

## PWBM Budget Contest: Privately-Organized Universal Health Insurance in the U.S.

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**Summary:** This brief analyzes the impact on health insurance premiums, out-of-pocket spending, and the economy for the healthcare proposal from Daniel Evan McGary as part of the PWBM Democratizing the Budget Contest.

### Key Points

- PWBM projects that, by 2050, mandating insurance coverage and eliminating the tax-advantaged treatment of employer-provided insurance together decrease private insurance premiums by 18 percent, out-of-pocket spending by 22 percent, and the percent of the population that forgoes medical care from 21 percent to 4 percent. Income and payroll tax revenues would increase, reducing debt by 11 percent by 2050, increasing GDP by 0.8 percent.
- Enhanced competition between the licensed insurance providers established by McGary's plan could reduce premiums by even larger amounts, leading to even more medical coverage and economic growth. We present a range of possible outcomes.

### Introduction

This brief analyzes one of three winning proposals from the [PWBM Democratizing the Budget Contest](#). That proposal—submitted by Daniel Evan McGary, M.S.—is a plan for privately organized universal health insurance. This brief analyzes how that proposal would affect private health insurance premiums, out-of-pocket spending, the fraction of the population that foregoes medical treatment, the health and size of the population, as well as hours worked, savings, and economic output. Because the effects on key cost parameters, such as administrative costs, provider reimbursement rates, and excess cost growth, are highly uncertain, PWBM presents results based on a range of assumptions.

### The Proposal

Under the proposed healthcare reform, the federal government would:

- License four nationwide health insurance companies to be the exclusive providers of private health insurance;
- Introduce an individual mandate to purchase health insurance;

- Prohibit employer-provided health insurance, thereby also removing the employer-based tax deduction for health insurance premiums;
- Leave Medicare and Medicaid unchanged;
- Require coverage of pre-existing conditions; and
- Require that the four licensed private health insurance companies self-finance via premiums and co-payments.

## Method

PWBM analyzes the economic effects of the McGary healthcare plan through our [integrated health model](#), which captures the links between changes in health, demographics, and the broader economy. For example, this model captures how individuals make decisions about which health insurance plan to choose—or whether to choose one at all—and how their insurance choices affect their future health and in turn their economic productivity. Health insurance premiums are derived as part of the model, meaning that a healthier population mix lowers premiums, which, in turns, also impacts how much people work and save. A healthier population is also more productive, which is captured by our model. Finally, the model accounts for the changes in macroeconomic aggregates such as the federal debt that result from reforms to the healthcare system, as well as how those changes affect the stock of productive capital and wages.

## Modeling Assumptions

How competition among the four health insurance companies would affect (i) payment rates to providers, (ii) administrative costs, and (iii) excess future cost growth, is highly uncertain and would depend on the many details of how such a system would be implemented. We, therefore, present a range of estimated outcomes based on three different assumptions:

- Payment rates:* We consider three different levels of changes in payment rates compared to current-law baseline: 1) no change; 2) an average decrease of 4 percent; and 3) an average decrease of 8 percent.<sup>1</sup> In each case, the reduction in payment rates occurs immediately. Medicare and Medicaid spending are unaffected by the decrease in payment rates.
- Administrative costs:* We consider a range of possible reductions in administrative costs: 1) no change; 2) a decrease of 25 percent; and 3) a decrease of 50 percent.<sup>2</sup>
- Excess cost growth* each year refers to the extent to which health care costs per person—after being adjusted for demographic changes—grow faster than potential GDP per person. Under current law, [excess cost growth](#) is projected to be highest among private health insurance plans, and lowest in Medicare, with Medicaid’s excess cost growth rates falling between those two. We consider two different excess cost growth rates: 1) no change; and 2) excess cost growth among private health insurance providers will be the same as under Medicare.

Under the proposal, employer-provided health insurance would be prohibited, and the tax deductibility of health insurance premiums would be removed. As a result, employers would stop subsidizing health insurance plans. In a competitive labor market, compensation that previously took the form of employer insurance subsidies would instead be paid out as cash wages.

## Effects on Enrollment and Premiums

As shown in Table 1, the proposed reforms would lower private health insurance premiums by between 14 and 33 percent in 2030 and by 18 to 41 percent in 2050 relative to current law.

Table 1. Effects on Private Health Insurance Premiums, Relative to Current Law

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Excess cost growth rates of private health insurance spending remain unchanged from current law.

