
MEDICARE FOR ALL VS. ALL THE HEALTHCARE THAT EACH CAN AFFORD

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We stand at the crossroads between guaranteeing healthcare to everyone through an improved and expanded Medicare program and leaving increasingly more people at the mercy of the market with legislation such as the American Health Care Act. Now is the time to take on our market-driven system and fight for an improved and expanded Medicare for all.¹

In contrast to our current system, a Medicare-for-all health plan would provide comprehensive healthcare benefits for all medically appropriate care without regard to income, employment, or health status. Instead of many insurers, each with a variety of health plans and cost-sharing schemes, funding for healthcare would be administered from a single government fund based on a uniform set of benefits.² Payments would be negotiated by representatives of the Medicare-for-all plan and representatives of hospitals, physicians, and other providers. Finally, prescription drugs, medical devices, and other related supplies would be negotiated in bulk for the entire U.S. population at reduced prices. There would be a single standard of excellence in care for all – not bronze for some and platinum for others. People would be free to seek care from any participating healthcare provider. We would receive the care our doctors and nurses determine we need – not what a profit-seeking insurer deems it will cover or deny. Finally, care would be provided without deductibles or copayments thereby easing economic inequality and health disparities.

This paper begins by examining our market-driven healthcare system and the failings of our private insurance system. It includes discussions on why adding a government-run public insurance option to the ACA private insurance marketplaces could not remedy the problems the marketplaces face and on the limitations in care under a market-driven system. Finally, it will examine the major features of a Medicare-for-all system and how our country could provide healthcare as a right, not a privilege.

Corporate Healthcare and the Games that Insurers Play

For decades, corporate healthcare has played a major role in defeating attempts to guarantee healthcare for all. The influence of this sector decisively shaped the Affordable Care Act (ACA). In the years leading up to and following the passage of the ACA, 2006 through 2012, the health sector spent \$3.4 billion on lobbying – more than any other sector for four out of seven years and second for the other three.³ It also contributed a whopping \$709 million in campaign contributions over that same time period.⁴ Of this \$709 million, \$332 million went to Republicans, \$304 million went to Democrats (\$23 million to candidate Obama in 2008), and the balance went to outside spending groups. The “investment” in lobbying and campaign contributions paid off. By spending these vast sums, corporate healthcare was able to block measures that would have improved our healthcare system, but interfered with the health industry’s ability to reap enormous profits, and win provisions

that guaranteed increased healthcare industry profits.

Still, in many ways, the ACA was a step forward. Those with pre-existing conditions can no longer be denied coverage and insurers cannot base premiums on health status. The number of uninsured has dropped considerably, with 20.4 million gaining coverage from 2010 to 2016.⁵ Unfortunately, the ACA didn’t go far enough. With plans available in the ACA insurance marketplaces requiring cost sharing ranging from 10% to 40%, on top of premiums, cost continues to make it prohibitive for many to access healthcare. Catastrophic plans are even worse. Even though the federal government has been propping up the insurance marketplaces through premium support and cost-sharing subsidies, paid by taxpayers to private insurers, these insurance marketplaces have struggled from the beginning. These struggles have been exacerbated under the current administration.

Some contend that adding a public option to the ACA insurance marketplaces could serve as a corrective to the abuses of the profit-based insurance industry and, perhaps, even be a first step on the road to Medicare for all. The public option plans, as designed by a pair of current congressional bills,⁶ would be administered by the federal government, funded by premiums, and have their own provider networks. The public option plans would be offered alongside the private insurance plans in the marketplaces and be subject to the same terms and conditions, including the premium tax credits and cost-sharing reductions as the other metal plans – bronze, silver, gold, and platinum. The idea is that a public option would be able to drive down insurance prices by competing against private health plans as a low-cost option that would not need to spend huge amounts on executive compensation packages, turn a profit, or pay dividends to shareholders.⁷ However, the market for health insurance differs dramatically from markets for most goods and services in such a way that increased competition does not necessarily drive down prices. Though the differences are many, consider just two. First, those buying insurance are unable to predict in advance what type of healthcare they may need; even those currently being treated for a health condition may have unanticipated health needs arise. The second and crucial point is that the private insurance business model, which seeks to limit claims paid on policies, conflicts with the very reason most people have for purchasing health insurance, the need for healthcare. Insurers' biggest costs are what they term *medical loss*, or the costs of paying for policyholders' covered healthcare services. Thus, insurers strive to limit how much they pay out in claims for care provided to their enrollees. Health insurers do not focus on maximizing policy sales, but on maximizing sales to individuals who they deem will pay more in premiums than they cost in care. Competition among health insurers amounts to competing to sell policies to healthier individuals (also known as “cherry picking”).

