

October 7, 2019

Senator Bernie Sanders
United States Senate

Dear Senator Sanders:

I am writing now to clarify some important issues regarding the financing of Medicare for All, specifically, the type of Medicare for All proposal that you introduced as a U.S. Senate bill S. 1804 in 2017, and subsequently revised with S. 1129 in 2019.

I understand that some commentators have been unclear on the question as to how much new tax revenues will be needed to finance Medicare for All along the lines you have proposed. Of course, any additional taxes paid by businesses or households will substitute for the premiums, deductibles, co-payments and out-of-pocket spending businesses and households now pay to private health insurance companies. For the most part, as I describe in a bit more detail below, under Medicare for All, *households and businesses will pay significantly less for health care than they spend at present under our existing system, even while all U.S. residents will be guaranteed access to good-quality care.*

The question on which I focus in this letter is: How much additional public revenue from new sources will be needed to finance Medicare for All over a 10-year period? I will take the period 2017 – 26 as our frame of reference. ***My short answer is: \$13.5 trillion.*** The table below shows the basics on how this figure is derived:

**Estimate of:
Total Medicare for All Health Consumption Expenditures for 2017 – 2026**

1) Total System Costs	\$37.8 trillion
2) Public Revenues from Existing Sources	\$24.2 trillion
3) <i>Additional public revenues required</i> (= row 1 – row 2)	<i>\$13.5 trillion</i>

Source: Figures derived from Pollin et al. (2018), *Economic Analysis of Medicare for All*

In what follows, I will provide more detail as to how I derive this estimate. In fact, the basics are quite simple, even while there are many detailed matters that must be worked through before one can become clear on the main findings. In briefly addressing these issues here, I will refer to the November 2018 study I published with co-authors, *Economic Analysis of Medicare for All*.¹ The figures in our study are based on your 2017 bill before the U.S. Senate and utilize primarily 2017 data for generating cost estimates. However, the basic findings of our study as regards financing Medicare for All would not be significantly altered through focusing on your 2019 Senate bill and through incorporating the most recent 2018 data.

Current U.S. Health Care Costs and Cost Estimate of Medicare for All

As of 2017, the U.S. was spending \$3.24 trillion on Health Consumption Expenditures (other than public health programs). Our study estimates the potential increase in health care demand as well as the potential cost savings through Medicare for All as follows:

Increased Demand for Health Care Services. To provide good-quality health care for all U.S. residents under Medicare for All, our study estimates that overall health care demand will rise by about 12 percent relative to current utilization levels. This is a relatively high-end estimate, which draws from both our own analysis of the relevant evidence as well as that of Professor Kenneth Thorpe of Emory University. By comparison, the 2018 study by Charles Blahous of the Mercatus Institute estimated that overall utilization would rise by 11.3 percent under Medicare for All.

Potential Cost Savings. We estimate that, through implementation of Medicare for All, overall U.S. health care costs could fall by about 19.2 percent relative to the existing system. The most significant sources of cost savings will be in the areas of: 1) administration (9.0 percent savings in total system costs); and 2) pharmaceutical pricing (5.9 percent of total system costs).

Overall System Costs. With Medicare for All generating both increased overall demand in the range of 12.0 percent and cost savings of about 19.2 percent, total Health Consumption Expenditures would fall from \$3.24 trillion to \$2.93 trillion. As such, Medicare for All could reduce U.S. Health Consumption Expenditures by about 9.6 percent while also providing good-quality health care coverage for all U.S. residents.

System Costs as Share of GDP. We estimated that Health Consumption Expenditures, at \$2.93 trillion, would equal 15.8 percent of U.S. GDP for 2017. We further estimate that, under Medicare for All, total U.S. health care costs could remain roughly constant as a share of GDP, that is, remaining at 15.8 percent of GDP over 2017 – 2026. We then work from the GDP projections of the Centers for Medicare and Medicaid Services (CMS) to establish the level of Health Consumption Expenditures that will take place under Medicare for All relative to continuing to operate U.S. health care through our existing system. Working with these CMS projections for 2017 – 2026, we conclude that Medicare for All would produce savings of \$5.11 trillion relative to our existing system—that is, the CMS projection of total costs under our existing system would be \$42.90 trillion over 2017 – 2026, whereas we project Medicare for All would cost \$37.79 trillion. These figures are summarized in Table S8 below, taken from our study.

¹ Robert Pollin, James Heintz, Peter Arno, Jeannette Wicks-Lim and Michael Ash (2018) *Economic Analysis of Medicare for All*: <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>. Our study was peer-reviewed by 11 eminent researchers in the field. Their full set of comments, including criticisms, are also posted online.

