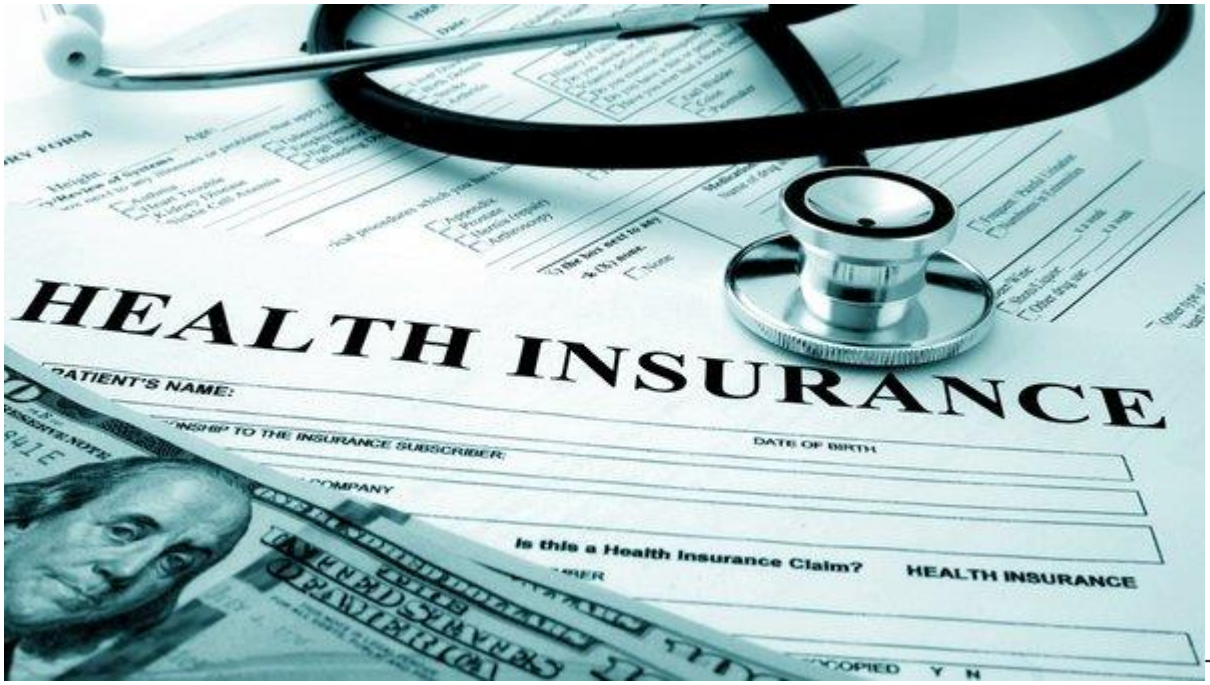
Single payer and Medicare For All: Continuing the discussion

Here are specific components of single-payer that have been tested and are likely to be key items for discussion.

By **Frederic Slade** | October 22, 2018 at 07:55 AM



The primary tradeoff with a single-payer system is cost, versus the social benefit of universal coverage and a healthier population. (Photo: (iStock)

In a previous **article in BenefitsPro**, I outlined some of the broader issues surrounding the increasing discussion of universal, **single-payer health care** for the United States, including Medicare for All (M4A). The primary tradeoff with such a system is cost, versus the social benefit of universal coverage and a healthier population.

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The following are more specific components of single-payer that have been tested and are likely to continue to be key items for discussion:

State versus federal program: A number of states have proposed government sponsored single-payer systems, including Michigan, New York and California. The biggest impediment to

implementation is cost, whether through payroll and/or business taxes. Tax increases would be required in states requiring a balanced budget. As with any differential in tax rates, there is the possibility that firms could relocate to lower-tax jurisdictions.

ACA and federal support: Currently, any transition toward universal coverage would require federal support through the Affordable Care Act (ACA) and Medicaid expansion. How do we get from here to there? Undoubtedly, a transition would take years. A congressional proposal draft, which assumes continuation of the ACA in its current form, would pool Medicare and state tax funds to provide **universal coverage**.

Worker displacement: Under M4A/single-payer, we would expect a diminished role for insurance companies and a reduction in people employed in the insurance industry, particularly those involved in administration and benefits processing. On the other hand, there is likely to be increased demand in the government sector for skilled labor to administer M4A. While in some scenarios, physician income under M4A may be negatively impacted by lower reimbursement rates, other workers may benefit, such as home health care professionals. Investment in worker retraining will be required.

A compelling statistic is that the United States, Greece, and Poland are the only countries of the 34 members of the Organization for Economic Co-operation and Development (OECD) that do not have **universal health care**. Whether the United States eventually joins the list will be an open question going forward. Stay tuned.

NOTE: Information presented herein on the healthcare sector is for discussion and illustrative purposes only and is not a recommendation or an offer or solicitation to buy or sell any securities. **Fred Slade** has over 25 years of experience in the investment management and retirement services industries. He is Senior Director, Investments for Pentegra Retirement Services, a leading provider of retirement services to financial institutions and organizations nationwide, founded by the Federal Home Loan Bank System in 1943. Mr. Slade manages over $1 billion in internal bond portfolios and provides analytics and strategy for Pentegra's Defined Benefit and Defined Contribution Plans. Mr. Slade holds a Ph.D. in Economics from University of Pennsylvania and a CFA, and has presented at a number of seminars and conferences.