		2030				2040				2050				
		Reimbursement Rates				Reimbursement Rates				Reimbursement Rates				
		0%	4%	8%		0%	4%	8%		0%	4%	8%		
Admin Costs	0%	-14%	-17%	-21%	Admin	0%	-15%	-19%	-23%	Admin	0%	-18%	-21%	-25%
	25%	-16%	-20%	-24%	Costs	25%	-18%	-22%	-25%	Costs	25%	-21%	-24%	-28%
	50%	-19%	-23%	-26%	Costs	50%	-21%	-24%	-28%	Costs	50%	-23%	-27%	-30%

Excess cost growth rates of private health insurance spending decrease to those of Medicare.

		2030				2040				2050				
		Reimbursement Rates				Reimbursement Rates				Reimbursement Rates				
		0%	4%	8%		0%	4%	8%		0%	4%	8%		
Admin Costs	0%	-22%	-25%	-29%	Admin	0%	-27%	-30%	-34%	Admin	0%	-30%	-33%	-36%
	25%	-24%	-28%	-31%	Costs	25%	-30%	-33%	-36%	Costs	25%	-33%	-36%	-39%
	50%	-27%	-30%	-33%	Costs	50%	-32%	-35%	-38%	Costs	50%	-35%	-38%	-41%

Note: The options under Admin Costs and Reimbursement Rates reflect decreases relative to current law. We assume that Admin Costs for private health insurance are 12 percent under current law, consistent with the findings in Congressional Budget Office, “How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare’s Fee-for-Service Program,” CBO Working Paper, December 2020, available at <https://www.cbo.gov/publication/56811>.

We project that the individual insurance mandate would reduce the percent of uninsured Americans from currently about 10 percent to zero. The reason stems from “adverse selection” that exists before a mandate: those who were previously uninsured are, on average, younger and slightly healthier with less healthcare spending than those who already carried health insurance. The mandate means that healthier uninsured people join the pool, reducing average per capita healthcare expenditure, which directly lowers health insurance premiums.

Over time, under current law, the fraction of the population that chooses to be uninsured would grow because insurance premiums would increase with excess cost growth. Since those who decline to be insured tend to be younger and healthier, insurance premiums under the McGary proposal will decrease further relative to those under current law.

Decreases in administrative costs, reimbursement rates, and excess cost growth would decrease health insurance premiums further. A drop in reimbursement rates or excess cost growth would lower the cost of medical treatment that health insurance companies would have to reimburse, thereby directly lowering their expenses and, as a result, premiums. While administrative costs would not affect spending on healthcare directly, they do affect the costs that health insurance companies aim to recover through premiums.

### Effect of Health Insurance Enrollment on Out-of-Pocket Expenditures

As shown in Table 2, total out-of-pocket expenditures will decrease by between 9 and 18 percent in 2030 and between 22 and 32 percent in 2050.

Table 2. Effects on Out-of-Pocket Expenditures, Relative to Current Law

[DOWNLOAD DATA](#)

**Excess cost growth rates of private health insurance spending remain unchanged from current law.**

Reimbursement Rates			
	0%	4%	8%
<b>2030</b>	-9%	-11%	-13%
<b>2040</b>	-15%	-17%	-19%
<b>2050</b>	-22%	-24%	-26%

**Excess cost growth rates of private health insurance spending decrease to those of Medicare.**

Reimbursement Rates			
	0%	4%	8%
<b>2030</b>	-14%	-16%	-18%
<b>2040</b>	-22%	-24%	-26%
<b>2050</b>	-29%	-31%	-32%

Note: The options under Reimbursement Rates reflect decreases relative to current law.

There are two reasons why out-of-pocket expenses decrease. First, with more people being covered by health insurance, fewer people are uninsured and paying their medical expenditures out of pocket. Second, the decrease in overall payment rates and excess cost growth lowers out-of-pocket expenditures, which are calculated as a percent of total medical expenditures, directly.<sup>3</sup> Offsetting these decreases in total out-of-pocket spending is the increase in utilization of medical services, which increases both, total medical expenditures, and total out-of-pocket expenditures. Note that out-of-pocket spending does not differ with the level of administrative spending. Out-of-pocket spending is a fraction of the underlying medical expenditures while administrative costs are incurred by the health insurance companies and are added to insurance premiums.

Over time, the decrease in out-of-pocket spending relative to those under the baseline becomes larger because the fraction of the population without health insurance steadily increases under the baseline, which

increases total out-of-pocket spending as many of those households pay their medical expenses directly. The number of uninsured increases under the baseline as a direct result of excess cost growth in health care: with faster growth in healthcare costs relative to incomes, fewer households can afford to purchase health insurance.

