

PERSPECTIVE

# MEDICARE FOR ALL 2020

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Healthcare reform has historically been an incremental process in the United States. What began nearly 100 years ago as a political slogan as part of President Teddy Roosevelt's unsuccessful run for a third term in 1912 evolved into a program proposed to Congress by President Harry S. Truman in 1945. However, it was not until 1965 that Medicare was signed into law by President Lyndon B. Johnson with former President Harry S. Truman becoming Medicare Member 0001 effective July 1, 1966.

delivered. On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law. This reform was largely built off the employer-based system and it reduced, but did not eliminate, the number of uninsured.



**Medicare for All would lead to lower physician salaries and shortages of health care services.**

**Medicare for All is supported by 27% of the entire House of Representatives and calls for a revamping of the US healthcare system that will result in reduced physician salaries and shortages of health care.**

Since 1965, healthcare reform in the United States has continued to move slowly and managed care has been a central and growing part of how health care is

On February 27, 2019, Representative Pramila Jayapal (D-WA) introduced H.R. 1384, the Medicare for All Act of 2019 with 117 cosponsors (out of 435 members, or 27% of the entire House of Representatives).<sup>1</sup> This bill was first introduced in 2003 and has been reintroduced many times since then, but never with the degree of support seen today. Simultaneously, the comparatively moderate ACA has declining enrollment paired with another legal challenge destined for the Supreme Court. In spite of challenges, the progressive wing of the Democratic party is supporting the proposal that would radically change how health care is provided in the United States. On April 30, 2019, Medicare for All had its first congressional hearing by the House Rules Committee.

## Overview of Major Changes in Medicare for All

Unlike the ACA, where the mantra, "if you like your care, you can keep it," held true, Medicare for All would unapologetically change coverage for the 85% of the country not currently in Medicare plus a third of those enrolled in Medicare.<sup>2</sup> The major changes include the following:

1. Every U.S. resident (including non-citizens) would be covered.
2. Managed care plans (which cover all of the commercially insured population), 34% of Medicare, and 81% of Medicaid would be eliminated.

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(President Lyndon Johnson signs the Medicare Bill at the Harry S. Truman Library and Museum in Independence, Missouri. LBJ Library photo by unknown, 34897-22. Taken July 30, 1965.)



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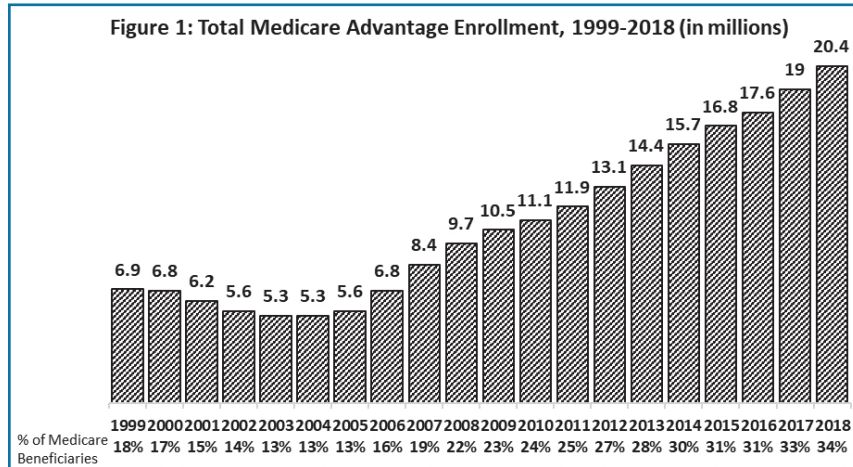


Figure 1: Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2018, and MPR, 1999-2007, enrollment numbers from March of the respective year, with the exception of 2006, which is from April. NOTE: Includes cost plans as well as Medicare Advantage plans. About 61 million people are enrolled in Medicare in 2018.

3. Cost sharing, which is 20% in the Medicare program today, would be 0% in Medicare for All.
4. Payment for the Medicare program has not been developed in the bill, but would be funded by Federal revenue, therefore, taxes would need to be raised to fund the coverage expansion.

There are fundamental economic, political, and legal ramifications associated with the extensive changes attendant to enacting H.R. 1384. Here, we limit our scope to consideration of the plausible economic consequences and political importance of H.R. 1384 in the approaching 2020 election. The lack of legal precedent in U.S. history and the ramifications on the employment of hundreds of thousands working in managed care in the workforce will not be addressed in this article.<sup>3</sup>

**Prices**

While Medicare and Medicaid currently set prices for all healthcare providers electing to participate in either government program, the coverage of the commercial population through Medicare will use global budgets to pay institutions. This implies the elimination of

commercial fees paid to hospitals, providers, and potentially pharmaceutical companies. There would no longer be “free market” prices—all fees for all providers would be set by the Federal government and, as with current government prices, would be lower than the commercial insurers’ prices today. Additionally, because most physician service costs are salaries, then salaries will go down for all healthcare providers including physicians, nurses, and other clinical and support staff. When salaries decline, the result is a *reduction in the supply* of physicians, nurses, and other clinical and support staff.

