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Turning Ideas Into Policy

What You Need to Know about Medicare for All

Medicare for all would be costly, would lead to more health-care rationing, and would not solve one problem in Obamacare.

John C. Goodman, Ph.D.
President and CEO
Goodman Institute

Quite a few Democratic candidates for office this year are campaigning on the idea of enrolling everyone in Medicare. It's not just the left. A significant number of doctors in the American Medical Association are for it. Public opinion polls show that 70 percent of Americans like the idea.

Here are ten things you need to know.

1. Medicare is not really government insurance.

Almost everybody on the political left thinks that Medicare is a government plan – one that is completely different from private insurance. Yet that view is wrong.

Although Medicare is largely funded with tax dollars, it has never been a strictly government program. Medicare's original benefit package copied a standard Blue Cross plan that was common back in 1965. And Medicare has always been privately administered – in many places by Blue Cross itself. That's the same Blue Cross that administers private insurance sold to non-seniors.

Moreover, in recent years, one-third of all seniors – and perhaps as many as half of young seniors – are enrolled in plans offered by Humana, Cigna, UnitedHealth care and other private insurers under the Medicare Advantage program. These private plans are virtually indistinguishable from the private insurance non-seniors have.

One-third of seniors on Medicare are enrolled in private health insurance plans.

2. The most successful part of Medicare is run by private insurers.

A study published in ***Health Affairs*** finds that the Medicare Advantage program costs less and delivers higher quality care than traditional Medicare. Moreover, within the Medicare Advantage program the most successful plans are the ones administered by independent doctors' associations. These plans are showing that integrated care, coordinated care, medical homes and electronic information sharing actually work – to keep patients healthier and improve medical outcomes.

But there is nothing special about Medicare in this regard. These are private sector innovations that are also available to non-seniors under contract with private insurers

3. Medicare is often the last insurer to adopt innovations that work.

In 2003, the benefit structure of Medicare looked pretty much the same as it did 40 years earlier. But in 1965, drugs were relatively inexpensive and their impact on care relatively modest. Through time, they became more expensive. They also became the most cost-effective medical therapy. When Medicare began covering drugs (through Part D) in 2004 it started providing coverage that virtually all private insurers and all employers had already offered years earlier.

Medicare has also been slow to adopt technologies that are becoming more common in the private sector. It won't pay for doctor consultations by phone, email or Skype. It won't pay for Uber-type house calls at nights and on weekends, although the cost and the wait times are far below those of emergency room visits. Nor will it pay for concierge doctor services, now available to seniors for as little as $100 a month – despite the potential to improve access and reduce costs.

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After years of foot dragging, Medicare now pays for telemedical services which link hospital specialists with patients in rural areas. But it won't pay for those same services in urban areas – where most people live.

4. Medicare has wasted enormous sums on innovations that don't work.

Medicare has spent billions of dollars on pilot programs and demonstration projects, trying to find ways of lowering costs and raising the quality of care. Many of these efforts have focused on integrated care and coordinated care. Yet instead of finding places in the health care system where these techniques seem to work (e.g., private Medicare Advantage plans), Medicare set out instead to reinvent the wheel. Three separate Congressional Budget Office reports concluded that these efforts would be unsuccessful, and those predictions seem to be vindicated by the test of time. Other efforts to change hospital behavior appear to have raised costs rather than lower them.

5. Most seniors in conventional Medicare are participating in stealth privatization, even though they are unaware of it.

By far the biggest recent change in Medicare has been the Obama administration's stealth program to privatize conventional Medicare and enroll seniors in managed care programs called Accountable Care Organizations. At last count, there were 32.7 million patients enrolled in an ACO, mainly people who think they are participating in traditional Medicare.

The reason for the word "stealth" is that President Obama never used the words "privatization" or "managed care" even though ACOs are mainly private entities with essentially the same economic incentives as the hated HMOs of the 1980s and 1990s. Not only did the

Obama administration never tell seniors they were participating in a grand experiment, it is illegal for an ACO to tell a senior he or she is actually enrolled!