### **Effects on Medicaid Enrollment, Hours Worked, Private Savings, and Consumption**

As shown in Table 3, under McGary's health care proposals, Medicaid enrollment would increase by between 6 and 9 percent in 2030 and by between 21 and 26 percent in 2050.

Table 3. Effects on Medicaid Enrollment, Hours Worked, and Private Savings, Relative to Current Law

[DOWNLOAD DATA](#)

### Medicaid Enrollment

Excess cost growth rates of private health insurance spending remain unchanged from current law.

		2030				2040				2050					
		Reimbursement Rates				Reimbursement Rates				Reimbursement Rates					
		0%	4%	8%		0%	4%	8%		0%	4%	8%			
		0%	8%	7%	6%	0%	16%	15%	14%	0%	26%	25%	24%		
<b>Admin</b>		25%	7%	7%	6%	<b>Admin</b>	25%	16%	15%	13%	<b>Admin</b>	25%	26%	25%	23%
<b>Costs</b>		50%	7%	6%	6%	<b>Costs</b>	50%	15%	14%	13%	<b>Costs</b>	50%	25%	24%	22%

Excess cost growth rates of private health insurance spending decrease to those of Medicare.

		2030				2040				2050					
		Reimbursement Rates				Reimbursement Rates				Reimbursement Rates					
		0%	4%	8%		0%	4%	8%		0%	4%	8%			
		0%	9%	8%	8%	0%	15%	15%	14%	0%	24%	23%	22%		
<b>Admin</b>		25%	8%	8%	8%	<b>Admin</b>	25%	15%	14%	14%	<b>Admin</b>	25%	23%	23%	21%
<b>Costs</b>		50%	8%	8%	7%	<b>Costs</b>	50%	15%	14%	13%	<b>Costs</b>	50%	23%	22%	21%

### Hours Worked

Excess cost growth rates of private health insurance spending remain unchanged from current law.

		2030				2040				2050					
		Reimbursement Rates				Reimbursement Rates				Reimbursement Rates					
		0%	4%	8%		0%	4%	8%		0%	4%	8%			
		0%	-0.3%	-0.7%	-1.1%	0%	0.3%	-0.2%	-0.6%	0%	0.7%	0.2%	-0.3%		
<b>Admin</b>		25%	-0.5%	-0.9%	-1.3%	<b>Admin</b>	25%	0.1%	-0.4%	-0.8%	<b>Admin</b>	25%	0.4%	0.0%	-0.5%
<b>Costs</b>		50%	-0.6%	-1.1%	-1.5%	<b>Costs</b>	50%	-0.1%	-0.6%	-1.0%	<b>Costs</b>	50%	0.2%	-0.2%	-0.7%

Excess cost growth rates of private health insurance spending decrease to those of Medicare.

		2030				2040				2050					
		Reimbursement Rates				Reimbursement Rates				Reimbursement Rates					
		0%	4%	8%		0%	4%	8%		0%	4%	8%			
		0%	-1.2%	-1.6%	-2.0%	0%	-0.8%	-1.3%	-1.7%	0%	-0.6%	-1.0%	-1.5%		
<b>Admin</b>		25%	-1.4%	-1.8%	-2.2%	<b>Admin</b>	25%	-1.0%	-1.5%	-1.9%	<b>Admin</b>	25%	-0.8%	-1.2%	-1.7%
<b>Costs</b>		50%	-1.5%	-1.9%	-2.3%	<b>Costs</b>	50%	-1.2%	-1.6%	-2.1%	<b>Costs</b>	50%	-1.0%	-1.4%	-1.8%

### Private Savings

**Medicaid Enrollment**

**Excess cost growth rates of private health insurance spending remain unchanged from current law.**

		2030			2040			2050				
		Reimbursement Rates			Reimbursement Rates			Reimbursement Rates				
		0%	4%	8%	0%	4%	8%	0%	4%	8%		
<b>Admin</b>	<b>0%</b>	-3.3%	-3.6%	-3.9%	<b>0%</b>	-2.5%	-3.0%	-3.5%	<b>0%</b>	-2.2%	-2.9%	-3.5%
	<b>25%</b>	-3.4%	-3.7%	-4.0%	<b>25%</b>	-2.7%	-3.1%	-3.6%	<b>25%</b>	-2.4%	-3.0%	-3.6%
	<b>50%</b>	-3.5%	-3.8%	-4.0%	<b>50%</b>	-2.8%	-3.3%	-3.7%	<b>50%</b>	-2.5%	-3.1%	-3.8%
<b>Costs</b>	<b>0%</b>	-3.3%	-3.6%	-3.9%	<b>0%</b>	-2.5%	-3.0%	-3.5%	<b>0%</b>	-2.2%	-2.9%	-3.5%
	<b>25%</b>	-3.4%	-3.7%	-4.0%	<b>25%</b>	-2.7%	-3.1%	-3.6%	<b>25%</b>	-2.4%	-3.0%	-3.6%
	<b>50%</b>	-3.5%	-3.8%	-4.0%	<b>50%</b>	-2.8%	-3.3%	-3.7%	<b>50%</b>	-2.5%	-3.1%	-3.8%