This practice continues under the ACA even with thousands of pages in statutes and related regulations. Studies have documented discriminatory insurance policies on the marketplaces that place key HIV/AIDS, cancer, and multiple sclerosis drugs in the

highest cost-sharing tier in a drug formulary.⁸ Selective provider network design offers another means of excluding costly patients. For example, the network may include a limited number of oncologists and other specialists or exclude academic medical centers and cancer treatment centers.⁹ Although increased competition generally may lower premiums in some of the ACA insurance marketplaces,¹⁰ the question remains whether a public option would have a sufficient competitive edge over private plans to keep premium rates affordable, particularly when the private insurers game the system.¹¹ As the public option would not want to replicate the unscrupulous practices of private insurers, it is likely to end up with a great number of costly enrollees that private insurers want to offload, making it nearly impossible for the public option to maintain competitively priced premiums, discrediting the role of the government, and undermining support for public programs such as Medicare and Medicaid.

Moreover, in many areas where the ACA marketplaces are down to a lone insurer, competition is not the problem.¹² Rather, many are losing money as the enrollees are much sicker and costlier.¹³ Insurers that remain in these areas have raised their premiums by double digits and, in one case, triple digits.¹⁴ In the four states which dropped down to one insurer in 2017, the increases ranged from 29% to 69%, while cities and counties with a single insurer saw increases ranging from 26% in Anchorage, Alaska to 145% in Phoenix, AZ – which dropped from eight insurers in 2016 to just one in 2017.¹⁵ Recent filings for 2018 indicate further dramatic rate increases.¹⁶ The only solution to bringing down premiums is to broaden the risk pool by inducing those who are younger, healthier, and less costly to enroll. Given the cost and quality of many of the insurance plans in the ACA marketplaces, this would be very challenging even without the sabotage of the current administration. It may prove to be impossible to cover costs while maintaining premiums at a level that enrollees can manage. Without federal premium support, the premiums required to cover the cost of care in these markets would surely outstrip many enrollees' ability to pay and, thus, end in a death spiral. The larger issue here is that even if a public option were the answer to saving the insurance marketplaces, we would still be left with the tiered plan model and 10% to 40% cost sharing or worse, a catastrophic plan.

Finally, not only do private insurers avoid covering the most costly patients, they also attempt to limit care to those they do cover. In a more insidious approach than outright denial, insurers impose clinical practice guidelines and protocols that interfere with physician autonomy by limiting the types of tests and treatments that the insurer will reimburse. Physicians may not be able to order a test because a patient does not meet the criteria in the “guideline” the insurer designates, whether or not the criteria are relevant to a particular patient’s circumstances.¹⁷ In cases where an insurer, hospitals, and physicians work together as a health plan, such as a health maintenance organization (HMO) or an accountable care organization (ACO), care is often limited through the electronic health record (EHR). EHRs go beyond an electronic version of a paper chart that merely records information.¹⁸ Protocols and guidelines, as well as programs to order tests and treatments, can be embedded in the EHR as clinical decision support. Although these software programs may be called clinical decision “support,” and the embedded clinical practice requirements may be called “guidelines,” they often function as hard-and-fast rules that override physicians’ professional judgment as well as limit the full professional practice of nurses and other practitioners that care for patients. As protocols and clinical practice guidelines are based on studies and data regarding a certain percentage of a patient population as a whole, they may not apply to a particular patient. Practitioners must be free to provide care based on their professional judgment about the tests and treatments appropriate for their individual patients.

