



Yale SCHOOL OF PUBLIC HEALTH

July 22, 2026

The Honorable Ro Khanna
United States House of Representatives
Washington, DC 20515

Dear Representative Khanna:

Thank you for your inquiry about the economic and public health impacts of transitioning to single-payer universal health care in the US, as proposed in the Medicare for All Act.

In response, we have updated our peer-reviewed 2020 analysis published in *The Lancet* with the most recent national data, accounting for the coverage retractions enacted in 2025. Our updated analysis incorporates both added costs and sources of savings. On the cost side, we account for the increased utilization by people who are currently uninsured or underinsured. On the savings side, we extend Medicare payment rates to all providers, rates that are higher than Medicaid's but lower than those paid by private insurance. We incorporate lower pharmaceutical prices as determined by international reference pricing, as proposed in the Prescription Drug Price Relief Act of 2025 (H.R. 3546), which you introduced alongside Senator Sanders' companion bill (S. 1818). We consider the efficiencies achievable through administrative simplification and the improvements to fraud detection that a unified claims system would facilitate. We further include the benefit of timely primary and preventive care in averting the higher downstream costs of emergency and inpatient care.

We project that Medicare for All would reduce annual national health expenditure from \$5.28 trillion to \$4.24 trillion, a system-wide saving of \$1.04 trillion¹, or 19.7% of current spending. Although the federal government would assume responsibility for financing the entire system, it already accounts for \$2.15 trillion of annual health spending and would recover a further \$288 billion in tax revenue now forgone through the exemption of employer-sponsored insurance

¹ These estimates build on the framework developed in our peer-reviewed studies "Improving the prognosis of health care in the USA" (Galvani AP, Parpia AS, Foster EM, Singer BH, Fitzpatrick MC. *The Lancet*. 2020;395:524–533) and "Universal healthcare as pandemic preparedness: the lives and costs that could have been saved during the COVID-19 pandemic" (Galvani AP, Parpia AS, Pandey A, et al. *Proc Natl Acad Sci USA*. 2022;119(25):e2200536119), updated with the most recent (2024) National Health Expenditure data and extended to include universal dental coverage. Full methods, parameter derivations, and sensitivity analyses are provided in the accompanying preprint [medRxiv: DOI to be inserted]

premiums from taxation. Net federal expenditure would rise by \$1.8 trillion annually². This increase would replace private spending under the status quo: premiums paid by employers and households would be eliminated, as would all copayments and deductibles, including those paid by Medicare beneficiaries.

Many providers would fare better under a single payer than the comparison with commercial rates alone suggests, for several reasons. Services now paid at Medicaid rates would rise to Medicare levels. Uncompensated hospital care, approximately \$52 billion delivered each year without payment, would be reimbursed in full. The billing apparatus that providers maintain to navigate prior authorization and other requirements of multiple payers, a drain measured in the hundreds of billions of dollars annually, would largely become unnecessary. Should targeted adjustments for particular specialties or hospitals prove warranted, the \$1.04 trillion saving provides ample headroom to accommodate them. With a lighter administrative burden, clinicians would have more time to treat patients, to the benefit of both. Medical debt collection and the uncertainty of claims reimbursement would be eliminated. Patients would face no surprise bills, and providers would be assured of full compensation for their work.

A single national insurer would also offer employment opportunities for today's insurance workforce. Medicare already administers claims through contracted private processors, a role that would expand considerably under universal coverage. The Medicare for All Act anticipates this transition: it allocates at least 1% of the program's budget for up to five years, roughly \$40 billion annually, to assist workers displaced from the insurance industry through wage replacement, retirement benefits, job training and placement, preferential hiring, and education benefits. The expanded utilization we project, including dental care, would furthermore generate demand for clinical and support staff in hospitals and health centers across the country.

Should Congress prefer an incremental step, expanding Medicare eligibility to age 50 would require \$180 billion annually³, taking into account employer-sponsored insurance offsets and the retention of premiums paid by beneficiaries.

We would be happy to discuss these findings or provide additional information that might be helpful.

Thank you for the opportunity to inform your work.

Sincerely,

² In the 2024 National Health Expenditure data, \$2.15 trillion of total health spending is already attributable to the federal government. Because Medicare would provide coverage in place of employer-sponsored plans, the premiums that are currently excluded from taxable income would instead be taxed, generating approximately \$288 billion in federal revenue. Netting both against the cost of financing the full system yields our net federal cost of \$1.8 trillion, which reflects first-dollar coverage—no copayments or deductibles for any beneficiary—and includes universal dental benefits.

³ This estimate applies the same accounting to a partial expansion covering adults aged 50–64 (those 65 and older are already Medicare-eligible). The cost of covering this group is offset by the federal spending already directed to it—principally marketplace subsidies and Medicaid—and by the employer-sponsored-insurance tax revenue recovered as those newly covered move from employer plans to Medicare, yielding a net federal cost of \$180 billion annually. Unlike full Medicare for All, this figure assumes new beneficiaries would continue to pay premiums and cost-sharing comparable to those faced by current Medicare beneficiaries.

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