# [Improved]Medicare for All

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# Disclosures

Drs. Eisenson and Kotch have nothing to disclose (except a passion for universal access to quality health care that is affordable, efficient, and equitable).

We are both members of Healthcare for All NC, a local affiliate of the nonprofit Physicians for a National Health Program:

*The mission of Health Care for All NC is to educate and activate health care providers and the general public on behalf of a comprehensive, high quality, universal, single payer health care system that is equitably provided to all Americans and is paid for exclusively by a federal program accountable to the people.*

# Outline

- Can we agree on goals for the US healthcare system?
- What's working well in US healthcare?
- Where does our current system fall short?
- What's in Medicare for All (MC4A) proposals
- How will it address shortcomings?
- Critical questions – including how will we pay for this?
- Commonly raised arguments against MC4A
- Public opinion/medical opinion about MC4A
- Current legislative proposals and prospects
- How to learn more, and how to advocate for an improved health care system

# Can We Agree on Goals for US Healthcare?

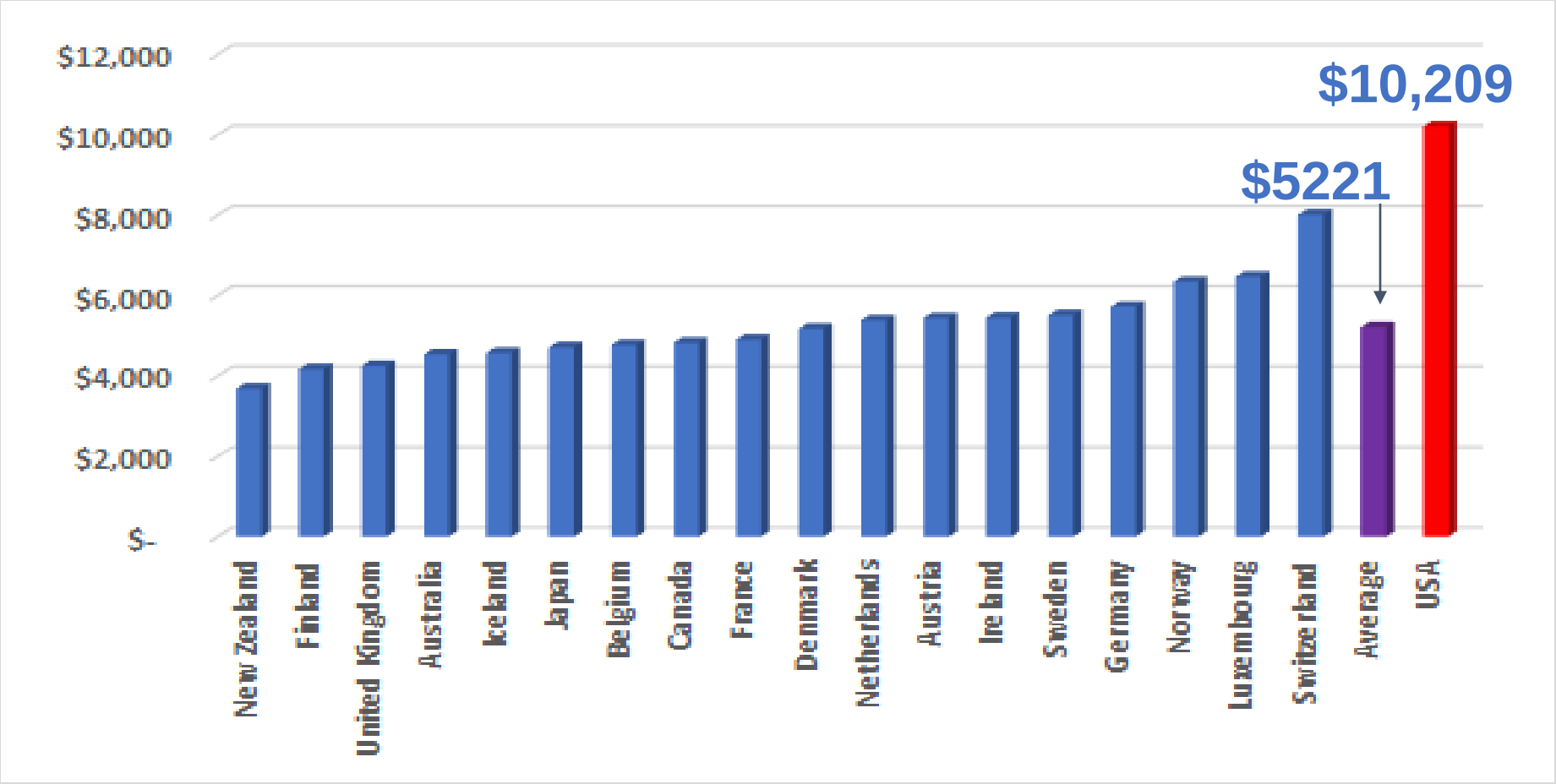
- **Universal coverage** (“everybody in/nobody out”)
- **Health equity** – better quality health for everyone regardless of race/ethnicity/geography/income etc.
- **Improved population health** – investing in communities
- **Affordability**
- **Adaptability** – responsive to evolving healthcare needs
- **Efficiency** – both in term of systems and finance