**Excess cost growth rates of private health insurance spending decrease to those of Medicare.**

		2030			2040			2050				
		Reimbursement Rates			Reimbursement Rates			Reimbursement Rates				
		0%	4%	8%	0%	4%	8%	0%	4%	8%		
<b>Admin</b>	<b>0%</b>	-6.6%	-6.8%	-7.0%	<b>0%</b>	-6.2%	-6.6%	-7.0%	<b>0%</b>	-6.0%	-6.5%	-7.1%
	<b>25%</b>	-6.6%	-6.8%	-7.0%	<b>25%</b>	-6.2%	-6.7%	-7.0%	<b>25%</b>	-6.0%	-6.6%	-7.2%
	<b>50%</b>	-6.6%	-6.8%	-7.0%	<b>50%</b>	-6.3%	-6.7%	-7.1%	<b>50%</b>	-6.1%	-6.7%	-7.2%
<b>Costs</b>	<b>0%</b>	-6.6%	-6.8%	-7.0%	<b>0%</b>	-6.2%	-6.6%	-7.0%	<b>0%</b>	-6.0%	-6.5%	-7.1%
	<b>25%</b>	-6.6%	-6.8%	-7.0%	<b>25%</b>	-6.2%	-6.7%	-7.0%	<b>25%</b>	-6.0%	-6.6%	-7.2%
	<b>50%</b>	-6.6%	-6.8%	-7.0%	<b>50%</b>	-6.3%	-6.7%	-7.1%	<b>50%</b>	-6.1%	-6.7%	-7.2%

**Private Consumption**

**Excess cost growth rates of private health insurance spending remain unchanged from current law.**

		2030			2040			2050				
		Reimbursement Rates			Reimbursement Rates			Reimbursement Rates				
		0%	4%	8%	0%	4%	8%	0%	4%	8%		
<b>Admin</b>	<b>0%</b>	-1.0%	-0.3%	0.3%	<b>0%</b>	-1.3%	-0.5%	0.3%	<b>0%</b>	-1.5%	-0.6%	0.4%
	<b>25%</b>	-0.7%	-0.1%	0.6%	<b>25%</b>	-1.0%	-0.2%	0.6%	<b>25%</b>	-1.1%	-0.2%	0.7%
	<b>50%</b>	-0.5%	0.2%	0.8%	<b>50%</b>	-0.7%	0.1%	0.8%	<b>50%</b>	-0.8%	0.1%	1.0%
<b>Costs</b>	<b>0%</b>	-1.0%	-0.3%	0.3%	<b>0%</b>	-1.3%	-0.5%	0.3%	<b>0%</b>	-1.5%	-0.6%	0.4%
	<b>25%</b>	-0.7%	-0.1%	0.6%	<b>25%</b>	-1.0%	-0.2%	0.6%	<b>25%</b>	-1.1%	-0.2%	0.7%
	<b>50%</b>	-0.5%	0.2%	0.8%	<b>50%</b>	-0.7%	0.1%	0.8%	<b>50%</b>	-0.8%	0.1%	1.0%

**Excess cost growth rates of private health insurance spending decrease to those of Medicare.**

		2030			2040			2050				
		Reimbursement Rates			Reimbursement Rates			Reimbursement Rates				
		0%	4%	8%	0%	4%	8%	0%	4%	8%		
<b>Admin</b>	<b>0%</b>	0.1%	0.7%	1.3%	<b>0%</b>	0.1%	0.8%	1.6%	<b>0%</b>	0.1%	1.0%	2.0%
	<b>25%</b>	0.4%	1.0%	1.6%	<b>25%</b>	0.4%	1.1%	1.9%	<b>25%</b>	0.5%	1.4%	2.3%
	<b>50%</b>	0.6%	1.2%	1.8%	<b>50%</b>	0.7%	1.4%	2.2%	<b>50%</b>	0.8%	1.7%	2.6%
<b>Costs</b>	<b>0%</b>	0.1%	0.7%	1.3%	<b>0%</b>	0.1%	0.8%	1.6%	<b>0%</b>	0.1%	1.0%	2.0%
	<b>25%</b>	0.4%	1.0%	1.6%	<b>25%</b>	0.4%	1.1%	1.9%	<b>25%</b>	0.5%	1.4%	2.3%
	<b>50%</b>	0.6%	1.2%	1.8%	<b>50%</b>	0.7%	1.4%	2.2%	<b>50%</b>	0.8%	1.7%	2.6%