TABLE S8
Summary Figures: Comparative U.S. Health Consumption
Expenditure Projections, 2017 – 2026

CMS Projection of cumulative Health Consumption Expenditures under existing system	\$42.90 trillion
PERI projection of cumulative Health Consumption Expenditures under Medicare for All	\$37.79 trillion
Cumulative 10-year savings through Medicare for All	\$5.11 trillion
Cumulative 10-year savings, as % of cumulative GDP	2.1% of GDP

Financing Medicare for All

1. **Existing public funding sources.** There will be two sources of financing for Medicare for All. The first is the same public health care revenue sources that presently provide over 60 percent of all US. health care financing. This figure for 2017 was \$1.88 trillion. These revenue sources fund Medicare, Medicaid, the Defense Department and other federal health coverage programs.² Given our estimate that the overall costs of Medicare for All will be \$2.93 trillion, the system therefore needs to raise an additional \$1.05 trillion from new revenue sources. Table S.3 below from our study, summarizes this result:

TABLE S3
Additional Public Revenues Required to Finance Medicare for All, 2017

1. Cost of full universal coverage under Medicare for All	\$2.93 trillion
2. All current public sources of financing	\$1.88 trillion
3. Additional financing required (= rows 1 – 2)	\$1.05 trillion

2. **Raising the additional \$1.05 trillion in revenue as of 2017.** There are multiple ways through which the U.S. federal government could raise \$1.05 trillion in additional revenues to finance Medicare for All. Our study provided a set of illustrative financing proposals that, in combination, could generate \$1.08 trillion as of 2017, thus providing a revenue surplus of about 1 percent for the system that year, given that only \$1.05 trillion would be required. Your own staff produced another paper, “Options to Finance Medicare for All.”³ This paper provided a revenue projection over 10 years at \$18.1 trillion, an average, therefore over the 10-year period of \$1.8 trillion per year.

² Under S. 1804, the Veterans Administration would remain as a separate and fully financed entity. We nevertheless have built into our cost estimates that VA expenditures will rise by the same 12 percent rate as a component of overall Health Consumption budget under Medicare for All.

³ <https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all?inline=file>

3. Projecting revenue requirements for 2017 – 2026. Based on our assumption that health care spending remains as a stable percent of percent of GDP over 2017 – 2026, it is reasonable to assume that the revenues generated from our two sources of funds—existing sources and additional sources—can also remain as stable percentages relative to the total spending requirement. Specifically, the \$1.88 trillion in existing public revenue sources for 2017 amounts to 64.2 percent of total revenue required for 2017, while \$1.05 trillion covered the remaining 35.8 percent. As shown in Table S8 above, we estimate total Health Consumption Expenditures over 2017 – 2026 at \$37.79 trillion, 15.8 percent of GDP for that decade. Therefore, as shown in the first table above, existing public funding sources will generate \$24.2 trillion (= 64.2 percent of \$37.78 trillion). It follows that new revenue sources will have to generate \$13.5 trillion over 2017 – 2026 (=35.8 percent of \$37.79 trillion). Note that this \$13.5 trillion revenue requirement over 2017 – 2026 is substantially below the \$18.1 trillion revenue estimate that your staff generated through its proposed set of new funding sources to support Medicare for All.

Savings for Businesses and Households

Regardless of the specific funding framework utilized for Medicare for All, all households and private businesses will be able to pay into the system an average of 9.6 percent less than they are presently contributing to the U.S. health care system. This is, straightforwardly, because Medicare for All is able to operate a funding level that is 9.6 percent below the current overall funding level for U.S. health care.

Based on our own financing approach, we estimated that businesses that have been providing coverage for their employees will see their health care costs fall by between 8 – 13 percent. For families, we find that Medicare for All can promote both lower average costs and greater equity in funding health care. For example, we find that for middle-income families, the net costs of health care will fall sharply under Medicare for All, by between 2.6 and 14.0 percent of income. By contrast, with high-income families, health care costs will rise, but still only to an average of 3.7 percent of income for those in the top 20 percent income grouping and to 4.7 percent of income for those in the top 5 percent grouping.

Of course, the distributional impacts on funding Medicare for All will depend on the specific new funding sources that are implemented. I note again that the funding sources proposed in your staff memo are different than the ones we examined in our study. I therefore cannot speak to the specifics of the distributional impacts of your staff proposal. But I am confident that, similar to the results we derived for our own proposal, the net impact of Medicare for All based on your staff proposal will be to generate substantial savings in health care costs for most businesses and all but the most affluent U.S. households.

I hope this letter clarifies some of the issues at hand. Please feel free to contact me with any questions.

Sincerely,



Robert Pollin

Distinguished University Professor of Economics and Co-Director, PERI