Point-Counterpoint

The Affordable Care Act versus Medicare for All

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Abstract Many problems facing the Affordable Care Act would disappear if the nation were instead implementing Medicare for All—the extension of Medicare to every age-group. Every American would be automatically covered for life. Premiums would be replaced with a set of Medicare taxes. There would be no patient cost sharing. Individuals would have free choice of doctors. Medicare's single-payer bargaining power would slow price increases and reduce medical cost as a percentage of gross domestic product (GDP). Taxes as a percentage of GDP would rise from below average to average for economically advanced nations. Medicare for All would be phased in by age.

Keywords Medicare for All, Affordable Care Act, single payer

It is striking how many problems facing the Affordable Care Act (ACA) would disappear if the nation were instead implementing Medicare for All—the extension of Medicare to every age-group (Morone 2002; Woolhandler et al. 2003; Seidman 2013a). Medicare has five decades of experience solving numerous practical administrative problems. Most Americans are familiar with how Medicare operates, either as covered seniors or as children of seniors who sometimes accompany their parents when they go to the doctor or hospital. They are familiar with the free choice of doctor under Medicare. Medicare's fee schedules for hospitals and doctors, which have been in effect for three decades, have not generated excessive waiting times, and Medicare fees have been sufficient to enable patients to obtain high-quality medical care. Given its performance,

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familiarity, and popularity, it is surely sensible to ask whether Medicare should be extended to all age-groups.

Medicare for All

Under Medicare for All, every American would be automatically covered for life regardless of employment, health status, income, marital status, or residential location; everyone would receive a Medicare card to use anytime or anywhere that individual obtains medical care. Like Medicare, Medicare for All would contract with private insurance companies to process medical bills. Job seekers would no longer have to choose jobs based on health benefits, and employers would no longer be burdened with providing insurance. Private health insurance premiums would be replaced with a set of taxes earmarked for Medicare. Everyone would bear some burden from these earmarked taxes, so that there would be no free riding—everyone would make a financial contribution to Medicare for All. There would be no patient cost sharing, so there would be no need for private supplemental, or Medigap, insurance policies to cover patient cost sharing or for Medicaid to pay medical bills. Individuals would have free choice of doctors. Medicare would use its single-payer bargaining power to negotiate the prices of medical goods and services. Individuals would be free to obtain and pay for medical services outside of Medicare after paying Medicare taxes, just as they are free to send their children to private schools after paying taxes for public schools. Medicare for All would be operated by the federal government, so problems that arise due to interactions with state governments would be avoided. Medicare for All would phase in by age—for example, zero to fifteen in year 1, sixteen to thirty-two in year 2, thirty-three to forty-nine in year 3, and fifty to sixty-four in year 4; as population phases in, Medicare taxes would phase in and premiums would phase out.

Problems Facing the ACA

Nearly all the problems facing the ACA are the result of retaining the current system of private employer-provided and individual insurance and relying on state governments. Consider the ACA's reliance on employer-provided insurance. Under Medicare for All, an individual would be covered regardless of a change in employment. By contrast, under the ACA an individual who loses his or her job will usually lose insurance because buying COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage is usually too expensive for someone without a job. Under

Medicare for All, employers would no longer have the burden of providing health insurance; employers would pay a higher Medicare payroll tax (and possibly a new Medicare value-added tax [VAT]) but then have no further involvement with health insurance. By contrast, under the ACA employers will have to decide whether to provide insurance and how many full-time and part-time employees to hire in light of the new ACA regulations, exchanges, tax penalties, and tax credits.

Consider the ACA's reliance on private individual insurance. Under Medicare for All, every American would be given a Medicare card for life; there would be no regulations, online exchanges, annual enrollments, tax penalties, or tax credits relating to individual insurance. By contrast, under the ACA individuals not covered by an employer, Medicaid, or Medicare must secure private individual insurance or pay a tax penalty. To assist these individuals in securing and changing insurance, ACA exchanges must be set up; the insurance can vary the premium according to some criteria but not others. Individuals who buy insurance are eligible for premium tax credits according to their current income, which must be documented each year. A mechanism must be put in place to enable prompt payment of the credit (rather than the usual waiting until the annual tax return is filed), so the individual can afford to pay the insurance premium. A procedure for "risk adjustment" must be established so that insurers who enroll a higher-than-average proportion of high-medical-cost patients do not experience severe financial losses as a consequence.

