Response to Criticisms of Our Analysis of the Sanders Health Care Reform Plan

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The Sanders campaign and David Himmelstein and Steffie Woolhandler reacted with sharp criticisms to our recent report, *The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending* (Holahan et al. 2016). The campaign argues that we understated reductions in the cost of prescription drugs, understated administrative cost savings, and ignored the availability of state and local funds to finance the plan. Himmelstein and Woolhandler (hereinafter referred to as HW) argue that our "ridiculous assumptions yield ridiculous estimates"; specifically, they argue that we overstated administrative costs, ignored administrative cost savings for providers, understated reductions in drug spending, and overstated utilization increases.[1]

Our analysis was based on detailed modeling of acute care for the nonelderly, acute care for the elderly, and long-term care services and supports. It is impossible to wholly impose a new health care system in the United States that changes the way all residents receive and finance their health care, even one that may be successful in another country, without disrupting many existing institutions, such as insurance companies, integrated health systems, hospitals, physicians, and pharmaceutical manufacturers. To be politically acceptable, compromises would have to be made, and those compromises are reflected in our assumptions.

In this brief, we discuss our key assumptions in these areas of disagreement and highlight ways in which we may have actually underestimated overall costs of the Sanders proposal. By and large our assumptions are laid out thoroughly in the original paper, but here we use them to address the specific statements made by the campaign and HW, and we provide additional reliable evidence to counter some of HW's claims.

- The increases in federal spending that we estimated ($32 trillion between 2017 and 2026) are so large because all current public and private spending would be transferred to the federal

government, benefits would be expanded, and out-of-pocket costs to consumers would be eliminated.

- Payment rates would have to be acceptable to providers. We assume a substantial reduction from current rates paid by private insurers and some increases over current rates paid by public programs. For example, the program would pay 25 percent less than current Medicare levels for prescription drugs, and physicians would be paid at Medicare rates. Both of these are increases relative to current Medicaid payment rates.
- Utilization of health care services will increase if benefits are expanded and cost sharing is eliminated. Our estimates include modest increases in the use of services based on actuarial standards and the health economics literature. Contrary to HW's claim in their article, health care use and spending for the elderly population did increase substantially once the Medicare program was implemented in 1965.
- We assume administrative costs of 6 percent. A new system would have a host of important administrative functions necessary to effective operations, such as rate setting for many different providers of different types; quality control over care provision; development, review, and revision of regulations; provider oversight and enforcement of standards; bill payment to providers; and other functions. We base our administrative cost estimates on Medicare's costs to administer the entire Medicare program. But even if we have modestly overestimated the appropriate administrative load, the difference in costs for the federal government would be only about 1 percent of total added federal spending per percentage-point reduction, a tiny fraction of the additional $32 trillion in federal funding that we estimate would be needed to fully finance the Sanders health plan.
- We provide estimates of current state and local spending on health care through the Medicaid program and on payments for uncompensated care. Requiring state governments to give the amount they currently spend on Medicaid to the federal government to help finance the single-payer system is of very uncertain legality given the Supreme Court's ruling in *National Federation of Independent Business v. Sebelius*.
- We may have underestimated the costs of the Sanders plan in several important areas. These were described in the original paper and are summarized below.

Why the Additional Federal Cost Estimates Are So Large

In short, the estimates are large because of the shift of all current public and private spending to the federal government, the expansion of benefits, and the elimination of out-of-pocket costs to consumers. For several reasons, we estimate the Sanders health plan would increase federal spending by $32 trillion between 2017 and 2026. Primarily, the plan would shift a large amount of existing public and private spending to the federal government, but there would also be additional spending in the health care system as a whole. Of the $32.0 trillion in additional federal costs, only $6.6 trillion reflects new

health spending in the system; the remaining $25.4 trillion is produced by shifting existing state and local government spending and private spending to the federal government. Those amounts account for changes in the pricing of health care services, encompassing both decreases in prices relative to current-law private levels and increases in them relative to current-law Medicaid levels.

For total health care spending on acute care for the nonelderly, we estimate a $1.9 trillion increase in federal spending in 2017. Of this, only $412 billion represents new spending. About 36 percent of that $412 billion (see table 5 of the original report, Holahan et al. [2016]) would be new spending on behalf of the uninsured and undocumented immigrants (most of whom are also uninsured). The uninsured would go from having no coverage to having comprehensive coverage without any cost-sharing requirements, and providers would be reimbursed at rates higher than Medicaid currently pays. Although the Sanders campaign's materials do not explicitly state that undocumented immigrants would be included in the new health plan, our original paper provided the reasoning behind our assumption that they would be included, and the campaign did not object to that assumption when responding to our original analysis.

