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Sixteen for '16 - Number 4: Medicare for All

By Salvatore Babones, Truthout | Op-Ed

That every American should have inexpensive access to all necessary health care is not a matter for debate. As with our education system, our long-standing traditions of local control and community care should remain bedrock principles of our health care system.

Medicare for all: The title says it all. A civilized country needs universal health care, and the only effective way to provide it is through a government-managed program. The United States already has several government-managed programs, but by far the most effective and most efficient is Medicare. Medicare may not be perfect, but it works.

Almost every American age 65 and over is covered by Medicare. If Medicare can deliver sound health care for this group - the highest-risk part of the population - it should be able to deliver sound health care for the rest of us. Medicare already pays more than 20 percent of all personal health care expenses in the country.(1) It is well on its way to being a universal program.

Medicare is an insurance program in four parts. Part A covers hospital bills. Part B covers doctors' bills. Part C, also known as Medicare Advantage, is an optional private insurance plan that Medicare recipients can choose to receive instead of Parts A and B. Part D, the newest part, is a private insurance plan for prescription drugs.

Medicare needs a lot of work. Private Medicare Advantage plans should be made simpler and more comprehensive. The federal government should take back the right to negotiate Part D drug prices that President Bush gave up in 2003. Many other tweaks, refinements and improvements should be made.

But the bedrock principle that every American should have inexpensive access to all necessary health care is not a matter for debate. Other civilized countries recognized that health care is a basic human right decades ago. Presidents Truman, Nixon and Clinton all believed in the necessity of universal health care and tried to pass legislation to make it a reality.

President Obama used his first-term majority to push through the Affordable Care Act of 2010 (ACA), popularly known as Obamacare. The ACA is better than nothing at all, but it is a band-aid for a sucking chest wound. It is too complicated, too expensive, riddled with perverse incentives for insurance companies and not truly universal in coverage. Worse, many states are simply not cooperating in its implementation.

By contrast, Medicare is straightforward and universal. Everyone is covered, and everyone gets the same minimum coverage. Add-ons are optional. Medicare doesn't cover everything, but it is good enough for most people most of the time. It is tried and tested; it is cost-effective; and it works.

Medicare was created in 1965 to deal with a simple fact of life: the fact that we're all going to die. Death can be very expensive, and someone has to pay for it. Fortunately or unfortunately (depending on your perspective), it can be difficult to collect from the dead.

Thus Medicare. By design, Medicare is an insurance program both for individuals and for hospitals. Individuals are insured against illness. Hospitals are insured against uncollectible bills. This insurance for hospitals is at least as important as insurance for individuals because it reduces the incentive for hospitals to turn people away based on their ability to pay.

Hospitals can't legally or ethically refuse to treat dying patients, but they can use many tricks to encourage the riskiest patients to go elsewhere. Medicare reduces the risks hospitals face in treating the elderly and thus makes it possible for elderly Americans to get appropriate care.

The need to save hospitals from bankruptcy is the reason Medicare is targeted to cover those most at risk of death: people over age 65, people who need regular dialysis to ward off terminal kidney failure, people with ALS (Lou Gehrig's disease) and some disabled people. In total, nearly 50 million Americans are covered by Medicare.

Medicare is not the only government health program, but it is the most universal government health program: Nearly everyone who lives to age 65 will be covered. Other government-sponsored health care programs are less effective at ensuring appropriate care - in part because they are not universal. They also tend to provide less generous benefits than Medicare. The result is that hospitals and physicians can be reluctant to treat people under age 65 without proof of their ability to pay.

The biggest government health care program isn't Medicare. It is the joint federal-state program Medicaid, which covers 56 million Americans.(2) Medicaid is a means-tested health care program for low-income families and individuals. Enrollment is not automatic, and many states severely restrict eligibility. Medicaid is not really one national program, but a panoply of distinct state programs.

The ACA expanded Medicaid eligibility from the poor to the near-poor. By operating through the Medicaid program, the ACA effectively put control over expanding government health insurance coverage for poor Americans in the hands of the states. The ACA also allows states to set up their own insurance exchanges for the non-poor. This further reinforced the fragmentation of the US health care system into multiple state systems.

Since Medicaid is administered by the states, coverage is a kind of poverty lottery: In general, it is much better to be poor in progressive-leaning states than in conservative-leaning states. The federal government pays the majority of the costs of Medicaid, but states are not required to take the money. As a result, most conservative-controlled states are refusing to implement the Medicaid expansion funded by the ACA.(3)

Worse, states tend to pay physicians much less to care for Medicaid patients than the federal government pays them for Medicare patients, making it difficult for Medicaid patients to find doctors. The Kaiser Family Foundation reports that the national average Medicaid physician payment is just two-thirds the level of Medicare physician payments.(4) The result is that many physicians decline to treat Medicaid patients, who end up in emergency rooms instead.