# What's Working Well in US Healthcare

- Robust health professional education and well-trained workforce
- Research, innovation, entrepreneurship leading to rapid and wide-ranging advances in medical science and technology
- Ready access to care for those with high quality insurance
- Rapid access to needed services for those hospitalized (at least until COVID)
- Comfortable hospital environments
- Once one accesses care, superior stats for surviving heart attack, stroke, cancer
- Health care safety nets – Emergency Departments, Community Health Centers, Hospital charity care programs…and Medicare and Medicaid (especially where expanded), for those who qualify

# Where our current system falls short

Per capita healthcare spending of top 19 countries *(OECD 2017)*

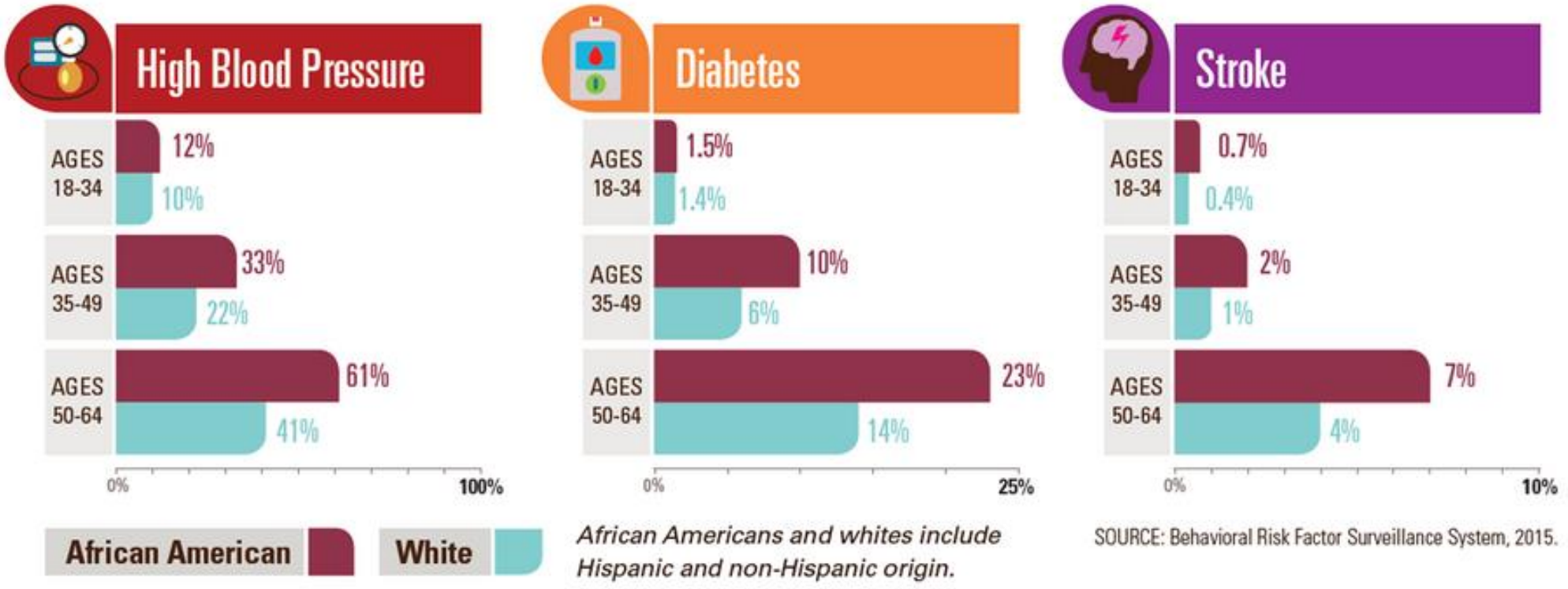


# Where our current system falls short, cont'd.

We have worse health care system performance than 10 other economically advanced countries *Commonwealth Fund, 2021. Mirror, Mirror: Reflecting Badly.*

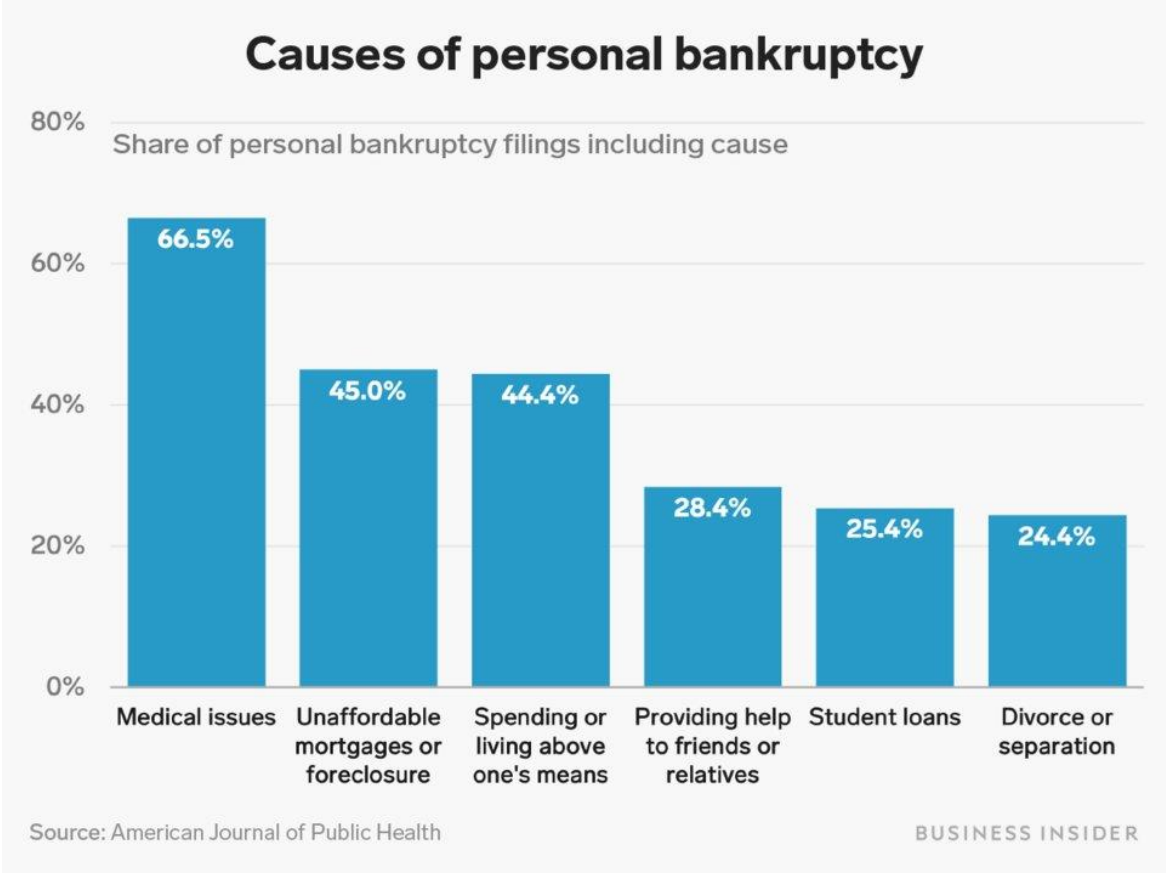
# Where our current system falls short, cont'd.