We estimate that spending would more than double relative to current law on uninsured legal residents and undocumented immigrants. Those are precisely the people who advocates of Sanders's approach want accessing and using health care more broadly, and the same two groups that Sanders supporters are pushing for greater investment in. We agree that Sanders's approach would have the desired significant effect on those otherwise uninsured. To find otherwise would mean that the reform has no redistributive purpose and that the plan's objectives would not be met.

We project that total spending on those who already have some form of coverage (either public or private insurance) would rise 15.5 percent under the Sanders plan. More would be spent on those who would otherwise be enrolled in Medicaid because provider reimbursement rates would be higher on their behalf. More would be spent on those who would otherwise have private insurance coverage for two reasons. First, out-of-pocket spending would be eliminated. Employer-sponsored insurance plans on average pay roughly 80 percent of the cost of covered benefits, and most private nongroup plans pay a lower share, as low as 60 percent in some ACA-compliant plans. Currently, beneficiaries pay for the remaining cost of covered benefits. Additionally, many plans currently have some type of service limits on covered benefits, and the Sanders plan would have none. If the government were to pay for all costs without limitations on covered benefits, total use of health care services would be higher, leading to higher total costs. Second, the Sanders plan would cover benefits that are not typically part of private insurance plans, such as dental and vision.

For those otherwise covered by Medicare (the elderly and some nonelderly with disabilities), existing spending by households, employers, and state and local governments would be shifted to the federal government. But the Sanders plan would also add new benefits for this population, including dental, vision, and hearing, and the plan would reduce cost sharing for those without supplementary public (Medicaid) or private (Medigap or employer-based) insurance. Accordingly, those otherwise covered by Medicare would also somewhat increase their utilization of health care services. We assume that Medicare payment rates for hospitals would increase modestly (they are currently estimated to be

89 percent of costs, and we adjust them in our estimates to 100 percent of costs) while Medicare payment rates for prescription drugs would be reduced 25 percent. Federal spending on behalf of those otherwise covered by Medicare would increase by $465.9 billion in 2017, but total new national spending on this population would increase by only $38.5 billion, less than 4 percent over current law, reflecting a modest increase in use of services.

The Sanders plan includes a new program for long-term care services and supports. These new benefits would lead to some new expenditures, but the new federal costs are largely a shift of current-law Medicaid spending and private insurance spending to the federal government. Federal spending would increase by $212.1 billion in 2017 but total new national spending by only $68.4 billion. Those numbers represent a relative increase of 36 percent over current-law government and private spending on these services. That is likely a conservative estimate of the spending increase because few individuals have coverage for such benefits today and about half of Americans will need high levels of such coverage for a prolonged period after age 65 to help them with everyday activities (Favreault, Gleckman, and Johnson 2015).

Paying Providers under a Single-Payer Plan

We believe that we assume reasonable reimbursement levels while acknowledging room for significant savings relative to today's private payment rates. We assume that payment rates under the Sanders plan would have to be acceptable to providers. In our estimates, we assume that hospital payment rates for all would be substantially lower than what private insurers currently pay but modestly higher than Medicare and Medicaid rates under current law. We assume that physicians and other noninstitutional providers would be paid Medicare rates. Thus, rates for those with private insurance would fall, but rates for Medicaid enrollees would increase. HW cite huge administrative costs now borne by hospitals and physicians that, when eliminated, make room for significantly lower provider payment rates. We agree that administrative costs would fall, but we do not agree they would be close to zero as HW assert. Administrative costs are not close to zero under Medicare or in other countries, including Canada. Reductions in administrative costs will surely make it easier for providers to live with lower payment rates, but there are limits on how low such rates can and should go.

For prescription drugs, we assume that the program would pay 25 percent less than Medicare and private insurance pay today. Such a reduction from current drug payments from those payers is large, but payments would be higher than current Medicaid rates. The Sanders campaign and HW both argue incorrectly that we ignored savings from paying less for prescription drugs. We think that the risk goes the other way: the savings we credited to the Sanders plan may be larger than can be achieved in practice.

Fundamentally, we do not believe that the new system could lower payment rates further in the near term, because the plan would change how all US residents receive and finance their health care and because political compromises with the entire panoply of health care stakeholders would be necessary to make the plan acceptable. We assume a reduction in the growth rate of health care spending of 0.5

percentage points below the current projected growth rate, and the projected growth rate is already lower than historical growth rates because of the effects of the Affordable Care Act. This 0.5 percentage points is the difference in growth rates between the US and the other 33 Organisation for Economic Co-operation and Development countries, based on the most recently available data (Organisation for Economic Co-operation and Development 2015). Could we have assumed an even slower growth rate? Perhaps, but achieving such a rate would be quite difficult politically. Even if a Sanders administration could force slower rates of health care spending growth than we have assumed, such rates would likely be achieved in later years, and the effects would be small in the 10-year budget window we estimate.