All the blame for high premium costs cannot be laid at the feet of insurers, however. Consolidation in hospital and physician practices has also contributed to the increased cost.¹⁹ The rate of increase in hospital consolidation has accelerated in recent years. Since 2009, the number of hospital mergers and acquisitions has doubled and the number of independent community hospitals has dwindled.²⁰ In 2015, the most recent year for which data is available, only one in three hospitals remained independent.²¹ Price gouging in the hospital industry becomes readily apparent by examining charge-to-cost ratios – that is, the relationship between how much a hospital

charges compared to its costs. The latest data show that, on average, hospitals charge 379%, nearly four times, more than an item or service costs. Hospitals that belong to systems have, on average, charge-to-cost ratios that are 53% higher than independent hospitals.²² Hospitals are quick to say that this is what they charge, but it is not necessarily what they receive in payment. Yet, as insurers typically negotiate rates based on a percentage of what hospitals charge, the more they charge, the higher their profit margin.²³ Unfortunately, the horrifying irony of our current system is that the uninsured pay the highest rates of all.²⁴

If there is any doubt that our market-driven healthcare system is failing us, two measures, expenditures and health status, make it clear. Although the United States consistently spends more on healthcare than any other country, it typically has poorer results. The most recent data from the Organisation for Economic Co-operation and Development (OECD),²⁵ a widely utilized source for making international comparisons, show that the United States spent 16.9% of GDP, nearly twice the average rate of 9% for the 35 member countries.²⁶ The differences are even greater in the amount we spent per person. At \$9,451, we spent nearly two and half times the \$3,814 average of OECD countries.²⁷ Yet, despite the amount we spend, the patchwork U.S. “system” leaves 28 million uninsured and millions more underinsured.²⁸ The result is poorer health and shorter lives. A widely cited study by the Commonwealth Fund comparing the United States to ten other countries ranked the U.S. dead last overall as well as in the categories of healthy lives, cost-related problems to access, equity, and efficiency.²⁹ A second study, covering 195 countries regarding deaths that were preventable had the patient received “timely and effective medical care,” ranked the U.S. at number 35 on its Health Access and Quality index – in between Estonia and Montenegro.³⁰ The worst U.S. scores were for lower respiratory infections, ischemic heart disease (coronary heart disease), and chronic kidney disease. Looking strictly at the United States, we find a recent dip in the average life expectancy,³¹ a gap of 10 to 15 years in life expectancy between the richest and the poorest among us,³² and numerous health disparities related to class, race, and sex.

Medicare for All: How it Works

Corporate control of healthcare and our misguided faith in the market has resulted in an inefficient, fragmented “system” that leaves millions with little or no access to healthcare. Our current approach treats healthcare as a commodity on a par with other commodities rather than a public good. We have accommodated the failure of the private insurance market by cobbling together the most expensive public-private system the world has ever seen. The shift to a Medicare-for-all plan reorients our system to providing healthcare as a right, not a privilege. It would be a tremendous step toward ending health disparities and would mitigate economic inequality. Finally, recent public opinion polls demonstrate that a strong majority of Americans favor Medicare for all. In December 2015, the Kaiser Health Tracking Poll found:

When asked their opinion, nearly 6 in 10 Americans (58 percent) say they favor the idea of Medicare-for-all, including 34 percent who say they strongly favor it. This is compared to 34 percent who say they oppose it, including 25 percent who strongly oppose it. Opinions vary widely by political party identification, with 8 in 10 Democrats (81 percent) and 6 in 10 independents (60 percent) saying they favor the idea, while 63 percent of Republicans say they oppose it.³³

A 2017 poll by the Pew Research Center demonstrates that support is growing.

