H2C PERSPECTIVES

Medicare for All? What Does It *Really* Mean?

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Does M4A sound like a good idea? If enough people think so, then be prepared for a fundamental rewrite of the federal tax code and significant disruption of the entire healthcare industry.

According to an August 2018 Reuters/Ipsos poll, 70 percent of those surveyed support Medicare for All ("M4A"), including more than half of Republicans surveyed. This followed a June 2017 survey by the Kaiser Family Foundation that found a majority of Americans favored a single-payer health system.

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in which 77 percent of Americans are concerned that rising healthcare costs will cause significant and lasting damage to the U.S. economy and 45 percent believe that a major health event could leave them bankrupt. Meanwhile, an estimated 65 million adults had a health issue for which they did not seek treatment due to costs.

Americans clearly and overwhelmingly express a strong interest in healthcare reform, and while their opinions differ regarding the type of reform they would like to see, the proportion of Americans favoring a government-sponsored, single-payer system like M4A has increased. The underlying cause of Americans' interest in healthcare reform is reflected in a more recent 2019 West Health/Gallup survey

In this survey, as well as countless articles and opinion pieces addressing the subject of healthcare reform, cost is far and away the central issue driving Americans' interest in change.

M4A is again in the news with the approaching presidential election cycle and is perhaps one of the most defining and contentious issues that separate the opposing political ideologies. However, much of the dialogue around M4A fails to connect the dots between who would pay for it, how the amount paid might differ from what consumers pay in taxes, for healthcare coverage, and services today, and what M4A might mean for the healthcare industry.

Connecting these dots is critical because an informed assessment of M4A requires careful evaluation of its potential consequences for the healthcare industry, as well as for those who receive its services and those who pay for them.

What M4A Might Really Mean: A Working Premise

Two critical assumptions inform our analyses:

1) *Medicare for All* means exactly that—Medicare (as currently organized, funded, structured, and paid for with respect to those qualifying to receive it) for everyone, but with two important clarifications. First, because Medicare coverage would be made available to all citizens, it would thus replace Medicaid and each state's portion of funding for Medicaid, and it would replace insurance provided by private health plans, whether offered by an employer or purchased through an Affordable Care Act ("ACA") exchange. While there are currently eight M4A and public plan proposals introduced in Congress, we are assuming a generic proposal most similar to that originally described by Sen. Bernie Sanders (I-Vt.) and used as the basis for the widely publicized July 2018 Mercatus working paper, *The Costs of A National Single-Payer Healthcare System* by Charles Blahous. Specifically, we assume an M4A proposal would entail *elimination of most or all out-of-pocket costs associated with the current Medicare program*.

2) Taxes necessary to fund M4A would be levied on a pro-rata basis according to each constituent's current share of total federal government tax receipts (e.g., individual income taxes, business income taxes, payroll taxes, excise taxes). In evaluating the tax impact, we refer to (and modify) the Mercatus working paper.

Does Projecting Savings by the Billions Translate into Net Spending in the Trillions?

Blahous begins with CMS' February 2018 10-year national healthcare spending projections, focusing on the 2022 figure of $3.86 trillion in forecasted personal healthcare spending[1], and calculates that M4A would reduce national healthcare spending (personal healthcare spending plus those items mentioned above) in 2022 by about $93 billion annually. This figure comprises $10 billion in savings on personal healthcare spending, which combines the offsetting effects of increased utilization and elimination of out-of-pocket costs against expanded application of the lower rates paid by Medicare. To that, it adds $83 billion in annual savings in combined government and private health insurance administrative costs.

Blahous concludes that despite the slightly lower overall national cost of health care, M4A would result in a 2022 net annual increase in federal costs of $2.535 trillion after including the government's assumption of costs currently borne by employers and individuals under private health insurance plans and after taking into consideration the elimination of federal health insurance subsidies. Federal health insurance subsidies include health insurance exchange subsidies and subsidies paid to states under current Medicaid programs.

In short, although the projected savings on personal healthcare spending are in the billions, and elimination or reduction of employer and employee health insurance premiums and out-of-pocket expenses around $1.5 trillion, the net increase in federal spending is anticipated to flirt with a $2.53 trillion figure. This will profoundly impact the status quo of cost (e.g., tax) allocation. Add to that the impact on healthcare providers, many of which would

[1] *This figure differs slightly from NHE Projections of $3.87 trillion due to Blahous' efforts to reconcile to MEPS data.*

have to change their structure and their operations to find ways to survive on Medicare rates.