Note: The options under Admin Costs and Reimbursement Rates reflect decreases relative to current law. We assume that Admin Costs for private health insurance are 12 percent under current law, consistent with the findings in Congressional Budget Office, “How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare’s Fee-for-Service Program,” CBO Working Paper, December 2020, available at <https://www.cbo.gov/publication/56811>.

The primary reason for higher Medicaid enrollment is that Medicaid eligibility depends on income and assets. Under the McGary policy proposal, households are better insured against costly health shocks. Households therefore worry less about potentially large future out of pocket costs—as a result, they work and save less and therefore are more likely to meet the Medicaid eligibility requirements. The result is that in 2030, households work between 0.3 and 2.3 percent less, consume between 1.0 percent less and 1.8 percent more, and save between 3.3 and 7 percent less compared to the baseline. In 2050, households work between 1.8 percent less and 0.7 percent more, consume between 1.5 percent less and 2.6 percent more, and save between 2.2 and 7.2 percent less.

The magnitude of the increases in Medicaid enrollment and consumption and the decreases in work hours and saving also depends on how much out-of-pocket spending and insurance premiums fall relative to current law. Larger decreases in out-of-pocket costs and health insurance premiums would lead to *smaller increases* in Medicaid enrollment, *larger increases* in consumption, and *larger decreases* in working hours and saving.

For example, in the scenario with no change to excess cost growth, no change in administrative costs (staying constant at 12 percent), and no decrease in reimbursement rates, healthcare costs do not change, and insurance premiums and out-of-pocket spending decrease the least, relative to current law. In that scenario, we observe the smallest reductions in savings (3.3 percent in 2030 and 2.2 percent in 2050) and hours worked (0.3 percent in 2030 and an increase of 0.7 percent in 2050), the largest decrease in consumption (1.0 percent in 2030 and 1.5 percent in 2050), and largest increase in Medicaid enrollment (8 percent in 2030 and 26 percent in 2050).

At the other extreme, in the scenario with the largest decreases in excess cost growth, the administrative cost (by 50 percent to 6 percent) and reimbursement rates (by 8 percent)—the scenario with the largest decrease in healthcare costs and health insurance premiums—we observe the largest reduction in household savings (7 percent in 2030 and 7.2 percent in 2050) and hours worked (2.3 percent in 2030 and 1.8 percent in 2050), the largest increase in consumption (1.8 percent in 2030 and 2.6 percent in 2050), and about the smallest increase in Medicaid enrollment (7 percent in 2030 and 21 percent in 2050).<sup>4</sup>

### **Effects on Treatment Choices and Overall Health and Productivity**

Table 4 shows various aggregate health outcomes under the McGary plan, which do not vary significantly between scenarios.

Table 4. Effects on Health Outcomes, Relative to Current Law

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	2030	2040	2050
<hr/>			
% of population forgoing medical treatment			
<hr/>			
Baseline	13%	16%	21%
<hr/>			
Policy	4%	4%	4%
<hr/>			
Total Population	0.02%	0.06%	0.11%
<hr/>			
Population in Good Health	1%	2%	3%
<hr/>			
Population in Poor Health	-8%	-11%	-14%
<hr/>			
Productivity	0.3%	0.5%	0.7%

Note: Health outcomes do not differ significantly across the range of health care cost reduction we assume. The % of population forgoing medical treatment is reported in levels and not relative to current law.

Because health insurance enrollment is universal under the McGary proposal, we project that the percentage of the population that forgoes medical treatment would decline from 13 percent in 2030 and 21 percent in 2050 to a steady 4 percent in each year. That large decline is the direct result of universal health insurance coverage—when people do not have to pay large sums out of pocket when seeking medical care, they are more inclined to get the treatment they need, which increases overall utilization. The 4 percent of the population that still foregoes medical treatment under the proposal are people who still face relatively large out-of-pocket expenditures despite having health insurance coverage.

