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The Precarious Path to Universal Health Coverage

by David Rosenbloom

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Medicare for All became the rallying point for health care reform early in the 2020 election, often without details as to how it could be provided and paid for. When Elizabeth Warren got specific, it sank her campaign. What the candidates—and a majority of the American people—really want is medical care for all. I will lay out the most important real barriers to achieving the goal of universal health care coverage in the United States and conclude with some predictions about what may happen to Medicare for All after the 2020 election.

SENATE DEMOCRATS ON WIKIMEDIA

The ironies and contradictions abound when we call the goal Medicare for All. Medicare, the government-run, single-payer national insurance program for everyone over 65 is massively popular. But public support for Medicare for All falls when it is described as a single-payer insurance program. Most Americans would like to lower their out-of-pocket medical expenses—traditional Medicare has a 20 percent copayment for all physician visits, diagnostic tests, and equipment. Typical Medicare recipients spend about 14 percent of their income on medical care by the time they are in their mid-70s, some of it for supplemental private insurance to pay for what traditional Medicare doesn't cover.

A majority of Americans support additional federal efforts to help people get access to medical care. However, the level of that support changes depending on the words used to describe it as a policy choice. For example, in May 2020, 63 percent of the public said they favored federal action to achieve "universal health coverage," but only 49 percent in the same poll favored "a single payer national health plan." The partisan divide over health care reform has dramatically widened. In 2006, 72 percent of Republicans told pollsters they favored federal action to help provide access to care, but only 42 percent of Republicans supported the same idea in 2020..

Creating medical care for all Americans is a policy choice, not a legal matter. Decades of litigation provide solid constitutional support for alternative ways to achieve universal health care. The tax and spend power of Congress is the foundation for traditional Medicare. A federal state partnership, Medicaid, which provides medical insurance to some groups of people, is fine, as long as the federal government doesn't coerce the states into doing something that

schedules. Congress made the policy choice to prohibit Medicare from negotiating or setting prices when it created the Medicare prescription drug program in 2005. The constitutional basis for a universal health coverage policy will almost certainly remain even if the Supreme Court declares the current ACA unconstitutional next year, based on the theory that the individual mandate was central to the whole scheme (*California v. Texas*).

President Obama made a political policy choice to build on existing private and public insurance mechanisms for his health plan, not replace them. If the ACA had been implemented as designed, it would have covered about 95 percent of the people in the country through tax- favored employer-sponsored or subsidized individual private insurance, Medicaid or Medicare. Most of the people left out were non-citizens. The Supreme Court decision that made Medicaid expansion voluntary at the state level left about 6 million people, mostly in southern States, with no health insurance. Some of these people have since gotten coverage, as more states have agreed to expand the program, but 14 states have still not expanded Medicaid. At the beginning of 2020, about 28 million, or about 10 percent, of non-elderly Americans had no health insurance. Another 20 million to 30 million people who had employer-sponsored insurance at the beginning of 2020 may have no insurance by the end of the year. Some will be eligible for Medicaid, depending on where they live, but many will have nothing. The pandemic is putting the design and operation of the ACA to a severe test. How it performs will be a key part of the policy debate next year.

The United States could have a national health plan that covers all residents at prices they can afford. The Congress and the president just have to decide to do it. The 100-year history of attempts to deliver universal health coverage to

ACA. If the House had not accepted the previously passed Senate version, it is unlikely that anything would have become law. Republicans controlled the White House and both houses of Congress in 2017, but their majority in the Senate was not great enough to achieve their primary objective—repeal of the ACA.

Medical care policy is controversial because it is redistributive. Those of us who are healthier and wealthier help pay for the care of those who are sicker or poorer. Often the transfers are not transparent and therefore rarely set off political firestorms. A majority of hospitals in the country report they lose money or barely break even on Medicaid and Medicare patients. However, hospitals typically make about a 30 percent profit on employer-sponsored insurance to make up for these losses—an invisible redistribution. Progressive federal and state tax regimes redistribute wealth when some of that tax money is used to pay Medicaid expenses. Those of us with higher salaries pay more in Medicare payroll tax than lower-wage workers, but we are all entitled to the same benefits. As soon as the Medicare for All debate among Democrats got into the details of how it would be paid for, the redistributive aspects became transparent and open to political attack as "socialized medicine."

Other factors will also shape the health care policy debates in 2021: COVID-19, past policy choices that determine how—and how much—we pay for medical care, and efforts to address systemic health disadvantage among Black and brown Americans.

COVID-19 is exposing many of the sordid truths about health care in America that have been hidden in plain sight for many years. The cumulative effects of racial and ethnic discrimination make Black and brown Americans far more

We do not yet understand the population health effects of the pandemic or how they will be interpreted in policy debates. What difference in population health, good or bad, did shutting the ambulatory care system for three months have? COVID-19 may accelerate care delivery changes and consumer expectations. Telehealth has exploded, and consumers seem to like it. The air has been cleaner in some places because driving and industrial activity declined sharply. If it turns out that heart attacks and asthma also sharply declined in these places, policy choices that invest more in pollution prevention may become more urgent. Inconsistent, ill-informed, and self-serving policy choices made by the president and agencies under his control enabled the virus to spread and kill tens of thousands of people. In the summer of 2020, the president made even wearing a face mask a politically based choice. Nobody knows how this government and political failure will play out, but whatever happens is likely to shape the health care debate in 2021 and beyond.