Why the Sanders Plan Would Increase Use of Health Care Services

Sanders's proposed plan would include first-dollar coverage for all types of care, including medical, dental, vision, hearing, and long-term services and supports. The health economics literature is consistent and powerful on this point: reducing the out-of-pocket price of health services to consumers will significantly increase their use (Swartz 2010), and only explicit regulatory controls to suppress the supply of care can stop such an increase. The Sanders plan reduces out-of-pocket costs two ways. First, the plan lowers the price of insured services by eliminating all deductibles, coinsurance, copayments, and service limits; second, it provides first-dollar coverage for services not currently covered by insurance, including all medical care for those otherwise uninsured and benefits frequently excluded from current insurance plans such as dental health, vision care, and long-term care. The findings of the health economics literature are perfectly consistent with standard economic analyses of "normal" goods: when you lower the price of a good that people value, they will consume more of it. That holds true for people with low incomes and people with high incomes, although in this case people with high incomes or those who have good health insurance under current law would increase their use of services less than would people whose access is now financially constrained.

Our estimates include reasonable increases in the use of services (and therefore health care spending) based on actuarial standards and the health economics literature (Buettgens 2011). In addition, we incorporate an assumption that not all the increased demand for health care would be met under the Sanders plan, at least in the short run, because of constraints in the supply of health care providers. The supply constraints implicit in our estimates are consistent with those experienced by enrollees in the current-law Medicaid program. Because of Medicaid's historically low payment rates to providers relative to private insurers and the Medicare program, empirical analyses have demonstrated that Medicaid beneficiaries use less care, particularly for specialists, than they would without such supply constraints. Although increasing the supply of physicians in the short run is challenging, changes to work hours, the use of physician extenders (such as nurse practitioners and physician assistants), and the hiring of more foreign-trained physicians can help. Moreover, the federal government could consider further subsidizing medical education to increase the supply of needed physicians over time; however, we have not estimated the cost of doing so.

In brief, we agree with HW's point that provider supply constraints under a Sanders plan would lower use and spending below where it would be if there were no constraints, and some supply constraints are modeled in our estimates. However, it is implausible that aggregate use of health care services would remain unchanged under a system that made all health care free and covered all services for every resident of the United States. HW indicate that use would increase for the newly insured but would decrease by a similar amount for those already covered as physicians cease unnecessary services for those otherwise covered and perform additional necessary care for those otherwise uninsured. This assumption is faulty for two major reasons. First, no uniform definition of what is necessary and unnecessary exists in medical care; if such a definition existed, insurers would stop paying for all unnecessary care under our current health system.

Second, there is absolutely no reason to believe that higher-income, currently insured individuals would lower their use of care under provider supply constraints. These are individuals who, by and large, already have a usual source of care, likely have established relationships with physicians, most likely live in areas with more provider supply than many of those without coverage, and have experience in effectively accessing health care services. One cannot simply assume that they would suddenly be denied access to care and that their use would be shifted to others who have different circumstances, live in different areas, and have less familiarity with the health care system. On the contrary, cost sharing for the well-insured would decrease as it would for others, encouraging them to raise, not lower, their demand for care. Over time, federal or state governments might fashion incentives to encourage new providers to focus their service toward underserved populations, but such an effort would take time and would be unlikely to reduce provider supply in areas where supply is currently plentiful.

Contrary to HW's claim in their article, health care use and spending for the elderly population did increase substantially once the Medicare program was implemented in 1965. The best empirical analysis on this topic (Finkelstein 2007) shows that the Medicare program, which included significant cost-sharing responsibilities and provided coverage that is significantly less comprehensive than that offered by the Sanders plan, was associated with an increase in hospital admissions of 46 percent and total spending of 28 percent in its first five years (larger relative changes were found in the author's unweighted analysis). About half of the increased admissions were attributable to the entry of new hospitals and the rest attributable to growth in existing hospitals. The analysis also found that the increases continued in the second five years after implementation, indicating that the program's long-term effect was larger than that found in the first period. Large impacts on aggregate use of health care services and health care spending attributable to the introduction of the Medicare program were confirmed in a subsequent, related study (Finkelstein and McKnight 2008).[2] Our assumptions about increased use of services under Sanders' plan by the otherwise insured and the otherwise uninsured are reasonable and, as explained, consistent with actuarial standards, economic research, and the imposition of some supply constraints. If the Sanders plan is predicated on explicit constraints on access to health care services (which would lead to longer waiting times and otherwise suppress consumer demand) that we have not incorporated into our estimates, then the campaign should explain as part of their advocacy for this approach how they would impose those constraints and their implications for consumers.