Currently, 60% of Americans say the government should be responsible for ensuring health care coverage for all Americans, compared with 38% who say this should not be the government’s responsibility. The share saying it is the government’s responsibility has increased from 51% last year and now stands at its highest point in nearly a decade.³⁴

So what’s stopping us? Supporters of our market-driven model typically sabotage efforts to provide Medicare for all by focusing on how we would pay

for it. This is disingenuous. We are already paying for it; we’re just not receiving it. Approximately two-thirds of U.S. healthcare expenditures already come from taxpayers in the form of federal, state, and local government spending.³⁵ Healthcare in the U.S. costs more both because of administrative complexity and higher prices, rather than increased utilization. The comparisons of U.S. spending and health outcomes to other countries strongly suggest that there is enough money in our current system to provide healthcare for all, if we spend that money fairly and wisely. The key point is to demonstrate that there is enough money currently being spent on healthcare in the U.S. to provide Medicare for all, rather than specifying particular funding mechanisms.³⁶

As mentioned above, we would reap enormous savings by eliminating private insurance company costs such as profits, shareholder dividends, excessive executive compensation, and marketing costs. Additional savings would come from the uniformity in health benefits and in claims and billing processing. Instead of many insurers, each with a variety of health plans and cost-sharing schemes, funding for healthcare would be administered from a single government fund based on a uniform set of benefits.³⁷ Hospitals, physicians, and other providers would no longer need large billing departments to manage payments or to pursue collections from the uninsured and the underinsured. Each of these areas is discussed in more detail below.

Cost sharing — copayments, coinsurance, and deductibles. Eliminating patient cost sharing is a first step to achieving health equity and easing the economic inequality that is rife in our country. The very idea of requiring patient cost sharing, also called “out-of-pocket costs,” derives from a market-based approach to healthcare. Those who take this economic approach to providing healthcare argue that people need to “have skin in the game,” meaning that they must have a financial stake in accessing

healthcare, otherwise they will use their health insurance indiscriminately and not just when they truly need it.³⁸

Research confirms that even minimal cost-sharing requirements reduce healthcare utilization.³⁹ Unfortunately, cost sharing keeps people from seeking both needed and unneeded care.⁴⁰ This should not come as a surprise; laypersons cannot be expected to know prior to seeing their healthcare provider whether or not they need medical treatment. As the cost of providing care has increased, costs have been shifted to individuals and families. Imposing higher deductibles, copayments, and coinsurance is a double win for insurers; healthcare utilization drops and they pay less when healthcare is used. Today, millions with health insurance delay seeking healthcare or filling a prescription because of high deductibles, but even copayments can be difficult for many to manage.⁴¹ Those who are sick or low income fare the worst.⁴² Thus, eliminating cost sharing reduces both health disparities and economic inequality.⁴³ Finally, while prompt treatment of injury and illness is reason enough to eliminate cost sharing, in some cases it also reduces the overall cost of treatment.⁴⁴

Administrative savings. Administrative savings would come from two primary sources: insurers and providers such as doctors and hospitals.⁴⁵ On the insurer side, eliminating private insurance company waste such as profits, shareholder dividends, excessive executive compensation, and marketing costs would produce tremendous savings. Having a single, comprehensive benefits package and a single payer, the federal government, creates uniformity in claims and billing processing. Doctors and hospitals would no longer need large billing departments to manage payments or to pursue collections from the uninsured and the underinsured, nor for preauthorizing tests and treatments or checking drug formularies before prescribing medications. This would produce additional savings that could be redirected to care. Overall, replacing our complex, fragmented health system with its many insurers – each with multiple benefit packages and numerous cost-sharing schemes – would produce savings of 9.3% to 14.7%.⁴⁶ Based on projected national health expenditures of more than \$3.5 trillion dollars in 2017, this would amount to \$330 to \$520 billion in administrative savings alone.⁴⁷

Global budgets. Hospitals, nursing homes, and similar facilities, as well as home care agencies, would receive a fixed lump-sum annual budget, called

a global budget, rather than getting paid separately for each patient’s hospital stay. A global budget, typically paid out in monthly installments, would reimburse the facilities for all their operating expenses and, under a separate budget, for capital expenses such as new buildings and equipment. The savings would accrue primarily from reduced administrative costs related to billing and insurance. The administrative savings estimated above derive, in part, from global budgeting for hospitals and other healthcare facilities. Multiple studies have documented the savings achieved by using the global budget approach.⁴⁸ A recent study of hospital administrative costs in eight countries found that Canada and Scotland, which are paid using global budgets, had the lowest administrative costs at 12.4% and 14.3%, respectively.⁴⁹ In contrast, hospitals in the United States, which must manage a far more complex billing system, had the highest administrative costs at 25.3%.