Determining how universal health coverage will be paid for has always been a challenge. The ACA ducked the issue by building on the existing framework while leaving its inequities in place. As medical care consumers, we want all the care we think we need, but we want to pay less out of pocket for it. We engage in magical thinking to have someone else pay for it: our employers, insurance companies, or the "government." Bernie Sanders told us that we would pay more in taxes but less in premiums and out-of-pocket costs, and therefore we would come out ahead in the end. Nobody believed him. We pay Medicare payroll taxes for 40 years based on the promise that it will be there for us but reject doing the same to pay for the care we get now.

The prices Americans pay for medical care are dramatically higher than any

posted prices, but private insurers pay much higher prices because they have limited bargaining power over the providers.

The United States has huge government deficits and high unemployment. Opponents of universal coverage will argue that the country cannot afford it now. A huge pitfall on the path to universal coverage is the reality that to afford care for all, we probably need to lower the prices we pay for medical care. The ACA paid for Medicaid expansion by reimbursement changes that slow down growth in Medicare expenses without lowering any Medicare member's benefits. The perceived threat to Medicare became a foundation of the Tea Party Movement that cost Democrats control of the House in 2012.

Some Medicare for All proposals made a frontal assault on costs by setting all payments at or near current Medicare rates. That is a big deal. Tens of billions of dollars would disappear from hospitals and doctors. Because more than 60 percent of health care spending is salaries for workers, hundreds of thousands of jobs would also disappear. Congress may not be willing to take a policy ax to high prices if consumers perceive the changes as a threat to their access.

The health care policy debate of 2021 will take place in the middle of a huge national discussion and perhaps reckoning about systemic racism. Black and brown Americans have been subjected to poor and discriminatory medical care forever. Black life expectancy is three years shorter than it is for whites. Black babies and mothers are much more likely to die than whites. Their shorter, sicker lives are more likely a reflection of the cumulative effect of the discrimination they have faced in education, employment, housing, and wealth accumulation than just the lack of medical care itself. Research has shown that having medical insurance improves health, in part by reducing stress; but

that actually improve population health may continue. It is important to note that other rich countries which have better population health than the United States spend less on medical care but much more on the social supports of education, housing, job security, and early childhood development than we do.

For all these reasons, there will be a window for health policy changes in 2021. COVID-19 is likely to still be raging. Millions will be unemployed and without health insurance. The Supreme Court may find the ACA unconstitutional. The outcomes of the elections will shape the package.

If Democrats take control of the White House and both houses of Congress, the reforms they pass will depend on the size of their majority in the Senate or their willingness to destroy the filibuster. A commanding majority in the Senate will enable them to pass universal health coverage for all citizens and perhaps non-citizen residents as well. They may make modest steps toward controlling provider prices, especially in ways that lower consumer out-of-pocket costs. They will retain all the popular features of the ACA, especially coverage for pre-existing conditions. A supermajority democratic Congress might decouple insurance from employment for most Americans through a national single-payer program. It is unlikely to pass a bill that eliminates private insurance companies. As Medicare does today, individuals will be able to choose to get their care through the public program or by joining a private managed care program sponsored by an insurance company, union, employer, or some other group. There will be a required broad benefit package for all plans, but the packages could vary in a number of ways that enable consumers to make trade-offs between out-of-pocket costs and provider or supplemental benefit choices. State-run Medicaid programs will continue, but the federal government might substantially expand its share of the cost. The supermajority

If the Democrats win only a modest majority in the Senate or if there is a split in the control of Congress, conditions may still open the window for policy change, but the result will be more modest. The focus will be on expanding access to care for COVID-19 services and immunization and perhaps an effort to expand Medicaid to all states in a way that is noncoercive. There will be some tinkering that seeks to lower consumer out-of-pocket costs. State Medicaid programs are likely to get additional money to cover the costs of newly enrolling unemployed individuals and their children.

Republican control of the federal government in 2021 will bring different health policy choices. Despite COVID-19 and the recession, they will try again to repeal the ACA with or without help from the Supreme Court. The focus will be on limiting cost to the federal government, a republican goal for many years. Medicaid expansion will be repealed and replaced by fixed grants to the states to support traditional Medicaid coverage for pregnant women, infants, and frail, poor elderly. Options for private insurance coverage will be expanded to include policies that have narrow benefit packages to enable consumers to buy the coverage they want. Efforts to change Medicare into a premium support program that limits total federal financial exposure and shifts more costs to Medicare recipients are likely to be renewed.

Depending on which party wins the elections, there may be other major policy reforms in 2021 that will have a greater impact on population health than changes in medical finance and organization. Clean energy investment that creates jobs and significantly lowers air pollution will reduce deaths. Conversely, continued hollowing out pollution standards will create more disease and deaths. Huge expansion of early childhood education, especially for low-income and rural residents, will lead to lifetime improvements in health

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