This experiment has largely been a failure. Without the tools routinely used by Medicare Advantage plans (including the right to transparent communication with patients) ACOs are neither saving money in the aggregate nor are they improving the quality of care.

Democratic candidates for office often rail against the idea of privatizing Medicare. AARP frequently parrots the same message. Yet most seniors who think they are in traditional Medicare are actually in a private sector ACO. It was Democrats who put them there with legislation that AARP supported!

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6. There is nothing Medicare can do that employers and private insurers can't do.

For many years the Physicians for a National Health Program argued that a single payer health insurer would be a monopsonist (a single buyer) in the market for physicians' services. It could therefore use this power to bargain down the fees it pays to physicians. Putting aside the puzzle about why a doctors' organization would advocate putting the financial squeeze on themselves and their colleagues, the whole idea turns out to be wrong.

Medicare doesn't bargain with anyone. It simply puts out a price and doctors can take it or leave it. But private insurers can do that too. In fact, they can put out a take-it-or-leave-it price lower than what Medicare pays. That's what has been happening in the (Obamacare) health insurance exchanges, where the only profitable insurers have tended to be Medicaid contractors who pay Medicaid rates to providers.

Unfortunately, that means that enrollees are often denied access to the best doctors and the best facilities.

Obamacare insurance, for example, excludes MD Anderson Center in Houston (cited by US News as the best cancer care facility in the country), Southwestern Medical Center in Dallas (rated as the top medical research center in the world by the British journal Nature) and the Mayo Clinic in Rochester, Minnesota.

Employers and private insurers could be far more aggressive in keeping prices lower than they are today and far more aggressive than Medicare is. Canadians who come to the United States for knee and hip replacements (because they get tired of waiting in Canada) pay about half of what Americans typically pay. Employers and private insurers could offer the same service to patients who are willing to travel and to pay up front.

MediBid is a service that offers patients a national exchange where providers submit competitive bids that are routinely less than what Medicare pays.

7. Medicare for all would be costly.

"Medicare for all" sounds attractive to some

people because it suggests you are going to get something for nothing. But, when pressed, even Bernie Sanders admits there is no such thing as a free lunch.

A study by Charles Blahous at the Mercatus Center estimates that Medicare for all would cost $32.6 trillion over the next ten years. Other studies have been in the same ballpark and they imply that we would need a 25% payroll tax. And that assumes that doctors and hospitals provide the same amount of care they provide today, even though they would be paid Medicare rates, which are about 40% below what private insurance has been paying. Without those cuts in provider payments, the needed payroll tax would be closer to 30%.

Of course, there would be savings on the other side of the ledger. People would no longer have to pay private insurance premiums and out-of-pocket fees. In fact, for the country as a whole this would largely be a financial wash – a huge substitution of public payment for private payment.

Medicare for all...is no free lunch. A study...estimates that Medicare for all would cost $32.6 trillion over the next ten years.

But remember, in today's world how much you and your employer spend on health care is up to you and your employer. If the cost is too high, you can choose to jettison benefits of marginal value and be more choosey about the doctors and hospitals in your plan's network. You could also take advantage of medical tourism (traveling to other cities where the costs are lower and the quality is higher) and phone, email and other telemedical innovations described above. The premiums you pay today are voluntary and (absent Obamacare mandates) what you buy with those premiums is a choice you and your employer are free to make.

With Medicare for all, you would have virtually no say in how costs are controlled other than the fact that you would be one of several hundred million potential voters.

Remember also that there is a reason why Obamacare is such a mess. The Democrats in Congress convened special interests around a figurative table – the drug companies, the insurance companies, the doctors, the hospitals, the device manufacturers, big business, big labor, etc. – and gave each a piece of the Obamacare pie in order to buy their political support.