With more households receiving necessary medical treatments, the population would be healthier and, as a result, larger and more productive than under current law. PWBM projects that by 2050, the percent of the population that is “healthy” would be about 3 percent larger.<sup>5</sup> Those are people that under current law would have had “poor” health,<sup>6</sup> but because of the improved access to health insurance and lower health care costs would receive medical treatment and thus tend to live longer. This leads to an increase of roughly 0.1 percent in the size of the population in 2050 relative to the baseline projection.

Healthy people are also more productive than sick ones and have higher earning ability. With better access to medical care and a healthier population, the productive capacity of the population increases over time. PWBM projects that by 2050, the population would be, on average, about 0.7 percent more productive than under the current law baseline.

### Macroeconomic Effects

Table 5 shows the macroeconomic effects of the McGary healthcare plan.

Table 5. Effects on GDP, Capital, Hours Worked, and Debt Held by the Public

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**Debt Held by the Public**

Excess cost growth rates of private health insurance spending remain unchanged from current law.

2030		2040				2050								
Reimbursement Rates				Reimbursement Rates				Reimbursement Rates						
0%		4%		8%		0%		4%		8%				
	0%	-7%	-7%	-8%		0%	-10%	-12%	-13%		0%	-11%	-13%	-15%
<b>Admin</b>	25%	-7%	-7%	-8%	<b>Admin</b>	25%	-10%	-11%	-13%	<b>Admin</b>	25%	-11%	-13%	-15%
<b>Costs</b>	50%	-7%	-7%	-8%	<b>Costs</b>	50%	-10%	-11%	-13%	<b>Costs</b>	50%	-11%	-13%	-15%

Excess cost growth rates of private health insurance spending decrease to those of Medicare.

2030		2040				2050								
Reimbursement Rates				Reimbursement Rates				Reimbursement Rates						
0%		4%		8%		0%		4%		8%				
	0%	-6%	-7%	-8%		0%	-9%	-10%	-12%		0%	-9%	-11%	-14%
<b>Admin</b>	25%	-6%	-7%	-8%	<b>Admin</b>	25%	-9%	-10%	-12%	<b>Admin</b>	25%	-9%	-11%	-14%
<b>Costs</b>	50%	-6%	-7%	-8%	<b>Costs</b>	50%	-9%	-10%	-12%	<b>Costs</b>	50%	-9%	-11%	-14%

**Capital**

Excess cost growth rates of private health insurance spending remain unchanged from current law.

2030		2040				2050								
Reimbursement Rates				Reimbursement Rates				Reimbursement Rates						
0%		4%		8%		0%		4%		8%				
	0%	0.0%	0.0%	-0.1%		0%	0.7%	0.8%	1.0%		0%	1.1%	1.5%	2.0%
<b>Admin</b>	25%	-0.1%	-0.1%	-0.2%	<b>Admin</b>	25%	0.6%	0.7%	0.9%	<b>Admin</b>	25%	0.9%	1.4%	1.9%
<b>Costs</b>	50%	-0.2%	-0.2%	-0.3%	<b>Costs</b>	50%	0.5%	0.6%	0.8%	<b>Costs</b>	50%	0.8%	1.3%	1.9%

Excess cost growth rates of private health insurance spending decrease to those of Medicare.

2030		2040				2050								
Reimbursement Rates				Reimbursement Rates				Reimbursement Rates						
0%		4%		8%		0%		4%		8%				
	0%	-0.9%	-1.0%	-1.0%		0%	-0.6%	-0.4%	-0.2%		0%	-0.2%	0.3%	0.8%
<b>Admin</b>	25%	-1.0%	-1.0%	-1.1%	<b>Admin</b>	25%	-0.6%	-0.5%	-0.3%	<b>Admin</b>	25%	-0.3%	0.1%	0.6%
<b>Costs</b>	50%	-1.1%	-1.1%	-1.1%	<b>Costs</b>	50%	-0.7%	-0.6%	-0.4%	<b>Costs</b>	50%	-0.4%	0.1%	0.6%

**Labor Supply**

### Debt Held by the Public

Excess cost growth rates of private health insurance spending remain unchanged from current law.