Consider the ACA's reliance on state governments as well as the federal government. Medicare for All would be a federal program. By contrast, under the ACA each state can set up its own exchange provided it meets ACA criteria. Each state can decide whether to participate in the ACA's expansion of Medicaid.

Automatic Coverage and Portability

Consider three alternative ways to obtain health insurance: private employer-provided insurance, private individual insurance, and government insurance. There are two problems with a system of private employer-provided insurance. First, many employers are unwilling or unable to provide insurance for their employees. Second, when employers provide insurance, an employee's coverage is usually interrupted when there is a change in employment, a health problem that prevents employment, divorce from a spouse whose employment provides one's coverage, or residential relocation that requires a switch in employment. The COBRA law requires that a former employee be given the option of keeping the insurance for

eighteen months, but the employee must pay out of pocket the full premium the employer previously paid—a burden hard to bear when the former employee may have no wage income and a health problem that prevents employment.

A system of private individual insurance would have automatic portability because insurance would stay with the individual regardless of a change in employment. But it would not provide automatic coverage. In the absence of government regulation and subsidies, a free market of competing private individual insurance plans would not provide coverage to many individuals. A private insurance company has a financial incentive to refuse coverage to an individual unless it can charge a premium that covers that individual's expected medical cost. If a health history questionnaire reveals that the individual's expected medical cost is very high, the insurer may simply inform the individual that he or she is not eligible for coverage rather than offer coverage at a very high premium that the individual would be unable to pay. If the expected cost is merely high, the insurer will offer coverage at a high premium that the individual may be unable to afford.

The ACA accepts the system of private insurance but tries to improve it. Under the ACA, individuals would be required to obtain health insurance or pay a penalty, and the government would try to compel insurance companies to enroll and charge a normal premium to everyone who applies regardless of preexisting conditions or high expected medical cost. The ACA will try to make insurance companies do what they don't want to do: enroll high-cost individuals at a normal premium. In an effort to reduce company resistance and maneuvering (described by a former insurance company insider [Potter 2009]), the ACA will try to implement "risk adjustment." Under risk adjustment, the government gives subsidies to companies that enroll an unusually high number of high-cost individuals. Without these subsidies, companies will seek subtle ways to discourage the enrollment, and encourage the disenrollment, of high-cost individuals. Risk adjustment, however, has already been attempted in the Medicare Advantage program and the Medicare drug program, and several studies have found that it is hard to achieve successful, equitable risk adjustment (Brown et al. 2011).

Although the ACA will make a significant improvement in coverage, it will not achieve automatic universal coverage or automatic portability. Because the ACA accepts the current system in which the majority of employees rely on employer-provided insurance, there will be no automatic portability for the majority given that any separation from employment will interrupt their employer-provided coverage and compel them to seek new individual insurance unless they can afford expensive COBRA

coverage or promptly obtain coverage from a new employer. The ACA will try to help individuals obtain private individual insurance through new insurance exchanges, subsidies, and regulation of private insurers, but new coverage will not be automatic.

No Patient Cost Sharing

Current Medicare has substantial patient cost sharing. As a consequence, many high- and middle-income households have bought private Medigap insurance policies to cover Medicare's patient cost sharing, and Medicaid has had to cover cost sharing for many low-income households. Medicare for All would eliminate patient cost sharing, so there would no longer be a need for households to buy private Medigap policies for patient cost sharing or for Medicaid to pay medical bills.

Patient cost sharing has three problems. First, patient cost sharing is too burdensome for low-income households. Second, patient cost sharing deters patients from taking early medical action that would avoid much greater costs and hardships later (Baicker and Goldman 2011; Baicker, Mullainathan, and Schwartzstein 2012). Third, patient cost sharing burdens patients whose need for substantial medical care is due to bad luck rather than bad behavioral choices.

Eliminating Health Insurance Distraction

Under Medicare for All, business managers, entrepreneurs, and job seekers would no longer be distracted by health insurance. Managers and entrepreneurs would concentrate exclusively on their business, and job seekers would choose jobs without considering health insurance. Removing the distraction of private health insurance would increase the productivity and efficiency of the economy.