Significant disparities by race and socioeconomic status in access to care and outcomes




*https://www.cdc.gov/vitalsigns/aahealth/infographic.html#graphic*

# The U.S. is the only developed country where citizens go bankrupt because they got sick or had an accident




*https://www.businessinsider.com/causes-personal-bankruptcy-medical-bills-mortgages-student-loan-debt-2019-6*

# Despite the Affordable Care Act

- Approximately 10% of Americans still lack healthcare insurance,
- Annual premiums, deductibles, and out-of-pocket costs all rising, causing many patients to forego appointments, recommended tests, filling prescriptions *Himmelstein et al, "Medical Bankruptcy: Still Common Despite the Affordable Care Act," American Journal of Public Health 109, no. 3, March 2019*
- **More people** with health insurance were underinsured in 2019 than in 2010, with the **highest increases** from employer-based plans *https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca?omnicid=EALERT1558577&mid=don@mccanne.org*
- Most private insurance (and Medicare) doesn't cover all the services people need (dental, vision, hearing, long term care, etc.)

# Other shortcomings of the US healthcare system

- Tying insurance to employment leaves people vulnerable to loss of coverage
- **Drug prices are out of control** – Medicare is by law is prohibited from negotiating drug prices with pharmaceutical companies
- Private insurers often maintain narrow provider networks – limiting patients' ability to choose those best suited to meet their needs
- Americans in rural and low-income communities where hospitals are closing and providers are leaving may have a hard time getting care
- "Churn" across insurance plans impedes investment in prevention
- American hospitals on average spend 25% of total revenues on administration – physician practices employ on average 2 administrative staff for every 3 clinical personnel - DUHS has 957 bed and employs more than 1,500 billing clerks *Uwe Reinhardt "Where does the Health Insurance Premium Dollar Go?"JAMA 317, no. 22, 2017*

# The provider-patient relationship is eroding

- Clinicians experience “moral injury” – knowing what a patient needs, but unable to meet that need because of barriers in the system
  - Needed services are not available
  - Patients are unable to afford a needed service even if they are available
- Patients are forced to navigate a maddeningly complex bureaucracy experiencing powerlessness vs. increasingly consolidated mega-health care insurers and providers
- Lowest satisfaction with our healthcare system among peer countries

  *Papanicolas et al. “Health Care Spending in the United States and other High Income Countries” JAMA 319, no. 10, 2018*

# What Medicare for All Is

- "**The government guarantees comprehensive health insurance to all Americans under a single, publicly funded plan.**"
- "Active ingredients" *El-Sayed and Johnson, 2021. "Medicare for All: A Citizen's Guide"*
  - Universal, comprehensive coverage
  - Pricing power
  - Administrative efficiency **(private insurance companies incur overhead costs 5X greater than Medicare)**
  - Progressive financing (low-income families would pay less relative to their incomes)
  - Public accountability (for-profit insurance companies are ultimately responsible to their shareholders, not to the subscribers, and not to the public)

# What Medicare for All is *Not*

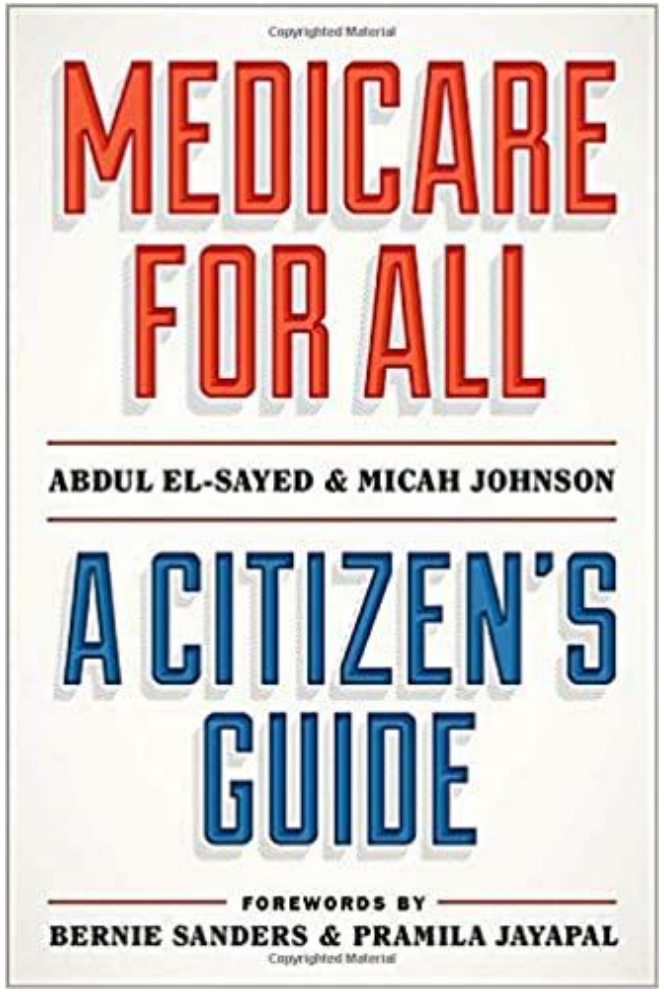
- *NOT* "socialized medicine" – private hospitals and doctors would remain private, and consumers could choose where and from whom they wish to receive care
- *NOT* simply expanding Medicare in its current form
  - there would not be separate plans for hospital care, physician coverage, and medications
  - there would be minimal or no out-of-pocket costs
  - dental, vision, hearing, home care and LTC would be covered