		2030				2040				2050				
		Reimbursement Rates				Reimbursement Rates				Reimbursement Rates				
		0%	4%	8%		0%	4%	8%		0%	4%	8%		
Admin	0%	-0.1%	-0.4%	-0.8%	Admin	0%	0.2%	-0.1%	-0.5%	Admin	0%	0.5%	0.1%	-0.2%
	25%	-0.2%	-0.6%	-0.9%		25%	0.1%	-0.3%	-0.6%		25%	0.3%	0.0%	-0.4%
	50%	-0.4%	-0.7%	-1.0%		50%	-0.1%	-0.4%	-0.8%		50%	0.2%	-0.2%	-0.5%
Costs	0%	-0.1%	-0.4%	-0.8%	Costs	0%	0.2%	-0.1%	-0.5%	Costs	0%	0.5%	0.1%	-0.2%
	25%	-0.2%	-0.6%	-0.9%		25%	0.1%	-0.3%	-0.6%		25%	0.3%	0.0%	-0.4%
	50%	-0.4%	-0.7%	-1.0%		50%	-0.1%	-0.4%	-0.8%		50%	0.2%	-0.2%	-0.5%

Excess cost growth rates of private health insurance spending decrease to those of Medicare.

		2030				2040				2050				
		Reimbursement Rates				Reimbursement Rates				Reimbursement Rates				
		0%	4%	8%		0%	4%	8%		0%	4%	8%		
Admin	0%	-0.8%	-1.1%	-1.4%	Admin	0%	-0.7%	-1.0%	-1.3%	Admin	0%	-0.5%	-0.8%	-1.1%
	25%	-1.0%	-1.3%	-1.6%		25%	-0.8%	-1.1%	-1.5%		25%	-0.6%	-1.0%	-1.3%
	50%	-1.1%	-1.4%	-1.7%		50%	-1.0%	-1.3%	-1.6%		50%	-0.8%	-1.1%	-1.4%
Costs	0%	-0.8%	-1.1%	-1.4%	Costs	0%	-0.7%	-1.0%	-1.3%	Costs	0%	-0.5%	-0.8%	-1.1%
	25%	-1.0%	-1.3%	-1.6%		25%	-0.8%	-1.1%	-1.5%		25%	-0.6%	-1.0%	-1.3%
	50%	-1.1%	-1.4%	-1.7%		50%	-1.0%	-1.3%	-1.6%		50%	-0.8%	-1.1%	-1.4%

### Gross Domestic Product

Excess cost growth rates of private health insurance spending remain unchanged from current law.

		2030				2040				2050				
		Reimbursement Rates				Reimbursement Rates				Reimbursement Rates				
		0%	4%	8%		0%	4%	8%		0%	4%	8%		
Admin	0%	0.0%	-0.3%	-0.5%	Admin	0%	0.4%	0.3%	0.2%	Admin	0%	0.8%	0.8%	0.8%
	25%	-0.2%	-0.4%	-0.6%		25%	0.3%	0.2%	0.0%		25%	0.6%	0.6%	0.7%
	50%	-0.3%	-0.5%	-0.7%		50%	0.2%	0.0%	-0.1%		50%	0.5%	0.5%	0.5%
Costs	0%	0.0%	-0.3%	-0.5%	Costs	0%	0.4%	0.3%	0.2%	Costs	0%	0.8%	0.8%	0.8%
	25%	-0.2%	-0.4%	-0.6%		25%	0.3%	0.2%	0.0%		25%	0.6%	0.6%	0.7%
	50%	-0.3%	-0.5%	-0.7%		50%	0.2%	0.0%	-0.1%		50%	0.5%	0.5%	0.5%

Excess cost growth rates of private health insurance spending decrease to those of Medicare.

		2030				2040				2050				
		Reimbursement Rates				Reimbursement Rates				Reimbursement Rates				
		0%	4%	8%		0%	4%	8%		0%	4%	8%		
Admin	0%	-0.9%	-1.1%	-1.2%	Admin	0%	-0.6%	-0.7%	-0.8%	Admin	0%	-0.4%	-0.3%	-0.3%
	25%	-1.0%	-1.2%	-1.4%		25%	-0.7%	-0.8%	-0.9%		25%	-0.5%	-0.5%	-0.4%
	50%	-1.1%	-1.3%	-1.4%		50%	-0.9%	-1.0%	-1.0%		50%	-0.6%	-0.6%	-0.5%
Costs	0%	-0.9%	-1.1%	-1.2%	Costs	0%	-0.6%	-0.7%	-0.8%	Costs	0%	-0.4%	-0.3%	-0.3%
	25%	-1.0%	-1.2%	-1.4%		25%	-0.7%	-0.8%	-0.9%		25%	-0.5%	-0.5%	-0.4%
	50%	-1.1%	-1.3%	-1.4%		50%	-0.9%	-1.0%	-1.0%		50%	-0.6%	-0.6%	-0.5%

Note: The options under Admin Costs and Reimbursement Rates reflect decreases relative to current law. We assume that Admin Costs for private health insurance are 12 percent under current law, consistent with the findings in Congressional Budget Office, "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program," CBO Working Paper, December 2020, available at <https://www.cbo.gov/publication/56811>.