Under today's private health insurance market, most managers and entrepreneurs must devote substantial resources and time to handling their employees' health insurance. They must select private insurance plan options for their employees, continually monitoring changes in the plans. The burden is especially severe on managers of small businesses. The premium charged by private insurers will usually vary with the average medical cost of the small group of employees. If one employee's family develops a chronic costly medical problem, the insurance company will usually raise the firm's premium to cover the higher medical cost for as long as the high-cost employee remains with the firm. Instead of being able to

concentrate exclusively on business, the manager must worry about the medical costs of employees and their dependents.

The potential private health insurance burden discourages entrepreneurship and small business creation. Consider someone who is deciding whether to work for an established large business firm or start up her own small business. If she works for the large firm, it will provide her health insurance, and she won't have to take care of anyone else's health insurance. But if she becomes an entrepreneur, she must immediately confront the problem of whether to provide health insurance for her employees. If she doesn't, she may be unable to attract the best employees, and she must also obtain and maintain individual health insurance for herself. The alternative is for her to search the private group health insurance market even before she begins to operate her new business.

Now consider the burden on each job seeker. An immediate question is whether a potential employer provides health insurance and the specifics of the employer's health insurance policy. Once a job seeker is employed, leaving the job would entail losing the employer's health insurance. As a consequence, some employees experience "job lock": they decide not to switch jobs because of the health insurance loss that such a switch would provoke (Madrian 1994). Workers who would be more productive or satisfied if they switched jobs are deterred from switching because of concern about health insurance. Job seekers on Medicaid fear losing health insurance coverage if they get a job that pays more than Medicaid permits but doesn't offer private health insurance.

Replacing Premiums with Taxes

What is the effect of replacing premiums with taxes? Taxes vary with ability to pay, while premiums do not (Seidman 2009). It would be better for the economy and fairer to use a set of earmarked taxes that have moderate rates (Seidman 2013b). The set of taxes earmarked for Medicare for All might consist of the following: the Medicare payroll tax, a VAT, and a Medicare for All income tax surcharge on the 1040 income tax return. The Medicare payroll tax is currently 1.45 percent on the employer and 1.45 percent on the employee—a combined rate of 2.90 percent on all wage income. The VAT is used successfully by virtually every economically advanced country except the United States. Many US economists have recommended a US VAT (Seidman 2004, 2013b; Hines 2007). Several analysts have recommended that a VAT be enacted and earmarked for universal health (Morone 2002; Burman 2009). The VAT burden on

low-income households would be offset by giving these households a refundable tax credit on their 1040 income tax return to compensate roughly for most of the burden they bear from the VAT (Seidman 2013b).

Today US medical costs are 18 percent of gross domestic product (GDP), while no other country exceeds 12 percent. Suppose Medicare for All aims to cut the huge 6 percentage point gap in half to 3 percent so that US medical costs are 15 percent of GDP. If Medicare for All succeeds in using its single-payer bargaining power (as explained below) to achieve its medical cost target of 15 percent of GDP, then Medicare for All taxes would need to be 15 percent of GDP. Government (federal and state) spending on Medicare, Medicaid, and other government health programs is currently about 7 percent of GDP (CBO 2012: 49, 55–57), so *new* earmarked taxes would need to be roughly 8 percent of GDP.

To put this 8 percent of GDP number in perspective, in 2007 (before the Great Recession caused a plunge in tax revenue) US taxes (federal, state, and local) were about 30 percent of GDP. Thus taxes would rise from 30 percent of GDP to 38 percent (federal taxes would rise by 9.5 percent of GDP, while state taxes would fall by 1.5 percent of GDP due to the reduction in state Medicaid expenses), which would still leave US taxes as a percentage of GDP slightly lower than the average of the economically advanced member countries of the Organisation for Economic Co-operation and Development (OECD) (roughly 40 percent) and far below the Scandinavian countries (roughly 50 percent).

Single-Payer Bargaining Power

For several decades the United States has been an extreme outlier among high-income countries with respect to medical cost as a percentage of GDP. Virtually all high-income countries have used government single-payer bargaining power to limit the rise in prices of medical goods and services. Payer bargaining power has been used to limit prices set by hospitals and drug companies and fees set by doctors and to set budgets—total spending caps—for hospitals, drugs, and doctors.