Capital investment. A Medicare-for-all program would require approval for investment in expanding medical facilities and major equipment purchases to ensure they are allocated fairly and where needed. The approval process would prioritize capital investment in projects that address medically underserved populations and health disparities related to race, ethnicity, income, or geographic region. This approach contrasts sharply with a market-driven approach which seeks to maximize revenue. For years, hospital corporations have shuttered “underperforming” hospitals in communities with high numbers of uninsured, often reopening them a few miles down the road in areas with better insurance coverage and higher incomes. Most public hospitals, which typically care for the uninsured, on the other hand, have been severely underfunded and stand in need of critical infrastructure and equipment upgrades. Thus, relying on the market has resulted in a maldistribution of healthcare resources from what should be the guiding rationale, providing care to those who need it. Finally, our current system often leaves expensive equipment standing idle. For example, in a profit-seeking healthcare system with hospitals in relatively close proximity to one another, if one hospital purchases an MRI machine, the other

area hospitals may feel the need to do so in order to claim the same capabilities as they compete against each other. In contrast, a Medicare-for-all plan would direct investment in expensive equipment, new hospitals, and medical offices where it is needed, not where corporate healthcare deems most lucrative.

Bulk purchasing. The pharmaceutical/health products industry has spent more money lobbying than any other industry every year since 1999. The spending topped out at \$274 million in 2009, with spending at a still sizeable amount of \$246 million in 2016.⁵⁰ In addition, the industry has contributed millions to federal campaigns. According to the Center for Responsive Politics: “The pharmaceutical and health products industry ... is consistently near the top when it comes to federal campaign contributions. ... The industry’s political generosity increased in the years leading up to Congress’ passage in 2003 of a Medicare prescription drug benefit.”⁵¹ This appears to have been money well spent. As part of the Medicare Modernization Act of 2003, Congress not only created a Medicare prescription drug benefit, but also prohibited the Health and Human Services Secretary from negotiating prices or creating a formulary of approved prescription drugs.⁵² The Center for Responsive Politics also found that “industry spending levels have fluctuated, though they have usually hovered around the \$30 million range...”⁵³ That is until 2012, when campaign contributions increased to over \$50 million and topped out in 2016 at nearly \$60 million.⁵⁴

A Medicare-for-all plan would negotiate prices on drugs and medical devices for the entire U.S. population.⁵⁵ Thus, it would garner far greater bargaining power than our fragmented system of insurers, each competing against each other and seeking to maximize profits. Negotiating with pharmaceutical companies would bring the costs of prescription drugs in this country in line with the rest of the world. A recent study found that this alone would have saved \$113 billion in 2017.⁵⁶

Primary care. Research shows that access to primary care, understood as having a usual place of care, continuity over time, care coordination, and a whole-person focus— rather than focusing on a particular disease or body part as specialty care often does – leads to better health.⁵⁷ Greater emphasis on primary care lowers overall costs by facilitating

earlier intervention in disease processes, staying current with preventive measures, and reducing the use of emergency departments. Eliminating cost sharing is crucial to meeting these goals.⁵⁸

The U.S. lags behind other countries in both access and health status, and spends far more, partially due to a shortage of primary care physicians.⁵⁹ Although estimates differ as to the magnitude of the growing shortfall of primary care physicians, all agree that it is significant. The mid-range projected shortfall in primary care physicians is 7,800 to 32,000 by 2025, increasing to 7,300 to 43,100 by 2030.⁶⁰ In addition to this general shortage, many geographic regions and populations are currently suffering due to a severe shortage of primary care physicians. According to the U.S. Health Resources & Services Administration, there are 6,790 health professional shortage areas⁶¹ that need primary care physicians, predominantly in rural and low- income urban communities and among specific population groups within a geographic area such as the homeless, migrant farmworkers, and other groups.⁶² Over 69 million people live in a shortage area – more than one in five Americans.⁶³ More than 10,000 primary care physicians are needed now to provide the care they need.⁶⁴