The elimination of the tax-advantaged treatment of employer-provided health insurance premiums would increase income and payroll tax revenues, which, in turn, would reduce debt by between 6 and 8 percent in 2030 and by between 9 and 15 percent in 2050, relative to current law. As a result of lower household savings, the stock of productive capital decreases by as much as 1.1 percent by 2030, relative to current law. However, the reduction in federal debt reduces crowding out of private capital and results in an increase in the capital stock over time. By 2050, the capital stock is between 0.2 percent lower and 2.0 percent larger than under current law.

Labor supply, which is a measure of productivity-weighted hours worked, decreases by between 0.1 percent and 2 percent in 2030 relative to the baseline, but increases thereafter relative to the baseline. That increase in labor supply is driven by faster wage growth relative to current law, which is the result of the capital stock growing at a faster pace than under current law. By 2050, labor supply is between 1.4 percent lower and 0.5 percent larger than under the baseline.

Combining capital with labor supply generates GDP. Under the low excess cost growth assumption (where excess cost growth equals that of Medicare), by 2030, GDP is between 0.9 percent and 1.4 percent lower than under the current law baseline. By 2050, however, the capital stock and labor supply start to recover and thus GDP is only between 0.3 percent and 0.6 percent lower than baseline. Under the high excess cost growth assumption, where households save more and work longer hours relative to the low excess cost growth assumption, GDP would only decrease by between 0 and 0.7 percent by 2030 and increase by between 0.5 and 0.8 percent relative to current law.

It is important to note here that a reduction in GDP does not mean that households are necessarily worse off. Policy changes that increase consumption and decrease hours worked generally improve people's wellbeing, irrespective of whether GDP decreases. For example, in the case where health care costs decrease the most (the case that assumes Medicare excess cost growth rates, a 50 percent decrease in administrative costs, and a 8 percent decrease in payment rates), GDP is lower than under the baseline in every year shown, but households consume more, save less, and work few hours. That indicates that households are better insured against health care shocks and therefore do not worry about self-insuring against possibly large future out-of-pocket medical expenditures. As a result, the average household can enjoy more leisure and consumption, which enhances their wellbeing despite an overall slightly smaller economy. Future work, along the lines of [PWBM's dynamic distributional analysis](#), can investigate the distributional welfare effects of this policy.

*This analysis was conducted by [Felix Reichling](#). Prepared for the website by [Mariko Paulson](#).*

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1. An 8 percent reduction in payment rates is consistent with the upper bound of a decrease in payments rates that the Congressional Budget Office calculates in an analysis of a single-payer universal health care system 5 years after implementation. See <https://www.cbo.gov/system/files/2020-12/56811->

- [Single-Payer.pdf](#), Exhibit 1-1, Options 2 and 3. Note that the 8 percent reduction in payment rates is a weighted average that CBO assumed for a single-payer healthcare plan. The CBO analysis finds that by 2030 private health insurance payment rates would lower by between 20 and 50 percent compared to current-law payment rates, depending on the covered service, and that Medicare payment rates would be higher by between 0 and 45 percent, depending on the service covered. ↩
2. A 50 percent decrease in administrative spending would lower administrative spending from currently 12 percent to 6 percent of medical expenditures of private health insurance companies. According to the CBO, administrative spending in other wealthy countries with universal health insurance systems ranges from 1 percent in Japan to 5 percent in German. See <https://www.cbo.gov/system/files/2020-12/56811-Single-Payer.pdf>, Exhibit 14-2. ↩
  3. We assume a competitive health insurance market, so that cost savings are fully passed on to consumers in the form of lower premiums and lower out-of-pocket expenditures. ↩
  4. The increase in Medicaid enrollment is slightly smaller in the scenario with greater excess cost growth, but that difference is magnified due to rounding. ↩
  5. The PWBM health model tracks five distinct health states that correspond to people's self-reported health status. The five categories are excellent, very good, good, fair, and poor. Here, "healthy" refers to the top three categories (excellent, very good, and good) and "poor" refers to the bottom two categories (fair and poor). ↩
  6. See the previous footnote for definition of "healthy" and "sick." ↩