As we show below, every single issue Obamacare had to contend with would be front and center in any plan to replace Obamacare with Medicare for all. So, the Democrats who gave us the last health care reform would be dealing with the same issues and the same special interests the second time around.

It takes a great deal of faith to believe there would be much improvement.

8. The real cost of Medicare includes hidden costs imposed on doctors and taxpayers.

Blahous estimates that the administrative cost of private insurance is 13%, more than twice the 6% it costs to administer Medicare. Single-payer advocates often use this type of comparison to argue that universal Medicare would reduce health care costs. But this estimate ignores the

hidden costs Medicare shifts to the providers of care, including the enormous amount of paperwork that is required in order to get paid.

Medicare is the vehicle by which the federal government has been trying to force the entire health care system to adopt electronic medical records – a costly change that appears to have done nothing to increase quality or reduce costs, while making it easier for doctors to "up code" and bill the government for more money.

There are also the social costs of collecting taxes to fund Medicare, including the costs of preparation and filing and the costs of avoiding and evading taxation. By some estimates, the social cost of collecting a dollar of taxes can be as high as 25 cents.

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A Milliman & Robertson study estimates that when all these costs are included Medicare and Medicaid spend two-thirds more on administration than private insurance spends.

Single payer advocates are also fond of comparing the administrative costs of health care in the United States and Canada – again claiming there is a potential for large savings. But these comparisons invariably include the cost of private insurance premium collection (advertising, agents' fees, etc.), while ignoring the cost of tax collection to pay for public insurance. Using the most conservative estimate of the social cost of collecting taxes, economist Benjamin Zycher calculates that the excess burden of a universal Medicare program would be twice as high as the administrative costs of universal private coverage.

9. Not a single problem in Obamacare would go away under Medicare for all.

If everyone could join Medicare, what premium would they have to pay? Would the premiums be actuarially fair, representing the expected cost of the enrollee's heath care? Or would there be subsidies and cross subsidies as there are under Obamacare? Would the premium vary by age? By income? By health status? By healthy living choices?

What about the role of employers? Obamacare tried to force them to pay a large part of the cost of reform by imposing a mandate and requiring them to cover a liberal set of benefits. Economists tell us that employee benefits are substitutes for wages and are therefore "paid for" by the employees. But on paper, employers write checks for about 75% of the cost of insurance for about 95% of the people who have private insurance. Under Medicare for all, would they get off scot free?

Then there is the exchange. Medicare has one. It's how roughly one-third of seniors get into Medicare Advantage plans. Like the Obamacare exchanges, the Medicare Advantage exchange has government subsidies for private insurance, mandated benefits, annual open enrollment and no discrimination based on health status. And, it seems to work reasonably well.

The Obamacare exchanges, by contrast, have been a disaster – with spiraling premiums, unconscionably high deductibles, extra charges for chronic patients who need specialty drugs, and a race to the bottom on provider networks

that exclude more and more of the best doctors and the best hospitals.

What will happen when the same politicians, catering to the same interest groups that gave us Obamacare, set out to design an exchange for their Medicare-for-all program? That's anyone's guess.

But if Democrats know how to defy the special interests and create a workable exchange, wouldn't they have done that already in the market for individual insurance?

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10. Medicare is already on a path to health care rationing.

Medicare is already on an unsustainable path. It has made future promises that far exceed expected revenues, based on the Medicare payroll tax and Medicare's share of general federal revenues. Ironically, Democrats, rather than Republicans, were the first to formally acknowledge this fact. At the time Congress passed the Affordable Care Act (ACA) creating Obamacare, the Medicare trustees estimated the unfunded liability in the program at $89 trillion – stretching out indefinitely into the future. Yet, in the next trustees' report that figure had dropped to $37 trillion.

Think about that. When Barack Obama signed the ACA into law, he wiped away $52 trillion of federal government debt. How did that happen? By theoretically putting the government's health care spending on a budget.