Why is government needed to negotiate prices for medical care but not for most other goods and services? For most goods and services, consumers pay the price, can judge quality, and are able to shop around, so if one firm sets its price higher than a rival firm but its quality is no higher, consumers will switch to competitors. But for most medical care, most patients (consumers) don't pay the price (except for a small co-payment), can't judge quality, and are in no condition to shop around. So consumers are incapable of limiting prices for medical care.

Of course, private insurers who pay most medical bills often refuse to pay the full price that medical providers charge. But when there are many private insurers, each insurer has weak bargaining power to restrain price increases because a provider can refuse to take a patient covered by an insurer who won't pay a high enough share of the price. Each insurer fears that patients will tell their employer to get another insurer who will pay a high enough share of the price so that medical providers will treat them. With many private insurers, no single insurer has sufficient bargaining power to significantly hold down prices. Merging private insurers into one is the wrong solution because that single private insurer would use its enormous monopoly power to charge very high premiums to employers and individuals. The best solution is for the government to become the single payer of medical providers.

High price, not high quantity, is the main reason that US medical expenditure—which equals price times quantity—is so high. That is the conclusion of an empirical study of OECD countries (Anderson et al. 2003), titled "It's the Prices, Stupid: Why the United States Is So Different from Other Countries." The study's authors analyze the split between price and quantity in 2000, presenting comparisons of different quantity measures including the number of doctors, nurses, hospital beds, hospital admissions, and hospital days. In most of these, the quantity per capita in the United States was at or below the OECD median. They conclude that prices, not quantities, are the drivers of cross-national differences in health spending and that a major cause of the difference in prices is the difference in the bargaining power of the payers of medical providers. They emphasize the difference between the United States and other OECD countries in the degree of bargaining power on the buyers' side of markets for medical care, writing:

> Although the huge federal Medicare program and the federal-state Medicaid programs do possess some monopsonistic purchasing power, and large private insurers may enjoy some degree of monopsony power as well in some localities, the highly fragmented buy side of the U.S. health system is relatively weak by international standards. It is one factor, among others, that could explain the relatively high prices paid for health care and for health professionals in the United States.
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> In comparison, the government-controlled health systems of Canada, Europe, and Japan allocate considerably more market power to the buy side. (Anderson et al. 2003: 102).

But will government single-payer bargaining power under Medicare for All lead to waiting lists and low quality? It depends on whether bargaining power is applied severely or moderately. The aim of the government single-payer should be to negotiate prices that are high enough to make it worthwhile for medical providers to provide high-quality medical care to all patients, but no higher. If the single-payer forces down prices too far, providers won't find it worthwhile, and there will be waiting lists and low quality. The single-payer should let prices rise enough to eliminate waiting lists and achieve high quality, but no higher. Without government single-payer intervention and negotiation, medical prices will be much higher than needed to prevent waiting lists and achieve high quality. In countries where payer bargaining power has sometimes been applied severely (Britain and Canada), waiting lists have sometimes been generated and quality has sometimes been inadequate. But in countries where payer bargaining power has been applied moderately (France and Germany), waiting lists have generally been avoided and quality has generally been high.

Conclusion

Many of the problems facing the ACA would vanish if the nation were instead implementing Medicare for All. Medicare for seniors has been operating and evolving for half a century and has performed very satisfactorily, so it is reasonable to ask whether extending Medicare to cover everyone regardless of age would be sensible public policy. Medicare for All would provide automatic coverage and portability for everyone regardless of employment, health status, income, marital status, or residential location. Taxes would replace premiums and everyone would bear some tax burden to finance it, so there would be no free riders, but there would be no patient cost sharing. Medicare for All would eliminate health insurance distraction for business managers, entrepreneurs, and job seekers, thereby improving the productivity of the US economy. It would use single-payer bargaining power to limit price increases and could thereby reduce medical cost as a percentage of GDP from 18 percent to 15 percent—still several percentage points above any other nation, thereby maintaining high-quality care and high incomes for medical providers and avoiding wait lists and rationing. It would require an increase in taxes from 30 percent of GDP to 38 percent—slightly less than the average for economically advanced nations. After the ACA is implemented, serious consideration should be given to enacting Medicare for All.

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