The market has clearly failed to distribute primary care physicians where they are needed or to fulfill overall demand. A difference in compensation between specialists and primary care providers, coupled with the massive debt many students incur in becoming physicians, has resulted in too few primary care physicians. On average, primary care physicians earn far less than specialists. A recent survey found that average annual full-time physician compensation was \$294,000 with specialist compensation 46% higher than primary care physicians at \$316,000 and \$217,000, respectively.⁶⁵ Orthopedic surgeons, at the top of recent compensation surveys, make more than twice as much as family medicine physicians, who are at or near the bottom.⁶⁶ A Medicare-for-all program could address these needs, for example, by increasing the number of primary care residencies, scholarships, and loan-repayment programs; targeting education of primary care physicians through dedicated Graduate Medical Education funding; and increasing the reimbursement of primary care physicians.⁶⁷ Although none of these ideas is new, a Medicare-for-all program

would reorient our healthcare system to put primary care at the center with a focus on preventive care and early intervention and treatment.

Physician compensation. First, to prevent inequity in access and care, physicians who accept payment from the Medicare-for-all plan would be prohibited from also receiving compensation for patient care from private payers, including patients themselves. Second, physicians would be required to accept payment by the Medicare-for-all plan as payment in full. There would still be some physicians who would cater to the wealthy, but there would not be inequity in access or care within the system based on higher reimbursement from private payers or additional fees charged on top of the Medicare-for-all payment rate. Finally, no part of physician compensation would derive from incentives to provide less care such as performance bonuses linked to utilization or profitability.⁶⁸

Representatives of physicians, and other practitioners, would negotiate compensation with representatives of the Medicare-for-all plan. Physicians and their staff would spend far less time on insurance-related administrative matters such as billing and prior authorization for treatment. This decrease in overhead expenses would factor into overall compensation. Compensation would be on either a fee-for-service basis or by a fixed salary, for those working for an organization paid on a per capita basis or operating under a global budget.

The negotiations would also address the difference in compensation between primary care physicians and specialists. This pay inequity lies in undervaluing the cognitive-based services that primary care physicians provide compared to procedure-based services that specialists tend to provide.⁶⁹ Unlike surgeons and other specialty physicians who are paid based on the number of procedures they perform and often use complex, expensive equipment, “primary care physicians spend most of their time providing cognitive services, such as acquiring and assimilating information, developing management strategies, coordinating care, and counseling.”⁷⁰ While some specialists would still be compensated at higher rates than the primary care generalists, the difference between rates would be reduced.

Conclusion

Numerous studies document the many inefficiencies of our “system” and its high financial costs. Likewise, study after study documents our failure to provide healthcare to all those who need it, as well as the vast disparities in health and healthcare in terms of class, race, and sex. Finally, our failure to guarantee healthcare to all exacerbates economic inequality through high out-of-pocket costs for care, medical debt, and bankruptcy.

The reason is clear. As discussed above, a market-driven approach to providing care is based on a business model that fundamentally conflicts with the very reason that people purchase health insurance. Whereas private insurers aim at limiting the amount they “lose” by paying for healthcare, people purchase insurance for the express purpose of accessing healthcare when they need it. A Medicare-for-all program would be accountable to the people, not to shareholders and the bottom line. Rather, it would facilitate the distribution of healthcare resources, such as new facilities and equipment, based on human need, not market share. Compensation for physicians and other healthcare providers would encourage better primary and preventive care. Rural and low-income urban areas would no longer be neglected. Additional resources would be directed to medically underserved areas and populations.

The threat by Congress and the Trump Administration to repeal the ACA makes this a crucial and timely issue. Although the ACA has improved healthcare insurance access, it did so by further entrenching the private insurance industry. Improving our current Medicare system and expanding it to cover everyone is the best solution. If we stand together, we can achieve it.

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- ³⁷ To prevent tiered care, insurers, including employers who self-insure, would be prohibited from providing coverage for benefits provided by the Medicare-for-all plan, but could offer supplemental insurance. Typically, temporary assistance for up to five years would be provided to workers displaced by the change.
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