# How Will Medicare for All Help?

- Numerous studies show that gaining health insurance reduces risk of death *S. Khatana et al. "Association of Medicaid Expansion with Cardiovascular Mortality" JAMA Cardiology 4, no. 7, 2019*
- Strong negotiating power will enable constraints on price increases
  - For example, **Department of Veterans Affairs negotiates drug prices and secures prices approx 40% lower than those paid by Medicare**
- Reduced insurance overhead and reduced administrative burden on providers would save hundreds of billions of dollars annually and free up resources for expanding clinical care
  - **13% overhead costs of private insurers** – administrative functions, marketing costs, multi-million dollars salaries, and profits **vs. traditional Medicare program with 2.3% overhead**
  - Health care providers would be freed of the administrative burden of billing hundreds of different health plans with different rules for prior authorizations, covered medications, quality metrics, networks of specialists, labs, imaging centers
  - Revenue for clinicians remains stable or is higher

# How Else Will Medicare for All Help?

- New costs of expanded coverage are likely to be similar in size to the savings from administrative costs, drug prices, and provider payment rates
- Equitable care provided across racial groups and socioeconomic statuses
- A unified payment system, covering patients for life, supports investments in prevention, public health and social services to improve conditions of life
- Would improve the experience of care by
  - simplifying onerous administrative tasks for providers (freeing them up to focus on clinical care) and
  - reducing constant intrusion of financial considerations into care for both patients and providers




# Should healthcare be treated as a consumer product or a public good? *Abdul El-Sayed and Micah Johnson, 2021. "Medicare for All: A Citizen's Guide," Oxford University Press*

- Under M4A, healthcare becomes **a public good,** free at the point of service, like the fire department, public libraries and public schools
- Doctor-patient relationships are a service, not a commercial transaction
- Users of healthcare services are **patients,** not consumers, not clients, not subscribers, and not "members"

