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A Policy Primer on the Framing, Feasibility, and Trade-offs of "Medicare for All"

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The notion that a broadening of public insurance programs such as Medicare or Veteran Affairs might correct the high costs, unequal access, and uneven outcomes emblematic of U.S. health care is not especially new.[1,2] However, with health care dominating much of the policy discourse over the past three years, it is unsurprising that Medicare for All (M4A) has become a platform issue for the Democratic Party during the early stages of the current presidential primary season. Thus far, five Democratic candidates—Kamala Harris, Cory Booker, Pete Buttigieg, Elizabeth Warren, and Bernie Sanders—have either voiced strong support for or put forward some version of M4A.[3] Furthermore, the 115th session of Congress featured the introduction of at least eight different M4A policy proposals.[4] M4A will likely become a tent-pole policy position between the eventual presidential candidates during the 2020 general election. This brief is an overview of some of the key issues in the ongoing M4A discussion and is not intended to be exhaustive or partisan.

THE FRAMEWORK FOR "MEDICARE FOR ALL"

If implemented under the most expansive iteration (as proposed by Sanders and Rep. Pramila Jayapal), M4A would be a single-payer insurance program administered by the federal government. It would cover medically necessary services for all U.S. residents, with eligibility likely conferred at the time of birth or upon attainment of legal resident status. In effect, M4A would replace public insurance programs like Medicaid, TRICARE, the Federal Employee Health Benefits program, the Child Health Insurance Program (CHIP), and all forms of private insurance including Affordable Care Act (ACA) marketplace and employer-sponsored insurance (ESI) plans. It would comprise a uniform set of essential health services (similar to or an expansion of Medicare's current offerings), be available to all Americans, and feature minimal cost sharing (i.e., deductibles and co-payments). These changes to the U.S. health care system would not just level the playing field with respect to health care access but would also be the most radical redesign of health insurance financing in the United States, and the world, in recent memory.

Although myriad proposals have been introduced under the banner of "M4A," they differ considerably with respect to implementation strategy, eligibility, covered benefits, and funding. These differences have significant implications for the health care workforce, patients, taxpayers, and employers. Adding to this confusion, multiple presidential candidates have gone on record to support several proposals.[5] However, a unifying theme is one of universal coverage for all U.S. residents involving some sort of a national health plan. It bears mentioning that universal coverage

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is not always synonymous with a single-payer system. For example, the Affordable Care Act (ACA) was well on its way to extending coverage to all Americans through a mosaic of Medicaid expansion plans, a requirement that all adults above the age of 26 years purchase health insurance ("individual mandate"), and a state-based private insurance marketplace. Moreover, it is worth noting that very few countries have a purely single-payer system. Most, including the oft-cited Canadian health system, employ a mix of public and private payers, with the latter providing supplemental coverage (dental, vision, and prescription drugs).[6]

An unfortunate byproduct of the surfeit of M4A proposals is a misperception among potential voters about the intent and path to M4A. For example, according to a poll by the Kaiser Family Foundation (KFF) of potential voters, majority support (56%) was noted for M4A.[7] However, 67% of these supporters misunderstood what M4A actually means—specifically, they falsely believed that individuals will be able to maintain their existing ESI coverage in a M4A policy environment.[8] Recognition of this potential political liability has led to the creation of additional M4A proposals that are more incremental in the approach to widening coverage.[9] For example, a plan co-sponsored by Sens. Harris, Booker, and Amy Klobuchar would allow older individuals (aged 50-64) to become early beneficiaries of Medicare through a "buy-in" option. Termed the "Medicare at 50" Act," buy-in would be administered through an ACA-like exchange marketplace or managed directly by Medicare. Another proposal, also co-sponsored by Harris, Booker, and Klobuchar entails a "public option"—a tax-funded plan that competes with private insurance offerings and that all working-age adults can opt into; this is known as the "Medicare-X Choice Act." Cost-sharing subsidies, similar to those available in the ACA state-run marketplace, could be used to encourage low-income families to enroll into a public plan. Lastly, a bill proposed by Sen. Jeff Merkley—the "Choose Medicare Act"—would allow some large employers to buy full insurance from a program called Medicare Part E, while others could remain self-insured with Medicare acting as a third-party administrator that adjudicates claims, creates provider networks, etc. In all of these examples, the underpinning strategy is to improve and not replace our current mosaic of private and public insurance systems.[10] These plans, and others like them, improve the political viability of M4A while enhancing plan choices for adults under 65 years of age and invigorating competition in the insurer marketplace.