For the past 40 years real, per capita health care spending has been growing at twice the rate of growth of real per capita income. That's not only true in this country; it is about the average for the whole developed world. You don't need to be an accountant or a mathematician to know that if an expenditure item is growing at twice the rate of growth of your income, it will crowd out more and more of other spending – eventually taking up the entire pie.

To deal with this problem, Obamacare promised to restrict three budgets to a rate of growth no greater than the rate of real GDP growth per capita plus about ½ of a percent . These budgets are total Medicare spending, Medicaid hospital spending and (after 2018) federal tax subsidies in the health insurance exchanges.

If these budgets are binding, the burden of excess growth in health care spending for the federal government will have been relieved – forever.

But here is the problem. The Obama administration only "solved" the problem with pen and ink. It didn't give the private sector any new tools to control costs. It didn't empower doctors or hospitals to practice medicine in a more efficient way.

There was an enforcement mechanism: An Independent Payment Advisory Board (IPAB), tasked with the job of keeping spending below the cap – mainly by recommending reductions in fees to doctors and hospitals. In a bipartisan budget deal this year, Republicans in Congress abolished IPAB. But in their latest report, the Medicare trustees imply they believe future

administrations will still have the power to enforce the spending cap.

That means that Medicare fees to providers will fall progressively behind private sector fees through time. And that means one of two things must happen. Either providers will respond to lower fees by providing less care to seniors or they will shift costs to non-seniors in the form of higher fees, higher insurance premiums and higher state and local taxes.

One way providers could cut costs is by providing fewer amenities. Hospital patients could be in wards with, say, 4 or 6 beds instead of single-room occupancy – the way hospitals used to be configured in this country and the way they still are in some other countries. Hospital food could be meals-ready-to-eat (what combat soldiers take into the field) rather than the fancy cuisine some facilities serve up today.

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Another way to cut costs is to deny seniors access to the most expensive care. Writing in ***Health Affairs*** soon after the passage of the ACA, Harvard health economist Joe Newhouse noted that many Medicaid enrollees are forced to seek care at community health centers and safety net hospitals because Medicaid payment rates are so low. He speculated that senior citizens may eventually face the same plight under Obamacare.

A third way to cut costs is rationing by waiting. It is already common practice for doctors to prioritize – seeing private-pay patients first, Medicare patients next and Medicaid patients last. As in other countries with rationing problems, those at the end of the line may never get seen.

But if everyone were in Medicare, wouldn't seniors be on equal footing with non-seniors? Since there would be no more cost shifting (no private patients to shift costs to) the entire burden of spending cuts would fall on Medicare patients themselves. Yet everyone in the medical world knows that older patients have more difficult problems and take more time. That observation wouldn't be lost on practitioners in a system in which time is money and the payment for time keeps getting smaller and smaller. Seniors would be less favored patients – just because they are seniors.

However they are made, the future cuts in spending will be large. Writing at the ***Health Affairs Blog***, former Medicare trustee Thomas Saving and I proposed several ways of thinking about what Medicare's global budget will mean for seniors. One way to think about these changes is to compare them to the average amount Medicare was spending on enrollees prior to Obamacare. For 65-year-olds, the forecasted reduction in spending is roughly equal to three years of average Medicare spending. For 55-year-olds, the loss expected is the rough equivalent of five years of benefits; and for 45-year-olds, it's almost nine years.

Another way to think about the Medicare spending reductions is to compare them to an alternative reform that would have reduced

spending by the same amount: increasing the age of eligibility. The Medicare spending cuts called for under Obamacare are the rough equivalent of raising the age of eligibility for 65-year-olds from 65 to 68. They are the equivalent of making 55-year-olds wait until they reach age 70 and 45-year-olds wait all the way to age 74!

Remember, these are spending cuts already called for under current law. They will be much more severe if seniors have to compete with younger patients for their care.

6335 W Northwest Hwy - #2111 • Dallas, TX 75225 • email: info@goodmaninstitute.org • +1 214 302.0406

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