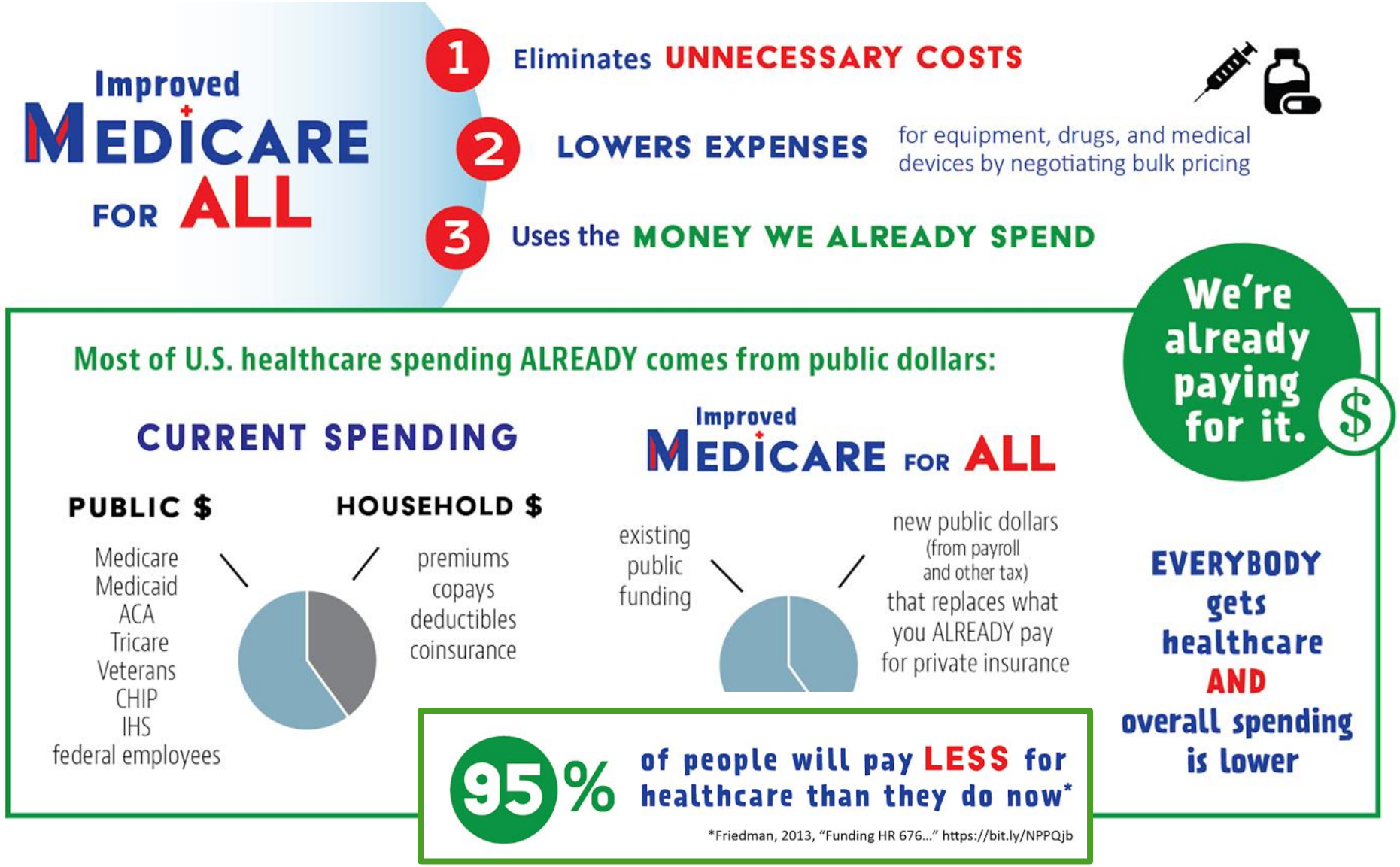
# Critical Questions for MC4A Policymakers

- Who will be eligible for benefits? – undocumented immigrants?
- Should there be any out-of-pocket fees for patients, and if so, how much and for what services?
- What role, if any, for private insurance? (Many countries with national health insurance allow supplemental private insurance.)
- How (fee for service, global budgets, capitation) and how much would providers be paid (e.g., current Medicare rates? Weighted average of Medicare and private insurance rates?)

# Critical Questions for Policymakers…cont'd

- How would MC4A cover prescription drugs?
  - Allowing Medicare to negotiate drug prices is very popular
  - Many options for how to do this
- How would the program be administered…federal, regional, and state roles?
- How to transition to MC4A?
  - More clinical jobs, but far fewer administrative jobs (plan must include income support, retraining, and job placement assistance for displaced admin employees)
  - Who would be eligible, and what would be the timeline?

