Medicare for All and Its Rivals: New Offshoots of Old Health Policy Roots

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The leading option for health reform in the United States would leave 36.2 million persons uninsured in 2027 while costs would balloon to nearly $6 trillion (1). That option is called the status quo. Other reasons why temporizing is a poor choice include the country's decreasing life expectancy, the widening mortality gap between the rich and the poor, and rising deductibles and drug prices. Even insured persons fear medical bills, commercial pressures permeate examination rooms, and physicians are burning out.

In response to these health policy failures, many Democrats now advocate single-payer, Medicare-for-All reform, which until recently was a political nonstarter. Others are wary of frontally assaulting insurers and the pharmaceutical industry and advocate public-option plans or defending the Patient Protection and Affordable Care Act (ACA). Meanwhile, the Trump administration seeks to turbocharge market forces through deregulation and funneling more government funds through private insurers. Here, we highlight the probable effects of these proposals on how many persons would be covered, the comprehensiveness of coverage, and national health expenditures (Table).

Medicare for All

Medicare-for-All proposals are descendents of the 1948 Wagner–Murray–Dingell national health insurance bill and Edward Kennedy and Martha Griffiths' 1971 single-payer plan (2). They would replace the current welter of public and private plans with a single, tax-funded insurer covering all U.S. residents. The benefit package would be comprehensive, providing first-dollar coverage for all medically necessary care and medications. The single-payer plan would use its purchasing power to negotiate for lower drug prices and pay hospitals lump-sum global operating budgets (similar to how fire departments are funded). Physicians would be paid according to a simplified fee schedule or receive salaries from hospitals or group practices.

Similar payment strategies in Canada and other nations have made universal coverage affordable even as physicians' incomes have risen. These countries have realized savings in national health expenditures by dramatically reducing insurers' overhead and providers' billing-related documentation and transaction costs, which currently consume nearly one third of U.S. health care spending (3). The payment schemes in the House of Representatives' Medicare-for-All bill closely resemble those in Canada. The companion Senate bill incorporates some of Medicare's current value-based payment mechanisms, which would attenuate administrative savings. Most analysts, including some who are critical of Medicare for All, project that such a reform would garner hundreds of billions of dollars in administrative and drug savings (4) that would counterbalance the costs of utilization increases from expanded and upgraded coverage. Reductions in premiums and out-of-pocket costs would fully offset the expense of new taxes implemented to fund the reform.

"Medicare-for-More" Public Options

Public-option proposals, which would allow some persons to buy in to a public insurance plan, might be labeled "Medicare for More." Republicans Senator Jacob Javits and Representative John Lindsay first advanced similar proposals in the early 1960s as rivals to a proposed fully public Medicare program for seniors. This approach resurfaced during the early 1970s as Javits' universal coverage alternative to Kennedy's single-payer plan and gained favor with some Democrats during the 2009 ACA debate.

Policymakers are floating several public-option variants, most of which would offer a public plan alongside private plans on the ACA's insurance exchanges. Although a few of these variants would allow persons to buy in to Medicaid, most envision a new plan that would pay Medicare rates and use providers who participate in Medicare. Positive features of these reforms include offering additional insurance choices and minimizing the need for new taxes because enrollees would pay premiums to cover the new costs. However, these plans would cover only a fraction of uninsured persons, few of whom could afford the premiums (5); do little to improve the comprehensiveness of existing coverage; and modestly increase national health expenditures. The Medicaid public-option variant, which many states might reject, would probably dilute these effects.

Medicare for America, the strongest version of a public-option plan, would automatically enroll anyone not covered by their employer (including current Medicare, Medicaid, and Children's Health Insurance Program enrollees) in a new Medicare Part E plan. It would upgrade Medicare's benefits, although copayments and deductibles (capped at $3500) would remain. The program would subsidize premiums for those whose income is up to 600% of the poverty level, and employers could enroll employees in the program by paying 8% of their annual payroll. The new plan would use Medicare's payment strategies and include private Medicare Advantage (MA) plans (which inflate Medicare's costs [6]) and accountable care organizations.

Medicare for America would greatly expand coverage and upgrade its comprehensiveness but at consid-

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Table. Characteristics of Major Health Reform Proposals as of March 2019

