Insight

Parsing the Rhetoric of Medicare for All

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Advocates of public health insurance have recently taken to naming their proposed legislation "Medicare [fill in the blank]." "Medicare Part E," "Medicare for All," "Medicare X," "Medicare Extra," and the "Medicare Buy-In and Health Care Stabilization Act of 2017" (Medicare Buy-In for short) are all bills or legislative proposals that follow this template. By naming a proposal after the popular program, the authors are seeking to communicate that their legislation expands Medicare or, at the very least, that their proposal is *basically* Medicare. But is that really the case? If so, what does that mean for the Medicare program itself?

PROPOSALS THAT WOULD DIRECTLY AFFECT MEDICARE

Despite the frequency with which policy makers are naming their proposals after Medicare, only two of the programs above directly alter Medicare: Medicare Buy-In and Medicare for All. Medicare Buy-In would allow people between 50 and 64 who are not otherwise eligible for Medicare to purchase Medicare coverage. The proposal states that the beneficiaries' premiums would be equal to the average, annual per capita cost of benefits payable under Parts A, B, and D, plus the applicable administrative expenses. It is unclear whether buying into Medicare at full price would be appealing to a diverse pool of consumers, as multiple studies have noted such plans would likely be subject to adverse selection, which leads to higher premiums and a riskier pool of buyers. Many potential enrollees are also already eligible to receive subsidized plans in the Affordable Care Act individual market with a higher actuarial value than Medicare. Without extra premium subsidies, it is probable that the Medicare Buy-In proposal would lead to relatively small enrollment and negligible effects on the Medicare program as a whole.

On the other hand, Medicare for All would set up the "Universal Medicare Program" that would, over time, replace every other source of insurance in the country. In particular, it would end Medicare as we know it. The Medicare Hospital Insurance Trust Fund would be liquidated and every dollar (along with those from the other public health programs' trust funds) would be transferred into a "Universal Medicare Trust Fund." While the Universal Medicare Program retains the Medicare name, it is unclear whether the benefits provided under the program would reflect current Medicare benefits. The bill is light on the details of the program's provided benefits and gives the Secretary of Health and Human Services the responsibility of regulating benefits, negotiating drug prices, establishing formularies, and making various other decisions. Studies by the Mercatus Center and the Center for Health and Economy have found this legislation would cost $32.6 trillion and $34.67 trillion over ten years, respectively.

PROPOSALS WITH NO DIRECT EFFECT ON MEDICARE

Every other proposal or piece of legislation mentioned above creates a program that is separate from Medicare and therefore would not directly affect Medicare. The other three proposals mentioned above—Medicare Part E, Medicare Extra, and Medicare X—are all variations of a proposal for a public option in the individual market along with increased premium tax credits, cost sharing reductions, and eligibility for both. Regardless of the isolated effects of a public option, federal spending is certain to increase for each of these plans because of the generosity and scope of the benefits prescribed.

What do these bills and proposals mean for the future of Medicare and its beneficiaries? Despite the authors' collective desire to keep these proposals separate from Medicare while using the name, even these bills could affect seniors' care. For example, each one sets up a public option where providers are compensated based on Medicare's rates, which are substantially lower than the rates of private insurance. A higher ratio of provider services reimbursed at Medicare rates could lead to a reduction in the number of physicians and the services they offer, an increase in the number of patients providers take on from private insurers, or an increase in the prices providers negotiate from private insurers.

THE BIG PICTURE

On a larger scale, such plans affect Medicare because they affect the federal budget. Medicare was never designed to be self-financing, and it relies heavily on general revenue from the Treasury. In 2017, Medicare had a cash shortfall of $352 billion, which represented nearly half of the federal deficit for the year. Medicare is a popular program, but the rate at which it spends money is currently unsustainable. Creating more unfunded public programs would increase the strain on the federal budget, create more competition with Medicare for general revenue, and thus threaten its future even further. Before trying to expand Medicare, policymakers should push to ensure it exists at all for future generations.