GAME CHANGERS
Economic Policies for a Working America

POLICY BRIEF

Medicare for All

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The Problem

The United States has a dysfunctional health care system. The U.S. spends about 50 percent more on health care as a share of the economy than other high-income economies, but its population is much less healthy. A primary factor is that about 50 percent of the population lack adequate health insurance.

Past Failures

About 8 percent of the U.S. population today have no health insurance and 48 percent of those with insurance are "underinsured" — they do have coverage but nevertheless forego needed care because their out-of-pocket costs are prohibitive. The Affordable Care Act (ACA) was enacted in 2010 under President Obama with the express purpose of dramatically improving health care coverage. The ACA did partially succeed. It cut the share of uninsured in half, even while the underinsured population share still rose. Yet these gains under the ACA are now in danger of being reversed, because the "One Big Beautiful Bill" that passed under President Trump in 2025 includes huge budget cuts to both Medicaid and the ACA. These Medicaid and ACA cuts are projected to force at least 12 million people to lose coverage.

Game Changer: Universal Coverage through Medicare for All

As one representative measure of health outcomes in a country, the U.S. ranks 29th in the world in terms of deaths that could be averted with medical care. All 28 countries with fewer preventable deaths than the U.S. provide a form of universal health insurance coverage to their respective populations, even while they spend, on average, about 50 percent less on health care as a share of GDP. The solution is straightforward: the U.S. should adopt its own system of publicly funded universal health care coverage — what is widely known as a "single-payer" health insurance system or "Medicare for All." A Medicare for All system could be implemented in the U.S. as a federal program, covering all U.S. residents or, initially at least, at the level of one or more individual states.

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Under a U.S. Medicare for All system, all residents would automatically receive good quality health care coverage as a basic right, without having to pay any premiums, deductibles, co-payments or out-of-pocket expenses.

Implementing Medicare for All initially at the individual state level has important precedents, as well as, throughout the U.S. today, a significant and growing level of political support. The Canadian universal coverage system, Canadian Medicare, was enacted initially in the province of Saskatchewan in 1947 as a hospital insurance plan only and then spread throughout the rest of the country as a comprehensive coverage structure over the next 20 years. Several U.S. states now have, or have recently had, universal coverage proposals introduced into their state legislatures, including Oregon, Colorado, Illinois, Massachusetts, Minnesota, New Hampshire, Rhode Island, California, and New York.

A central feature of a Medicare for All system for the U.S., either at the national or individual state levels, will be that the funds from the existing public insurance programs — including Medicare, Medicaid, ACA, and the Veterans' Administration — will continue, but under the newly established single-payer framework. At present, public funding amounts to about 60 percent of total funding, with the other 40 percent provided through private insurance, individual co-payments, and philanthropy.

Under Medicare for All, the current private funding sources will be replaced by taxes on businesses and households. The new tax structure will be designed so that most households and businesses will pay significantly less in taxes than they had been paying for their existing coverage. This can be achieved, even while providing universal and expanded care, because Medicare for All can also deliver large-scale savings by reducing administration and prescription drug costs, by improving the efficiency of service delivery and by substantially cutting fraud and abuse in the healthcare payment system.

Economic Rationale and Feasibility

We have most recently considered a state-level proposal for New York State, the New York Health Act. As of 2024, New York State spent approximately $400 billion on health care. After accounting for both cost increases and savings, we estimate that the overall New York Health budget will be $356 billion under the New York Health Act. This amounts to an approximately 11 percent level of savings relative to the state's $400 billion health care budget for 2024.

In order for the approximately $190 billion in federal funding to be transferred into the New York Health operating budget, the New York State government will have to obtain what is termed a "waiver" approval from the federal government. The New York Health Act bill explicitly states its intention to obtain this waiver, but it cannot be assumed that the federal government will grant it. As such, the bill presents a "wraparound" financing framework as a workable alternative. Under this framework, all federal programs would continue to operate under their existing arrangements. New York Health would then provide complementary forms of support alongside these ongoing federal programs. This would achieve the same end result of universal coverage with no cost sharing by care recipients and reduced overall health care costs.

*For more information on this topic, including the **Background Paper**, please visit our policy page.*

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