LETTER TO THE EDITOR/RESPONSE

MEDICARE FOR ALL: A REBUTTAL TO DR. HIMMELSTEIN

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We are grateful for the response and detailed critique from Dr. David Himmelstein as we work towards improving health care in the United States. We look forward to continuing to read Dr. Himmelstein and colleagues' vast contributions to the health policy literature.

1) Dr. Himmelstein counters that new demand for services would be limited because in the past, other insurance expansions did not lead to high utilization growth. However, Medicaid payments grew by 12% in 2014, at the start of the ACA.[1] Further, a study in the *Quarterly Journal of Economics* found that coverage expansion of Medicare in 1965 resulted in a 46% increase in hospital admissions and a 28% increase in spending between 1965 and 1970.[2] The Medicare for All legislation would compound that because most of the population would move from large deductibles and other cost sharing to $0 in cost sharing. Additionally, there would be a broad expansion of service coverage including home care, dental care, and long-term care services.

2) Dr. Himmelstein cites that we do not address administrative savings. However, savings from administrative costs were discussed in our "Medicare for All 2020" article and our estimate of 10% administrative savings was confirmed in a paper published by Himmelstein and Woolhandler in *JAMA* stating that 12% of health insurer cost is administration compared to *about 2% in Canada, and Medicare is a 10% differential.[3] It is unclear that reduced administrative costs would exceed the increase in costs that result from increased demand caused by lowered cost sharing and expansion of coverage of services.*

3) While we agree that the Medicare for All bills do propose global budgets as the method to fund hospitals, government budgets are historically not "protections" for provider reimbursement rates. Government reimbursements are generally lower than commercial rates in the US and abroad.[4,5] Therefore, we expect lower budgets for hospitals and providers as a result of Medicare for All; and economics holds that lower wages for providers leads to fewer providers.

We believe the primary conclusion stands: the reduction in copayments will lead to an increase in demand for care while a reduction in provider reimbursements will result in a reduction in supply. These basic economics shift from our current equilibrium to a shortage of services.

Separately, having personally experienced the political challenges of passing the ACA, which impacted the health care for less than 10% of the population, advocating health reform for 100% of the population is not prudent even with a supermajority in the Senate.

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