**Cost Sharing**

H.R. 1384 says there will be no cost sharing, meaning \$0 cost at the point of service. While this will have little impact on demand for inelastic services such as brain surgery and dialysis, more elastic services such as physical therapy and outpatient specialist visits will see large volume increases, thereby increasing *demand*.<sup>4</sup> Health economics predicts that reducing cost sharing to zero would lead to overutilization of services.<sup>5</sup> When an increase in demand meets a decrease in supply, there is a shortage, resulting in the longer lines

and waiting times that we see for certain services in Canada and the United Kingdom.

**Premiums versus Taxes**

Many opponents of Medicare for All will decry the multi-trillion dollar estimated costs of the program. However, the costs are misleading because 50% of health care is already paid for by the government via Medicare and Medicaid. And the other 50% is paid by a combination of employer premium contributions, employee premium contributions and to a smaller extent, consumer out of pocket costs. For the working population, both taxes and healthcare premiums are line items deducted from a paycheck—workers never see those dollars in their bank accounts. If premiums are eliminated and absorbed into taxes on average, this makes no difference to the taxpayer. On average, Medicare for All would *not* be a new expense, it would simply be paying the same bill to a different vendor, like switching cell phone companies or electricity providers. However, at the individual level, the wealthy would shoulder a higher percentage of medical costs and lower income persons would pay less. For example, Medicare is paid for with a payroll tax of 1.45% (disregarding the employer portion for simplicity). This means that a family earning \$50,000 in wages pays \$725 towards Medicare per year in taxes. A family earning \$500,000 a year pays \$7,250 per year. The proposal does not identify how the cost burden of the program would be distributed.

**Administrative Savings**

Estimates of administrative costs due to private insurance vary, but they may be as high as 12%, while countries like the United Kingdom and Canada likely have much lower administrative burdens and Medicare’s costs are closer to 2%.<sup>4</sup> Overall administrative costs could theoretically

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be reduced from the 12% of private insurers to 2% in the Medicare program, at best a 10% point reduction. Still, the administrative savings come at a price, particularly physicians' reduction in reimbursement rates, since historically, government-set fees are lower than commercial fees.

**Managed Care Organizations**

While many consider managed care organizations a cost driver in the system due to very real, time intensive and frustrating administrative complexities, such as claims denials and pre-authorizations, these organizations have become *more popular*, not less, in the past 15 years as a part of the Medicare program. Nearly 80% of Medicaid beneficiaries and 32% of Medicare beneficiaries were enrolled in an MCO by 2017.<sup>6</sup> Given the increase in market penetration, it seems unlikely that policymakers would take a popular, voluntary program insuring one-third of Medicare beneficiaries and end it. In addition, no developed country has restricted private insurance in the way that HR 1384 would require.<sup>7</sup>

**Next Steps for Medicare for All**

Medicare for All as it is currently written in H.R. 1384 will not happen. However, its presence and the mere discussion in the House Rules Committee hearings on April 30<sup>th</sup> and May 1<sup>st</sup> forces health policy on the offensive and creates a litmus test for Democrats running for the 2020 nomination to determine whether they are part of the Progressive wing, like Bernie Sanders and Elizabeth Warren who support the bill, or the centrist wing like Joe Biden who opposes it. Expanding health care has proven a reliable source of strength for Democrats; health policy is also a lightning rod, and nobody knows this more than the current frontrunner, Joe Biden. The political backlash resulted in the loss 63 of 256 Democratically held seats (25% of all House seats held

by Democrats) in November 2010, less than 8 months after the passage of the ACA. Therefore, there are a few likely scenarios after the 2020 election and only one of them results in any chance of a serious effort to pass Medicare for All.

**What Happens in 2020?**

It is understood that Medicare for All cannot move past hearings in the House of Representatives before the 2020 election. After the election there are a limited number of possibilities:

- If Donald Trump is re-elected, we can expect no action on Medicare for All and possibly a renewed legislative effort to overturn the ACA.
- If a centrist Democrat, like Joe Biden, is elected then the health policy focus will be incremental, such as fortifying the strength of the ACA.
- Medicare for All legislation only has a chance at gaining momentum with a strong electoral victory of a Progressive Democratic candidate paired with control of the Senate and elimination of the filibuster. In addition, the new president would have to take this on as the primary legislative task amidst other pressing issues such as income inequality, climate change, tax policy, and others.

These three scenarios show that there is a narrow, winding, but plausible pathway for Medicare for All at the start of the new Presidential term in January 2021. However, Medicare for All, with all of its economic issues, is likely a progressiveness litmus test for Democrats rather than a realistic and viable piece of legislation.

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