Evaluation of Federal Healthcare Spending and Cost of M4A

Assuming Blauhous' figures are correct, identifying politically acceptable sources of revenues to pay for the $2.535 trillion estimated cost of M4A is perhaps its most challenging and controversial aspect. If the federal government funds M4A by raising taxes in proportion to current sources of tax receipts, implementing such a large program would fundamentally alter the balance of power among winners and losers in our country's tax and public benefits structures.

According to the most recently available Internal Revenue Service Data Book (2016), the largest source of federal revenues comes from individual income taxes, where the highest 4.5 percent of earners account for nearly 58 percent of individual tax revenues. Using 2016 as a base year (the latest year for which there is public information, notably before the tax changes implemented by the Trump Administration in 2017), marginal tax rates would have to climb to as high as 70 percent on the highest earners and spike to as high as 27 percent for low-income taxpayers to pay for M4A (see Figure 2), even before considering the impact on individuals of pro-rata increases in payroll taxes. This does not take into account the recent tax reform changes, in which most of the individual tax reductions created in the Tax Cuts and Jobs Act of 2017 are not permanent.

Payroll taxes are the second-largest source of federal revenues and represent about 15.3 percent of

Figure 1: 2016 Sources of U.S. Federal Revenue

Source	Percentage	M4A Funding & Tax Implications
Individual Income Taxes	47.9%	Would require up to a 77% increase in what individual taxpayers paid to the IRS over what they paid in 2016
Payroll Taxes	35.0%	Split equally between employers and employees
Corporate Income Taxes	9.0%	Would require a corporate tax rate as high as 60%
Estate and Other Taxes	5.6%	
Excise Taxes	2.5%	Would add up to $0.14 for each gallon of gas and up to $0.78 for each pack of cigarettes

Figure 2: 2016 Breakdown of Individual Tax Revenues by Adjusted Gross Income

Adjusted Gross Income	Percentage of Filers	Highest Marginal 2016 Tax Rate for MFJ*	Highest Marginal Tax Rate for MFJ Under M4A
$500,000 or higher	0.9%	39.6%	70%
$200,000 to $500,000	3.6%	35%	62%
$100,000 to $200,000	12.3%	28%	50%
$50,000 to $100,000	21.8%	25%	44%
$30,000 to $50,000	17.6%	15%	27%
Less than $30,000	43.8%	15%	27%

**Married Filing Jointly*

individual income up to $132,900 and about 2.9 percent thereafter, split more or less equally between employers and employees. There is an additional 0.9 percent payroll tax under the ACA for individuals with wages exceeding $250,000 for married-filing-jointly taxpayers ($200,000 for all others). Increases to payroll taxes would bring the rate up to as high as 35 percent. This represents an additional burden on individuals beyond increased individual income taxes and is regressive in that it imposes a larger proportional tax on the discretionary income of lower-income households as compared with higher-income households.

Individuals whose insurance is covered through an employer-offered plan, or whose income is low enough to qualify for full or partial subsidies of their insurance premiums (less than 400 percent of the federal poverty level), may see an increase in their income taxes and payroll taxes paid, without seeing much difference in their personal expenditures for health insurance premiums. On the other hand, they would see the elimination of out-of-pocket costs, such as copays and deductibles, which may be meaningful if they are above the federal poverty level and frequently seek health services.

Those at the highest tax brackets are likely to experience a significant increase in their personal income taxes and a large, but proportionately more modest, increase in payroll taxes, with a disproportionately smaller

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relief in their personal healthcare expenditures as compared with their increased tax costs. Business owners reporting their business activities on their personal returns who currently pay for their employees' health insurance will see increases in taxes as with other personal income taxpayers, but they may benefit from offsetting reductions in business health

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insurance expenses. Self-employed, middle- to upper-income taxpayers paying their own health insurance premiums whose incomes are currently too high to qualify for government subsidies are likely to experience the highest income and payroll tax increases and are unlikely to benefit to the extent their tax increases are more than the health insurance premiums they are saving. However, those whose incomes are largely derived from non-employment sources, such as investments, would be less affected since that income is not subject to payroll taxes and is often realized through capital gains, which are taxed at favorable rates.