# How will we pay for this?



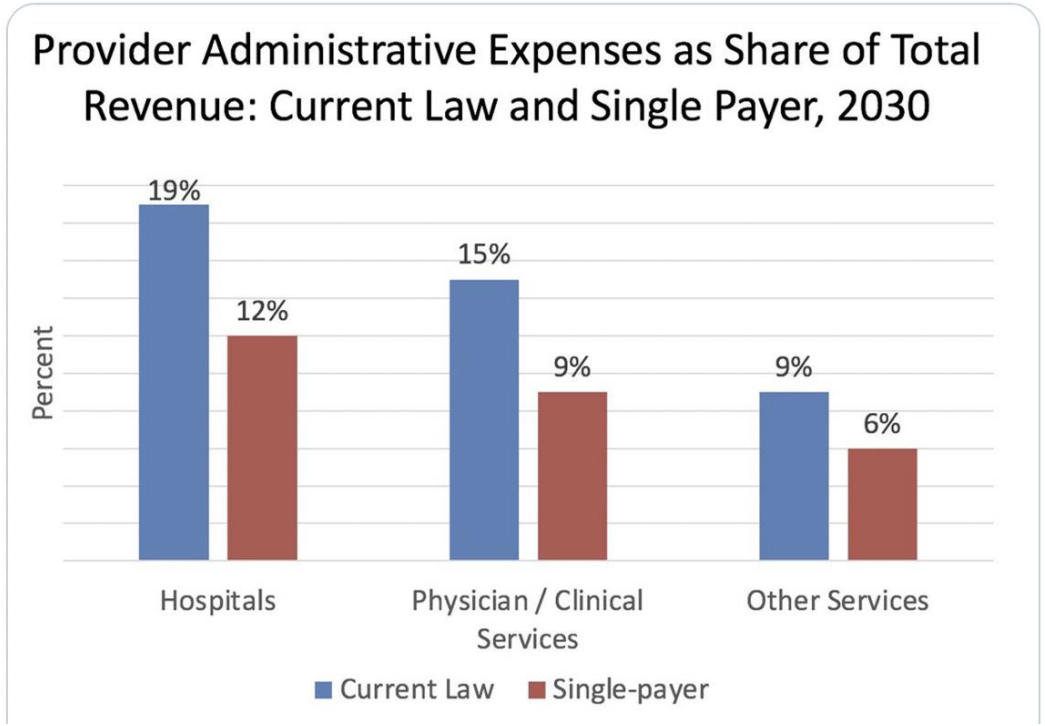
# How will we pay for this?…cont'd

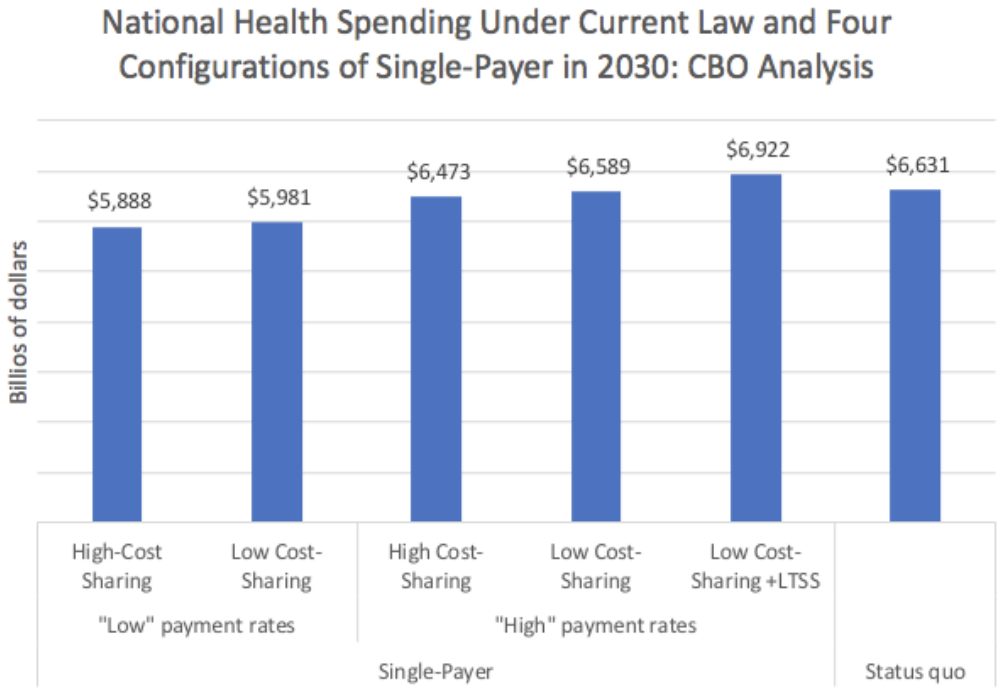
- Currently we all contribute via taxes, insurance premiums, and out-of-pocket expenses
- Private healthcare spending is steeply regressive,
  - Poor and middle-class Americans pay a larger share of their income for healthcare
  - On average the poorest fifth of households *are paying more than a third of their income for healthcare* *Carman, Liu, and White. "Accounting for the Burden and Redistribution of Health Care Costs: Who Uses Care and Who Pays for It," Health Services Research, Jan 28, 2020*

