptions.

Finally, the provider efficiency gains required to prevent M4A from adding still more financial strain to our nation's health care system, for whatever reason, have not been achieved to date. While some may believe that only a single-payer system can deliver these productivity improvements, this is far from certain. In this respect, the adoption of a single-payer system is essentially a multitrillion-dollar bet on a long-shot outcome.

Effects on Other Health Markets

The list of unanswered questions about single-payer health care is long and includes questions about how it might affect drug prices, as well as other effects of eliminating (or dramatically reducing the role of) private health insurance.

The Sanders M4A bill would instruct the secretary of Health and Human Services to directly negotiate drug prices, specifically to promote the use of generic drugs where possible, while granting the secretary flexibility to establish copayment formulas pursuant to maximizing generic penetration. Although an objective of these provisions is to reduce drug prices, it is unclear how they would be applied in practice. It should not necessarily be assumed that the federal government would

prioritize cost-containment more than private insurance does, relative to maximizing the availability of prescription drugs to constituent beneficiaries. While government would wield enormous negotiating power under a single-payer system, no one can say with certainty that government would deploy that power on behalf of taxpayers more than on behalf of health care consumers. To the extent that M4A follows the historical political dynamics of Medicare, the political power of participants as beneficiaries may outweigh their political power as taxpayers, pushing costs higher rather than lower.

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Further complicating the picture, the US has by far the biggest and most powerful drug industry of any nation in the world, with the result that lower drug prices do not represent the unalloyed financial gain for the US that they might for other nations lacking a comparable pharmaceutical industry. It is widely noted that the US has higher drug prices than other nations (Sarnak 2017). It is less often noted that other nations with large pharmaceutical industries (such as Switzerland) spend more per capita on drugs than the levels single-payer advocates believe can be achieved through M4A. While my study (Blahous 2018) showed potential for substantial savings in drug costs if M4A succeeds in replacing most brand-name drugs with their generic equivalents, it is highly doubtful that a single-payer system could knock one-third off the prices of US drugs as advocates have projected without impairing the pace of pharmaceutical innovation or undercutting the viability of much of the existing US pharmaceutical industry (Friedman 2013, 3).

Policymakers would also need to determine whether private health insurance would continue to have a role under single payer and, if so, what it would be. In particular, they would need to decide whether private insurance would be allowed to finance health services beyond those covered by the single-payer system or to provide expedited

access to the same services. The Sanders bill does not envision a significant continuing role for private health insurance, as it expressly prohibits private insurance from offering the same benefits as the single-payer system, in addition to offering a single-payer system so expansive that it would render supplemental coverage largely superfluous (S. 1804).

The effective demise of private health insurance upon the enactment of a single-payer system is riddled with sensitive political pressure points. Political advertising during the 2018 congressional campaigns highlighted patients' fears about eliminating employer-provided insurance in favor of single-payer health care (NRCC 2018). The Sanders bill would create a fund to assist workers in the health insurance industry displaced by the shift to single payer. On a national level, welfare gains by those who receive enhanced health insurance would be somewhat offset by the economic losses associated with effectively eliminating the private health insurance business. This by itself does not

argue for or against a single-payer health system, but demonstrates that some Americans' economic losses would need to be balanced against others' gains.

In sum, much about the consequences of single-payer health care remains unknown, either because it is difficult to project or because legislators have yet to confront and resolve important policy trade-offs. Among the things we do not know are whether the federal government can absorb the costs of M4A, how these costs would be financed, how steeply providers' payments would be cut, whether health spending growth would slow or accelerate, whether US health care supply would be sufficient to meet demand, and whether the US pharmaceutical and health insurance industries would survive the transition. All these questions and more need to be answered before serious consideration can be given to pursuing the rhetorical vision of Medicare for All.

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