A much-reported study showing dramatically increased emergency room usage among people who receive Medicaid coverage proved this point.(5) Medicaid is not a vehicle for reducing health care costs because Medicaid is so poorly designed. Medicaid is a better-than-nothing anti-poverty program, not a good health care program. It is no substitute for a true national program like Medicare.

In addition to Medicare and Medicaid, another 19 million Americans are covered by other government insurance programs.(6) Accounting for people who hold multiple government insurance policies at the same time, just over 100 million Americans are covered by some form of government health insurance.(7) That's nearly one-third of the US population.

With one-third of the population already covered by government-sponsored health insurance, two conclusions are obvious. First, the 100 million people covered by government insurance should be consolidated into a single program. Second, the other 200 million Americans should be offered access to that program as well. And the obvious program to offer them is Medicare.

The strength of Medicare is that it combines national funding and program administration with local service and provision of care. Doctors and hospitals accept patients secure in the knowledge that they will be paid a reasonable fee for their services. Patients can choose their own doctors and hospitals, so they can develop relationships with people they trust from their own communities.

Patients also have the ability to trade away their right to choose in exchange for expanded services under Medicare Part C (Medicare Advantage). Medicare Advantage now enrolls 28 percent of Medicare patients, up from less than 7 percent a decade ago.(8) Nonetheless, despite financial incentives to switch to Part C, most Medicare enrollees decide to keep traditional Medicare coverage - and with it control over their own health care.

Medicare Advantage plans cost more than traditional Medicare coverage because the private insurers who run them have to cover the costs of marketing, shareholder returns and exorbitant executive salaries.(9) Once these extra costs are factored in, Medicare Advantage providers are unable to compete with traditional Medicare. Medicare Advantage enrollment rose above 7 percent only after the federal government started to subsidize these plans in 2003.

In effect, Medicare enrollees had to be bribed to move over to Medicare Advantage. Without the sweeteners, nearly everyone preferred traditional Medicare. The private sector simply could not

generate enough efficiencies to overcome its higher costs and enrollees' preference for control over their own health care.

That should be a lesson to the rest of us. The ACA uses the threat of a tax penalty (the "individual mandate") to push everyone under age 65 into employer-sponsored health insurance, Medicaid, or the new health insurance exchanges. All of these systems limit patient choice and put either public or corporate bureaucrats in charge of our health care.

The argument for bureaucratic control over health care - or managed care - is that it is supposed to reduce costs. But the experience of Medicare Part C shows that this is not the case. Medicare Part C Medicare Advantage programs cost, on average, 13 percent more than traditional Medicare.(10) Even with this 13 percent subsidy, 72 percent of Medicare patients turn down the managed care option.

Along with the education system, the health care system is a key component of America's human infrastructure. As with our education system, our long-standing traditions of local control and community care should remain bedrock principles of our health care system. The strength of our communities is ultimately the strength of our country.

Managed care is not community care. The choice between managed care and Medicare is more than a choice between an expensive system that generates corporate profits and an efficient system that serves the public interest. It is a choice between bureaucratic decision-making and personal empowerment.

Considering that traditional Medicare is both cheaper and more desirable than the options offered under the ACA, the simple promise of Medicare for all should be a top progressive priority for 2016. The whole US health care system is broken, but Medicare isn't what broke it. Medicare is what holds it together. Instead of having to wait until they turn 65, Americans should be enrolled in Medicare at birth.

All progressives accept the principle that everyone needs health care. The question is how to pay for it. The ACA is a baby step in the right direction. The next step should be much more ambitious. If everyone needs health care, we should make sure they get it in the most effective way possible. Medicare for all is simple, efficient and affordable. It is a winning policy for 2016.

1. Centers for Medicare & Medicaid Services National Health Expenditure Data Table 6.
2. Centers for Medicare & Medicaid Services National Health Expenditure Data Table 22.
3. Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision, 2014
4. Kaiser Family Foundation, Medicaid-to-Medicare Fee Index, 2012.
5. Taubman et al (2014), "Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment," Science 343: 263-268.
6. Centers for Medicare & Medicaid Services National Health Expenditure Data Table 22.

7. Census Bureau Current Population Survey Annual Social and Economic Supplement Table HI01. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2012.
8. Kaiser Family Foundation, Medicare Advantage Fact Sheet, 2013.
9. The Advisory Board Company, "Pay for Health Care CEOs Exceeds All Other Industries," 2013.
10. Biles et al (2009), "The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to $11.4 Billion in 2009," The Commonwealth Fund.