A married couple with one child would break even under M4A if the couple has had income of $70,000, assuming tax rates are increased on a pro-rata basis and the couple's personal healthcare spending averaged $6,000 per year under the current system. Those below this threshold could potentially save under M4A, while those earning above $70,000 per year could face more in tax increases than they would save in healthcare costs. This breakeven point is about $10,000 higher than the median household income in the United States.

Increases to the corporate tax rate and employers' share of payroll taxes would undo the recent reduction in tax rates, negatively impacting nearly all businesses. However, businesses with a high labor component to their cost structures—which include health care (which will soon represent the largest employment sector in the

U.S. economy), retail, hospitality and food services, administrative and support services, professional and technical services, finance, and insurance—and that currently provide employee health insurance benefits may see a net advantage to the extent that elimination of health insurance costs and the consequent increase in earnings outweigh increased payroll and income taxes. State and local governments, which have large labor forces with generous benefit packages, stand to gain the most with the elimination of health insurance premiums, while their only tax exposure would be the increased payroll taxes. The federal government, which is the largest employer in the country, would recognize similar benefits, but would also bear the cost of the overall M4A program.

Net tax increases may ultimately be paid for through reduced return on investment for owners, price increases passed along to consumers, and pressure to reduce wage increases for the labor force. Unionized workforces that have negotiated higher increases in health benefits as compared with salary increases may be negatively impacted, as the M4A program might not resemble the enhanced benefits their members are currently receiving, while their salaries will not necessarily increase to offset any lost benefits. Finally, retiree health benefit plans, such as voluntary employee beneficiary association plans ("VEBA plans"), would likely be impacted, as they contain funds set aside for benefits that might now be covered under the expanded Medicare program.

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The tax rates and revenues above are based on simplified models that are intended to demonstrate the impact this policy may have. Any changes to the tax rates and structures will result in corresponding behavior changes, which could impact this analysis. Higher corporate tax rates could result in more companies changing their tax homes to foreign countries with friendlier corporate tax arrangements. Industries with smaller economic exposure to the new system might become more attractive for investors, all other factors being equal. Outsourcing jobs to other countries may become increasingly popular if there are further payroll tax savings to be had. In short, the shift in the winners and losers under this type of revenue and benefits program could have a substantial impact on the U.S. economic system for employees, businesses, and investors.

One of the largest challenges M4A will face is finding politically palatable legislation to significantly raise tax revenues, especially on the heels of the Tax and Jobs Act of 2017, which provided significant tax breaks. Further, the majority of the growth in the 65-and-older population is projected to occur between 2012 and 2030 as the baby boomers enter the older age group. By 2030, all baby boomers will be older than 65, and one in five Americans will be of retirement age. This will impact not only the costs of health care, but also federal tax revenue and the tax pendulum.

M4A's Potential Impact on the Healthcare Industry: Winners and Losers

Under M4A, we assume providers would be paid according to current Medicare rates for their services. Clearly, there would need to be adjustments to the rates just as much as there would need to be adjustments to the federal tax code to accommodate M4A. Without such adjustments, the near-term impact on healthcare industry participants would be dramatic. Healthcare stakeholders may view this as either a benefit, acting to capitalize on rapid change, or as a detriment to their operations

should their current operating model not be nimble enough to evolve with significant changes in reimbursement and cash flow mechanisms.

Medicare reimbursement is often not a welcome topic among many providers, as the industry currently is being forced to evolve with entirely new metrics and payment models (ranging from alternative payment models to bundled payment, risk-sharing, Medicare Shared Savings Plans, and more). It's a monumental undertaking with present-day reimbursement, and given a new paradigm of the M4A scenario, the results might be, simply put, framed into two categories—the winners and the losers:

- Hospitals, health systems, and integrated delivery entities absent significant changes to their current operating structures: Mostly losers with a few winners
- Independent physicians: Mostly losers
- Health plans: Mostly losers with a few winners

Not addressed herein is the substantial impact M4A would have on the many other stakeholders in the industry—post-acute care and ancillary providers, service providers such as revenue cycle companies, IT system providers, and others whose fortunes would rise or fall under M4A:

- After the short-term M4A disruption, the longer term might have a brighter future for those who successfully adapt. Consider the potential benefits: EHR interoperability, defined patient clinical pathways, and revenue "enhancement" and recovery efforts could be greatly simplified with the reduction in time-consuming and costly administrative efforts.
- M4A should encourage further consolidation of providers across the care continuum through increased reduction of burdensome and redundant administrative infrastructures and consequent reduction of waste. Given current estimates that 30 to 34 percent of U.S. healthcare spending is attributed to waste, and with wasted spending exceeding more than $1 trillion annually, there are substantial gains to be made.

