Medicare for All rally, June 2017.
Should we support Medicare buy-ins?
Only your health economist knows for sure!

Interest in “Medicare for All” health reform is accelerating in Congress. Many of the November 2018 “blue wave” winners advocated vocally for single-payer health insurance. In the House of Representatives, now controlled by Democrats, the bill H.R. 1384 (Rep. Pramila Jayapal [D-WA], replacing H.R. 676) is the mainstay, and committee hearings have been announced, while in the Senate, Bernie Sanders (D-VT) has introduced his version, S. 1804.

Public support for single-payer insurance is astounding, with 68 percent in a recent poll placing high importance on achieving it. The most vociferous supporters are progressives and minorities, but single payer garners support from across the political spectrum. Perhaps it’s unsurprising that so many people are pulling for a reform that is both efficient and generous—how often do those go together? Single payer insurance is not just a policy tweak, nor another layer of complexity on our health-care non-system. It’s revolutionary and transformative and has the potential to both benefit from and build powerful coalitions.

The same cannot be said for all approaches offered by Democrats. They have also proposed several bills for Medicare expansions—mechanisms for individuals to “buy in” to Medicare coverage. At first, they sound attractive, an incremental insurance expansion in the direction of Medicare for All. But close consideration reveals fundamental flaws. There is a long list of reasons that all of us—and especially the labor movement—should oppose these Medicare-for-All impostors in favor of the real deal.

Let’s start by clarifying key terms. “Medicare for All” and “single payer” refer to plans that scrap existing health insurers (private, Medicaid, safety net programs, etc.) in favor of a single universal public insurance program, an “improved Medicare for All.” Everyone is covered, cradle to grave, with an identical comprehensive benefits package. Health-care providers use a single billing schedule and mechanism. All current public funding (65 percent of health spending) shifts to the new program; private insurance premiums and out-of-pocket spending end; and progressive additional taxes pick up the slack. Single payer raises costs by increasing access to care, but saves even more money through administrative efficiency, lower drug costs, and other approaches, such as restricting the use of ineffective procedures. Over time, comprehensive budgets for the entire system—called “global budgets”—slow the growth of health spending. Thus, everyone is covered while costs are brought under control.

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“Medicare buy-in” or “public option” plans are an entirely different entity. These set up mechanisms (e.g., in the state health exchanges)
for populations less than 65 years old (the eligibility age for Medicare) to join Medicare or a similar public program by paying a premium. Initially, it sounds like a gentler alternative—easing passage in Congress, increasing “choice” of health insurance, and slowly building our premier public health insurance plan. However, looks are deceiving. Medicare buy-in is fundamentally different than Medicare for All—a slight tweak (indeed an added complexity) to our already Rube Goldberg health system, instead of the needed wholesale revamping. And certainly not a meaningful step toward Medicare for All.

There are crossover versions as well. One plan outlines a many-decades-long process of building to a predominantly public insurance system. Even within some single-payer bills, some more problematic features of the current financing system are continued, such as subsidies for for-profit providers. (See Max Fraser’s “Organized Money” column in this issue, which details the maneuvers of the health-care industry to prevent meaningful Medicare for All.)

For those interested in details of all of these plans, Vox recently published a thorough, clear, and nuanced review of Democratic “Medicare” reform plans. This review adopted a neutral stance: all the plans would increase coverage. The authors remained agnostic on the relative merits of Medicare for All and Medicare buy-in expansions—an “It’s all good” perspective.

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But is it? Where should labor position itself? Supportive of any “Medicare” expansion? Or resolutely committed to Medicare for all? After 25 years researching, writing, educating, and advocating in this arena, I propose that single payer is the only solution consistent with universal, affordable health care and with the solidarity values long supported by the labor movement.

Why? There are 13 reasons that Medicare for All is superior to Medicare buy-ins:

1. **Medicare for All insures everyone.** Only with single payer do we reach 100 percent coverage. Medicare buy-ins will leave 5 percent or more of the population uninsured (15 million people), and even more underinsured, with inadequate plans. This matters—having reliable insurance enhances happiness and health. There’s no reason we shouldn’t seek full coverage, if it’s affordable . . . which it is (see point 7).

2. **Medicare for All insures everyone well.** Underinsurance—substantial deductibles, financial caps, and uncovered providers and services—leads to foregone and delayed medical care. In the current system (preserved under Medicare buy-ins) under-coverage is rife, as a cost-control mechanism for employers and insurers. With single payer, coverage is first-to-last dollar, for all medically appropriate care, and with no provider restrictions. This assures optimal access to care.

3. **Medicare for All keeps everyone in the same game.** If everyone is covered by the same insurance, everyone will share a commitment to that insurance. Think how well public fire departments and utilities, such as garbage collection, work. This shared experience has both practical and solidarity benefits. On the applied side, it assures that implementation challenges are resolved in a suitable fashion, with excellent performance standards preserved. In the current piecemeal financing system, insurance for the poor (like Medicaid) and for the middle class (private plans), lacking powerful political support, suffer underfunding and onerous rules. Shared participation also fosters social cohesion. This benefit should not to be under-valued. Single payer would represent a major statement for solidarity and thus provide a foundation for a society that values and pursues social justice.