EMPLOYER-SPONSORED OR COMMERCIAL INSURANCE

Plans that replace or nearly displace ESI, a common element of comprehensive M4A proposals like Sanders', have been criticized by several stakeholders in the health care community.[11,12] According to recent estimates, ESI covers nearly 60% (180 million) of insured persons in the U.S., making it a major component of health care financing and production.[13] ESI originated in the post-World War II labor market as a means for employers to compete for and retain highly prized workers without running afoul of federally mandated wage freezes. ESI's popularity can be explained by its administrative ease of implementation; lower premiums for employees due to less adverse selection (e.g., covering fewer sick patients than other forms of private insurance);[14] and the tax-exempt status of employer contributions to said premiums.[15]

Many policy experts feel that certain features of ESI are to blame for the ongoing inefficiencies and high cost structure of U.S. health care delivery. Specifically, greater reliance on sub-specialists for care delivery (relative to other economically advanced countries) and piecemeal reimbursement for health services (termed "fee for service") have contributed to our current cost-intensive (18% of the GDP[16]) and inefficient (unequal access, suboptimal population-level outcomes) health care system. The Sanders bill blocks insurance companies

from offering any coverage benefit that would be available under his comprehensive national plan. This functionally limits private health insurance, ESI or otherwise, to only supplemental coverage. Complicating this approach is the fact that ESI remains extremely popular among segments of the general population enrolled in it. Recent polling data revealed that 76% of the general public and 86% of individuals with employer coverage have a largely favorable view of ESI.[17]

In addition to current consumers of ESI, there is ample reason to believe that extending current Medicare fee schedules to all patients will be deeply unpopular among physician and hospital groups. This is because Medicare fees are projected to generate a negative balance sheet and a significant financial shortfall for both provider sectors if applied to all patients. According to 2016 data, on average, ESI pays physicians 100% to 300% of Medicare payment rates.[18, 19]

A similar pattern emerges for hospital services, as ESI reimburses at 149% of health care production costs[6] and 200% to 300% of Medicare levels, depending on the site of service (i.e., inpatient versus outpatient). For hospital systems, this translates to an almost 16% margin reduction or $85.6 billion annually.[20] This raises the question as to what, if any, would be the behavioral response on the part of providers (hospitals and physicians) to the implementation of a comprehensive M4A program (i.e., the Sanders or Jayapal proposal). There is empirical evidence to suggest that providers might do some or all of the following: increase the volume of billed services (termed an "income effect") or preferentially deliver higher margin services.[21] Lastly, abolishing ESI raises the question as to whether M4A will stifle innovation and discovery in the biomedical sciences. This is because many nonprofit academic medical centers use clinical revenue, often driven by ESI patient volume, to subsidize the research mission.

FINANCING

Funding for M4A across the different bills has also drawn significant policy attention. Advocates assert that large portions of M4A costs will be offset by the diversion of funds previously allocated for CHIP and matching federal contributions to Medicaid. Furthermore, recouping the tax exemptions intended for ESI, an estimated $300 billion in 2018, would be a significant boon for M4A financing. [22] However, conservative estimates still show that a single-payer M4A bill will come at great societal cost: $32.6 trillion dollars in federal government outlay over the first 10 years of implementation.[23] Under the same analysis, in 2022 alone, projected national health expenditures will be $4.562 trillion dollars, of which the federal share will be $4.244 trillion dollars (93%).[24] Realistically, this level of federal financial commitment can only be borne out of sustained, broad-based tax increases (payroll, income, capital gains, and corporate). Additionally, it is highly probable that this level of funding could have a spillover effect of deepening the federal deficit.

CONCLUSION

In addition to the issues mentioned above, M4A presents far more questions than answers. How exactly will it drive down spending? How will it affect care delivery for special populations such as individuals with disabilities, pregnant women, or those with rare medical conditions (e.g., cystic fibrosis, Lou Gehrig's disease)? What will happen to the large, displaced health insurance workforce? Is there any role for state flexibility in implementation?

Perhaps more than anything else, the M4A policy discussion should be repurposed as a call for a broader societal discussion on health care coverage. Should it be an entitlement (like free public education) or an earned benefit (like Medicare)? Only after we have reached a majority agreement on this issue can we begin to make the thoughtful investments, hard trade-offs, and broad policy changes necessary to reimagine the U.S. health care delivery system.

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