Administrative Costs under Single Payer

Our analysis attributes substantial savings in administrative costs to the Sanders single-payer approach, setting those costs to 6 percent of health care claims. That is below the administrative costs attributed to most large employers, and it is consistent with analyses of the Medicare program, which includes both fee-for-service Medicare and Medicare Advantage plans (Sullivan 2013). We assume the latter would still be available under the Sanders approach because of the value such plans provide beneficiaries in utilization management and coordination of care. HW indicated after our analysis was released that Sanders would like to eliminate all managed-care plans from his system, suggesting that administrative costs would be closer to 3 percent or even 2 percent, which they believe is consistent with the Canadian system.[3] But what is gained in administrative savings would likely be more than lost in the increased use of services that care management avoids.

Administrative costs are challenging to measure and they are especially challenging to compare across countries with very different health care systems and approaches to measuring health care spending. Considerable academic debate has arisen over the most accurate rates and comparisons. And although we recognize that our 6 percent assumption is likely not precise, we believe it is critical when estimating the costs of such a substantial change, as is being proposed to the largest industry in the United States, to account for the many responsibilities required to effectively administer it. Eliminating waste is always preferable, but not all administrative costs constitute waste. It would be inadvisable to cut administrative costs so much that important functions could not be carried out effectively under a new system. Such functions include rate setting for many different providers of different types facing different costs across the country; quality control over care provision; development, review, and revision of regulations; oversight for fraudulent activity; provider oversight and enforcement of standards; bill payment to providers; consumer services; and more. Arguably, the Medicare fee-for-service system does not invest sufficiently in several of these areas, particularly coordination of care, and therefore the lowest possible measures of administrative costs are not necessarily the most advisable. In fact, respected analyses suggest that Medicare could save money overall if it spent more on administration (Berenson 2003). Managed-care organizations, such as Kaiser, Geisinger, and others, provide valuable coordination of care and utilization management functions. Eliminating such organizations entirely would necessitate replacing those functions or increasing utilization of care, potentially in inefficient ways. Either would have some cost to the federal government.

Given our political system and context, it might not be feasible to eliminate all managed-care organizations or the insurers providing administrative functions to pay claims, at least in the near term. Estimating costs for the first 10 years of a massive new program should not assume that an ideal situation would be put in place on day one. So even if our administrative cost estimate of 6 percent were too high in the long run, we think it is a reasonable and responsible estimate for the development and start-up of a single-payer plan in its first 10 years. But even if the appropriate administrative load is closer to 4 or 5 percent than to 6 percent, the difference in costs for the federal government would be only about 1 percent of total added federal spending over 10 years per percentage-point reduction, a

tiny fraction of the additional $32 trillion in federal funding that we estimate would be needed to fully finance the Sanders health plan.

Uncertainty around Court Decisions regarding State Maintenance-of-Effort Spending Requirements

We acknowledge in our report that a state maintenance-of-effort requirement may be an option for offsetting some portion of the costs presented here, and we provide in that report an estimate of the amount potentially available (Holahan et al. 2016). We make it clear, however, that the federal government's ability to impose that requirement is not certain. Although courts have upheld maintenance-of-effort requirements within the same program (continuing Medicaid payments made in the past into the Medicaid program), the court may prohibit requiring that state payments made within one program be used for an entirely new program. *National Federation of Independent Business v. Sebelius* found that where states would have been required to spend money on an expanded Medicaid program to keep funds flowing to the old one, the requirement would amount to prohibited coercion. The Sanders plan would require states to spend what they would have spent on Medicaid and uncompensated care on the entirely new national health system. At best, the Sanders plan advocates an untested theory. At worst, it would directly violate the principle of *National Federation of Independent Business v. Sebelius*, which indicated that the federal government cannot force states to pay into a new program as a condition of getting other federal benefits. However, even if the legality of the maintenance-of-effort requirement were approved by the Supreme Court, the offset would be a fraction of the funding shortfall they face according to our analysis and estimates of revenue and other program costs by the Urban-Brookings Tax Policy Center (Mermin, Burman, and Sammartino 2016). The elimination of a 10-year estimate of $4.1 trillion in state Medicaid and uncompensated care spending is small compared with $32 trillion in new federal costs for the Sanders health proposal as well as compared with an $18 trillion funding shortfall when all of Sanders's domestic program proposals are accounted for.