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- With consolidation, physicians and other healthcare professionals could therefore experience a reduced administrative burden, as scribing and coding in EHRs, augmented malpractice premiums due to exposure to tort liabilities, and rapid changes in technology are often reported as the bane of their profession. This scenario could enable these professionals to devote more of their time to productive patient engagement.

Short-Term Impact on Hospitals

MedPAC's March 2018 *Report to the Congress: Medicare Payment Policy* notes that for hospitals, "Aggregate Medicare margins continue to be negative," but "Medicare payment rates remain about 8 percent higher than the variable costs associated with Medicare patients." The latter comment may not completely address the fact that there is a wide range of costs borne by hospitals depending on the market they occupy. Some might do well under M4A, but many will not.

There is often a substantial difference between the rates that federal and state governments pay hospitals for healthcare services and the much-higher rates that private/commercial insurers pay. Blahous states that Medicare payment rates are, on average, roughly 40 percent lower than those paid by private/commercial insurers. The difference in many states is even larger for Medicaid payment rates. However, in high-cost markets like the San Francisco Bay area, New York, Chicago, Los Angeles, and others, private health plans may pay up to five times the rate paid by Medicare for the same service.

Many proponents of M4A appear to show little appreciation of the magnitude and importance of this hidden fee on employers and

employees known in the industry as "cost shifting." Under M4A, this substantial fee on private/commercial insurers (and, in turn, employers and employees) necessarily goes away, to be replaced by federal taxes, which are more transparent.

Those that would experience the greatest negative impact under M4A are hospitals with substantial privately insured patient volumes and/or high operating costs—the two frequently appearing together. Hospitals in the San Francisco Bay area, Chicago, and New York, among others, would be very seriously injured by the enormous loss of revenue associated with a shift to M4A unless they successfully bring about significant change to their structure and operations, which would be challenging. While the organizations most affected also tend to have substantial cash resources and thus the means to make the attempt at operational transformation, the magnitude of the challenge would be significant and may exceed the capacities of management used to the status quo.

For example, an analysis of the nation's 50 largest health systems shows median unrestricted cash balances of about $4 billion, median revenues of about $6 billion, and about a 3 percent median operating margin. A recent *HealthLeaders* article claims that M4A could reduce hospital revenues by an average of 16 percent. Assuming that the 16 percent figure is roughly correct for all healthcare services provided by these top-50 health systems and that 16 percent is the correct figure for them as well, it would take five years of resulting losses to absorb that cash absent a significant restructuring to their operations.

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Alternatively, some hospitals operating in low-cost areas and urban and rural safety net providers that disproportionately serve Medicaid and Medicare populations today and that rely on various forms of government subsidization may do as well under 100 percent Medicare reimbursement or even see their prospects improve under M4A. According to MedPAC, "Hospitals with high shares of Medicare and Medicaid patients tend to have more pressure to control costs and therefore tend to have lower costs per discharge."

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An exacerbating issue for hospitals related to M4A is the prospect of increasing patient volumes associated with easier access to care. While physical resources today may be sufficient to address that potential added volume, it is unclear whether the human resources necessary to meet that additional volume are obtainable at the cost necessary to deliver services under an M4A payment model. Even more alarming, when adding the impact of aging demographics on demand for healthcare services, current physical resources are clearly insufficient, and human resources, perhaps more so.

All of this may challenge the traditional, asset-intensive nature of healthcare services delivery and the nature of health care currently practiced and epitomized by the modern hospital and its associated physicians. The inherent pressures of M4A may force rethinking by providers about the advisability of continuing high rates of capital investment and whether there are viable alternatives to this asset-intensive model. This line of thinking would be expected to reinforce ideas already emerging, such as the importance of social determinants of health, the role of social services, as well as fundamentally different approaches to health care, such as the more general approach practiced by primary care physicians, osteopaths, and others. This is not to say that there would not be an important role for the traditional, highly focused, anatomical systems-

based approach to health care, as epitomized by academic medical centers for those with extreme healthcare needs. However, out of necessity, providers may need to consider whether they can survive under M4A without taking a more active approach to integrating and managing non-medical services and getting paid to do so. This last point is critical because cost savings and economies of scale can be achieved on a broad scale by focusing on conditions and health determinants that go well beyond the exam room, including behavioral health, dietary habits, and other factors influenced by routine human activity.