# How will we pay for this?...cont'd

- Nearly all estimates conclude that, in the decade after enactment national health spending under MC4A, costs would be similar to current health spending, *plus or minus 15%*
- Likely that MC4A would **decrease yearly growth rate** of healthcare costs – per person spending in Medicare increased 20% from 2008-2018, while per-person spending in private insurance increased by 50% *R. Kamal et al. "How has US Spending on Healthcare Changed over Time" Peterson-Kaiser Health System Tracker, Dec 20, 2019*
- Key to financing – repurposing of existing public funds (public sources already finance 61% of healthcare spending) and replacing private healthcare spending with progressive taxes...**most households would save money** under single payer *J Liu et al. "An Assessment of the New York Health Act: A Single-Payer Option for New York State" – RAND Corporation, 2018*

# Would national health spending be *more*, or *less*, under MC4A? Congressional Budget Office report shows…




- Single payer cuts down significantly on administrative expenses
- 50% reduction in clinician time spend on admin activities

# Shouldn’t the free market control health care prices, without government interference?

- The free market isn’t “free” with respect to healthcare
- Consumers don’t know exactly what they are buying, or what it costs;
- They do not face the full cost of their purchases;
- They don’t have the time and ability to deliberate and make the most rational decisions;
- They don’t have many options for where (and from whom) to make their purchase;
- It is often impossible for them to choose not to make a purchase at all

# Other Commonly Raised Arguments Against MC4A

- Concern about a larger role for government in decisions about health coverage
  - **Medicare remains very popular,** through multiple sessions of Congress and presidential administrations
- Won't there be less investment in R&D if drug prices come down?
  - Big Pharma spends more on marketing than on R&D
  - Most of the cost of basic scientific research is paid for by government and conducted by government, universities or contract research companies
  - High prices *DON'T* necessarily incentivize the production of new, innovative, therapeutically beneficial drugs
  - They *DO* incentivize the deployment of innovative legal strategies that keep prices high without delivering important new benefits to patients
  - MC4A could use some of the savings from lower drug prices to fund **increased** public investment in R&D

# Public and professional opinion about Medicare for All

- Kaiser Family Foundation conducted 15 polls from 2017 – 2020 on "a national health plan…in which all Americans would get their insurance from a single government plan." ….a majority of Americans supported Medicare for All in all 15 polls *("Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage," Kaiser Family Foundation, May 27, 2020)*
- In 2020 the ACP (American College of Physicians*) endorsed a single payer, universal, comprehensive national health plan

**ACP is a national organization of 161,000 internists, the largest medical-specialty organization, and second-largest physician group in the United States.*

# HR 1976: The Medicare for All Act of 2021

- **Covers** all U.S. Residents from birth to death
- **Eliminates** out of pocket costs (No more premiums, co-pays, deductibles)
- **Expands** coverage to include dental, mental health, hearing aides, vision, prescription drugs, home healthcare and long-term care
- **Cost control measures** like global budgeting, and negotiating pricing for drugs and medical devices
- Substantial investment into medically underserved areas – overseen by an **Office of Health Equity**
- **Ends** drug patents if company price gouges

# Consider Professional Ethics and Responsibility

- Professionalism requirements of the Accreditation Council for Graduate Medical Education include:
  - Demonstrate respect, compassion, and integrity; **a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession;** and a commitment to excellence and on-going professional development
- Fundamental principles of medical ethics
  - Primary concern for patient welfare
  - Respect for patient autonomy
  - Respect for social justice -The five main principles of social justice include **access to resources, equity, participation, diversity, and human rights**.

# Advocacy Opportunity

- The current budget reconciliation bill gives us an opportunity to move us closer to an Improved Medicare For All single-payer system
  - Expand services covered to include dental, vision, and hearing
  - Lower eligibility age to 55/60
  - Place caps on out-of-pocket costs for traditional Medicare (to limit the growth of privatized Medicare Advantage plans)
  - Allow Medicare to negotiate prescription drug prices

# Join the fight for single payer healthcare that is:

- High quality,
- Comprehensive,
- Universal,
- Equitable, and
- Affordable

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