Areas Where We May Have Underestimated Costs

As we noted in our original report, we may well have underestimated the costs of the Sanders plan because of several issues. These include, among others, (1) the potential political backlash against setting provider payment rates to levels consistent with current-law Medicare (well below the levels paid by private insurance plans, which now cover 168 million nonelderly people); (2) several components of our estimate of the new costs of the long-term services and supports benefit, including possibly assuming provider payment rates would be too low at only 15 percent above current Medicaid rates (particularly given recent reports that long-term care costs are rising quickly),[4] assuming Medicaid-like limits on the benefit (although Senator Sanders does not indicate he would impose such limits), and assuming a continued substantial reliance on informal care by friends and relatives; (3) that our assumption about aggressive savings on prescription drugs may not be politically feasible; and (4)

that we have not accounted for some categories of increased use that would likely apply because we do not have data to estimate them (these are described the original report).

Conclusion

All cost estimates of new programs carry some uncertainty, but ours are based in the best empirical literature and data, methodological expertise, and a deep knowledge of the health care system. We believe we have made conservative assumptions with regard to this proposed plan, but it is possible we have somewhat overestimated administrative costs and underestimated long-term care and assorted other costs; we acknowledge this, of course. However, using reasoned analysis based upon empirical research and in-depth knowledge of the US health care system, there is no way to avoid the conclusion that the Sanders plan, while achieving universal coverage, would massively increase federal spending and require much larger tax increases than he has proposed.

Notes

1. David Himmelstein and Steffie Woolhandler, "The Urban Institute's Attack on Single Payer: Ridiculous Assumptions Yield Ridiculous Estimates," *Huffington Post* (blog), May 9, 2016, http://www.huffingtonpost.com/david-himmelstein/the-urban-institutes-attack-on-single-payer-ridiculous-assumptions-yield-ridiculous-estimates_b_9876640.html.
2. The analysis that HW seem to have relied upon for their claim that health care use did not change in aggregate for those enrolled in Medicare was based on weak research evidence, the effects of which were strongly confounded by the fact that providers were forced to desegregate in 1965. See Aday (1976).
3. Data from the Canadian Institute for Health Information indicates that there are additional administrative costs not included in the 1.8 percent estimate on which HW rely. These include the managing costs and cost of care delivery, which are computed separately and likely should be added to the 1.8 percent in whole or in part. See Canadian Institute for Health Information (2014).
4. Associated Press, "Study: Costs for Most Long-Term Care Keep Climbing," *New York Times*, May 10, 2016, http://www.nytimes.com/aponline/2016/05/10/us/ap-us-long-term-care-costs.html.

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Linda J. Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in select states and nationally. Examples of other research include codirecting 22 state case studies of stakeholder perspectives on ACA implementation, assessing the implications of self-insurance among small employers on insurance reforms, and comparing the importance of employer and individual mandates in reaching ACA objectives. She also led the quantitative analysis supporting the development of a "Roadmap to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. Blumberg is frequently asked to testify before Congress and is quoted in major media outlets on health reform topics. She serves on the Cancer Policy Institute's Advisory Board and has served on the *Health Affairs* editorial board. From 1993 through 1994 she was a health policy advisor to the Clinton administration during its health care reform effort, and she was a 1996 Ian

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John Holahan is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

Lisa Clemans-Cope is a senior research associate in the Health Policy Center at the Urban Institute. Her areas of expertise include health insurance reform legislation and regulation, Medicaid and the Children's Health Insurance Program (CHIP), dual health spending, access to and use of health care, private insurance, eligibles health-related survey data, and Medicaid claims data. Her current work includes quantitative and qualitative analyses of federal and state implementation of the Affordable Care Act, and an evaluation of children's access to and use of health services in CHIP. Clemans-Cope has published her research in the *New England Journal of Medicine*, *Health Affairs*, *Pediatrics*, and *Inquiry*. Her work has been widely cited in the media, including the *Wall Street Journal*, *Los Angeles Times*, *Forbes*, *National Journal*, *FactCheck.org*, *Huffington Post*, *Incidental Economist*, and *Modern Healthcare*. She has appeared on *National Public Radio* and *Fox News*. Clemans-Cope has a BA in economics from Princeton University and a PhD in health economics from the Johns Hopkins Bloomberg School of Public Health.

Matthew Buettgens is a senior research analyst in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have

included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

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