Short-Term Impact on Physicians and Other Health Professionals

Following a similar pattern for hospitals, physicians and other health professionals are compensated, on average, by Medicare at approximately 75 percent of the rates paid by private health plans. As the majority of physicians are now employed, directly or indirectly, by hospitals and health systems, the financial impact of M4A for them may be blunted somewhat relative to their private practice counterparts, perhaps showing up in the form of changing work practices and demands for greater productivity at the same or perhaps somewhat lower compensation levels. For those in private or group practice, however, the impact would be more direct, driving many to either change their practice structures or else abandon private practice for salaried employment.

Currently, the United States faces a significant shortage of physicians, with a predicted shortage of roughly 120,000 physicians by 2030, according to a 2018 report published by the Association of Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2016 to 2030*. It is not difficult to imagine that many physicians practicing in groups or independently might rethink their career choices if they were to find they must rely exclusively on Medicare payments for their services. Many, to the extent able, would likely seek to become employees of larger health systems, practice only concierge medicine, or choose to retire. This dynamic has important implications for patients, as the added demand associated with M4A, together with diminished reimbursement to physicians and other clinicians, should reasonably be expected to drive the supply of clinicians down, thus making patients' access to care increasingly difficult. It would not be an exaggeration to suggest that M4A could therefore bring about a true two-tiered healthcare system: one privately paid by those relatively few willing to pay for it in addition to their higher tax burden, and a much larger and perhaps much less attractive system for the masses.

Short-Term Impact on Health Plans

Consolidating most insurance policies under a single government payer would likely spell the end for many health plans, while those contracting with state and federal governments to offer Managed Medicaid and Medicare Advantage plans might do well, especially if the federal government were to encourage or require citizens to enroll in such plans as a cost-savings or administrative-simplification measure.

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Under this scenario, private/commercial health plans could still play important roles in a single-payer system like M4A, but their service emphasis might change. The largest health plans would focus on contracting with the federal government for full-risk and value-added administrative services, much as they do today for federal and state governments and for large employers. However, there would necessarily be many fewer and far larger health plans doing this, with those having significant government contracting capabilities enjoying substantial competitive advantages. Similarly, health plans such as UnitedHealthcare/Optum, whose business model favors facilitating the management of

healthcare services for healthcare providers and other health plans, may also do well under M4A. Likely to emerge as well would be private health plans offering concierge-type health insurance products and services to facilitate a "superior" healthcare experience to those willing to pay for it.

Specialty services and technology providers that would sell products and services to health plans and the federal government also would likely thrive, especially during providers' tumultuous transition to M4A.

Overall, depending on how it is implemented, M4A could be a welcome event for larger health plans and their investors. Smaller health plans and administrative services organization providers would need to scramble to prove their worth to larger entities that may acquire them. Health plans that fail to adapt to the new system and that are unable to secure the requisite political support would clearly go out of business unless they are able to pivot into specialty services.

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Conclusion

With the approaching election cycle, the importance of health care as a key election issue, the clamor of attention surrounding various competing healthcare proposals, and the general public's interest in and confusion about single payer and M4A, this topic will increase in importance for healthcare providers. However, there is one thing that is sure to come from all of this attention: intense and growing pressure for healthcare providers to significantly change their business models.

The key to healthcare providers' ability to influence outcomes in a way that will be constructive is to first understand the economic impacts and implications of proposals that may, in whole or in part, become law. Many providers' ability to undertake these kinds of evaluations is currently hampered by a traditional budgeting/financial planning/forecasting/strategic planning cycle that is ill-suited to evaluate broader, enterprisewide, population-based implications of major changes in care delivery, reimbursement, and utilization. Without a different approach, healthcare providers will find themselves less able to plan and influence according to their needs and the needs of the communities they serve. Despite current limitations, there is hope. Healthcare organizations are using innovative tools to manage patient care, quality and safety, and the revenue cycle like never before. With a long enough runway facilitated by measured regulatory implementation, providers along the healthcare continuum ready and willing to be nimble could ultimately succeed in an M4A environment with equal or better outcomes for their patients and themselves.

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