4. **Medicare for All removes health care as a bargaining burden.** In contract negotiations, the time-consuming effort
to achieve and protect health care would be off the table if the country adopts Medicare for All. The bargaining focus would return to wages, non-medical benefits, work conditions, and other central labor concerns.

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5. Medicare for All delinks health care and employment. Assuring health insurance regardless of work setting, indeed regardless of work status, allows workers to make job and training choices based on personal and professional preferences. No more suffering a dead-end job for the insurance. This would empower individuals to change jobs or take on new business ventures as desired. With the option to exit, workers would have increased leverage to improve suboptimal work situations.

6. Medicare for All enhances administrative efficiency. Our health-care system wastes $400 billion per year in unnecessary complexity of billing and payment. That’s about $1400 per person per year in excess paperwork. Single payer would thus result in a one-time 10 to 12 percent savings in health spending, about evenly split between the insurance and provider sides. These funds would shift to clinical care.

7. Medicare for All controls health-care costs in other ways. Aside from administrative streamlining, single payer saves money in other ways. The two most important: 1) Drug costs drop by about 30 percent, through the use of a single-drug formulary and tough price negotiations with pharmaceutical companies. The U.S. Veterans Administration already has these savings, as do other wealthy nations. 2) Growth in spending is controlled over time, through the use of the above-mentioned global budgets. Only an integrated system with central fiscal authority can accomplish this. Instead of impossibly complex oversight of specific clinical decisions (“utilization review”) or “accountable care” strategies that have proven ineffective, single payer would impose financial limits and providers would figure out how to work within them. The resolution of program performance and costs would be acceptable, because everyone would need them to be (see point 3).

8. Medicare for All enhances quality. Single payer sets the stage for improved quality. With a single billing system, there would be comprehensive uniform clinical data, which would facilitate technically sound monitoring of care choices and clinical outcomes, including evaluation of care innovations.

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9. Medicare for All reduces clinical waste and fraud. According to the U.S. Institute of Medicine, about 20 percent of care is unnecessary, not indicated, or just plain fraudulent. The same comprehensive clinical data systems that enhance quality may also save substantial money by detecting and reducing waste and fraud.

10. Medicare for All empowers patients. Under a single-payer health plan, individuals can choose the doctors they like. There are no restricted provider networks, so people will choose based on quality, reputation, and personal preference rather than insurer approval.

11. Medicare for All empowers doctors (and other providers). Health-care
providers, relieved of administrative hassles, can focus fully on clinical issues. The electronic health record, which has become an onerous intrusion on provider time and patient communication, can with simple insurance once again serve its proper role of clinical documentation. Doctors can return to full-time—doctoring!

12. Medicare for All fosters a comfortable and lasting patient-doctor relationship. With patients empowered to choose preferred doctors, and doctors empowered to concentrate on clinical care, the patient-doctor relationship will experience a renaissance. Medicine will be more humane and effective.

13. Medicare for All ends battles to protect myriad pieces of the current health system. Achieving single payer requires a massive political struggle, to be sure. However, with an unsympathetic administration in Washington D.C. and in some states, there are endless ongoing battles, to preserve funding and functionality for Medicaid, to regulate private insurers, to protect traditional Medicare. Under single payer, these battles would cease.

Ultimately, Medicare for All Supports Core Labor Values

For complicated reasons, largely centered on employer-based health-care plans, some unions have opposed single payer. This misses larger considerations: single payer is about supporting working people (and the unemployed, and the rich) with the resources needed for a comfortable, secure life. The labor movement did as much as any great social reform to foster health and security. Single payer is the next great step in this tradition.

Determined opponents of single payer will strive to undercut these critical strengths, even within the context of Medicare-for-All bills. For example, the current version of Senator Sanders’ bill, S. 1804, allows for use of “Accountable Care Organizations” (ACOs)—structures that try to financially incentivize medical groups to lower costs, developed under Obamacare. There are two big problems with this approach. First, there’s no evidence that ACOs (also known as “risk sharing”) meaningfully reduce costs or increase quality. It was a reasonable idea, but large tests demonstrated that it doesn’t work, except in the most tentative and miniscule ways. Second, using ACOs requires organizing providers into large groups, which insurers will attempt to exploit as a back-door to retaining a (profitable) role in health-care financing. Thus, we must work with the champions of Medicare for All in Congress to retain the core elements of true reform and resist counterproductive add-ons.

Beyond this it is important to end the confusion among plans—to clarify the differences between the impostors and the real thing. Let coworkers know what the real Medicare for All is: Everyone is covered, with the same comprehensive benefits package, from cradle to grave. This is critical to reduce the opposition of some unions, which represent a large portion of workers with employer-provided health care, but a small portion of working people overall. Everyone needs to understand that true Medicare for All is the only way to assure excellent access to health care, regardless of income and employment, and to empower providers and patients to focus on quality care and on each other, not on insurance glitches and administrative paperwork. We all need to reach out to elected representatives.

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