Characteristic	Medicare for All (Single Payer)	Medicare for America	Medicare Public Option	Medicaid Public Option	Trump Administration White Paper and Budget Proposal
Chief sponsors	Jayapal (D-WA) and Sanders (I-VT)	DeLauro (D-CT) and Schakowsky (D-IL)	Merkley (D-OR) and Murphy (D-CT) Higgins (D-NY), Kaine (D-VA), and Bennet (D-CO) Schakowsky (D-IL) and Whitehouse (D-RI) Others	Schatz (D-HI) and Lujan (D-NM)	Executive branch actions and proposals; not yet in legislative form
Provenance	Wagner–Murray–Dingell Bill (1948) Kennedy–Griffiths Bill (1970)	Javits Bill (1970) Center for American Progress (2018)	Javits Bill (1962) Javits–Lindsay Bill (1964)	Lindsay proposal (1964)	Nixon proposals (1971) Long–Ribicoff Bill (1973) Medicare Modernization Act (2003)
Enrollment	Automatic for all U.S. residents	Automatic for all U.S. residents unless an employer chooses to provide private coverage	Available as an option on ACA exchanges	States may choose to provide this strategy as an option on ACA exchanges	Little change
Extent of coverage expansion	Universal	Universal	Modest	Very modest; some states would probably decline to participate	Coverage would probably decrease
Comprehensiveness of coverage	Broad benefits; no copays or deductibles	Broad benefits; out-of-pocket costs capped at $3500	Somewhat broader than the current Medicare plan; out-of-pocket costs are similar to or somewhat lower than those under current ACA plans	Similar to ACA exchange plans; states set copays and deductibles	Weakens ACA mandates on coverage of "essential benefits" and preexisting conditions; relaxes network-adequacy standards; encourages higher deductibles
Role of private insurers	None	Large employers may choose to provide private insurance; MA continues with stricter regulations	Probably modestly reduced	Probably modestly reduced	Private MA plans expand at the expense of traditional Medicare
Payment structure	Global budgets for hospitals; physicians paid according to a fee-for-service system or receive a salary; negotiated drug prices	Similar to the current Medicare system with increased primary care fees; negotiated drug prices	Little change	Medicaid adopts Medicare payment rates	Accelerated shift from a fee-for-service system to value-based purchasing and ACOs
Funding mechanism	New taxes replace current out-of-pocket payments and premiums	New taxes; individual and employer premiums; out-of-pocket payments	Enrollee-paid premiums	Enrollee-paid premiums	Proposed cuts of $1.5 trillion to Medicaid and $818 billion to Medicare over 10 y
Effect on overall national health expenditures	Initially similar to the status quo but lower thereafter because of administrative and drug savings	Probably moderate to large increases	Small increases	Small increases	Uncertain
Other major provisions	Coverage of long-term care varies	Premiums capped at 9.69% of income	Some proposals increase ACA subsidies	Premiums capped at 9.5% of income	Lifts moratorium on new for-profit specialty hospitals; expands the scope of practice of nonphysician providers; relaxes standards for FMGs; overrides states' "any-willing-provider" and certificate-of-need regulations

ACA = Patient Protection and Affordable Care Act; ACO = accountable care organization; FMG = foreign medical graduate; MA = Medicare Advantage.

erable cost. As with other public-options reforms, it would retain multiple payers and therefore sacrifice much of the administrative savings available under single-payer plans. Physicians and hospitals would have to maintain the expensive bureaucracies needed to attribute costs and charges to individual patients, bill insurers, and collect copayments. Savings on insurers' overhead would also be less than those under single-payer plans. Overhead is only 2% in traditional Medicare (and 1.6% in Canada's single-payer program [7]) but averages 13.7% in MA plans (8) and would continue to do so under public-option proposals. Furthermore, as in the MA program, private insurers would inflate taxpayers' costs by upcoding as well as cherry-picking and enacting network restrictions that shunt unprofitable patients to the public-option plan. This strategy would turn the latter plan into a de facto high-risk pool.

The Trump Administration White Paper and Budget Proposal

Unlike these proposals, reforms under the Trump administration have moved to shrink the government's role in health care by relaxing ACA insurance regulations; green-lighting states' Medicaid cuts; redirecting

U.S. Department of Veterans Affairs funds to private care; and strengthening the hand of private MA plans by easing network-adequacy standards, increasing Medicare's payments to these plans, and marketing to seniors on behalf of MA plans. A recent administration white paper (9) presents the administration's plan going forward: Spur the growth of high-deductible coverage, eliminate coverage mandates, open the border to foreign medical graduates, and override states' "any-willing-provider" regulations and certificate-of-need laws that constrain hospital expansion. The president's recently released budget proposal calls for cuts of $1.5 trillion in Medicaid funding and $818 billion in Medicare provider payments over the next 10 years.

Thus far, the effects of the president's actions—withdrawing coverage from some Medicaid enrollees and downgrading the comprehensiveness of some private insurance—have been modest. His plans would probably swell the ranks of uninsured persons and hollow out coverage for many who retain coverage, shifting costs from the government and employers to individual patients. The effect on overall national health expenditures is unclear: Cuts to Medicaid, Medicare, and the comprehensiveness of insurance might decrease expenditures; however, deregulating providers and insurers would probably increase them.

In 1971, a total of 5 years after the advent of Medicare and Medicaid, exploding costs and persistent problems with access and quality triggered a roiling debate over single-payer plans. As support for Kennedy's plan grew, moderate Republicans offered a public-option alternative, 1 of several proposals promising broadened coverage on terms friendlier to private insurers. Kennedy derided these proposals by stating, "It calms down the flame, but it really doesn't meet the need" (10). President Nixon's pro market HMO strategy—a close analogue of the modern-day accountable care strategy—ultimately won out, although his proposals for coverage mandates, insurance exchanges, and premium subsidies for low-income persons did not reach fruition until passage of the ACA.

Five years into the ACA era, there is consensus that the health care status quo spawned by Nixon's vision is unsustainable. President Trump would veer further down the market path. Public-option supporters hope to expand coverage while avoiding insurers' wrath. Medicare-for-All proponents aspire to decouple care from commerce.

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