

## Beyond Medicare for All

Lisa R. Chacko, MD, MPH

(Fam Med. 2020;52(3):171-3.)

doi: 10.22454/FamMed.2020.324597

**M**uch like the population we serve, family doctors in the United States are divided along party lines on the issue of health reform,<sup>1</sup> and we are not the only divided medical group. Recently, the American Medical Association voted to maintain formal opposition to single-payer proposals in spite of a growing contingent of medical trainees who wanted to see that position amended.<sup>2</sup> The American Academy of Family Physicians acknowledges the challenge of political diversity in medicine, asserting that there is “lack of consistent dialogue around health care reform” and that we need “flexibility in our conversations and advocacy efforts.”<sup>3</sup>

Unfortunately, elections don't lend themselves to this needed flexibility. Campaigns rebrand complex issues as slogans that voters can easily digest. “Medicare for All” has emerged as a buzzword that, in reality, could represent a wide range of policy solutions for which price tags and implementation timelines are unclear. The details that matter most to everyday Americans, such as out-of-pocket expenses including prescription drugs and taxes, are still up for debate. Health care policy is incredibly complex, with interwoven challenges such as the opioid crisis, the burden of chronic disease, health disparities, and drug pricing each meriting its own policy conversation. Given this degree of complexity, debates often jump between payment, delivery, and public health reform. This shifting focus confuses the American public and challenges policy makers to simplify both the problems and their possible solutions. It is critical that we clearly understand what problem we are trying to solve before we can advocate for targeted policy solutions that might have bipartisan appeal.

What problem is Medicare for All trying to solve? There are two key economic concepts

that help clarify the core issue. First is the intimate relationship between the provisions of our free market and those of our government. Historically, government has served to protect that which our markets cannot, in order to foster economic stability and public well-being. When a critical service or function cannot be guaranteed by the free market—a situation sometimes called a market failure—we enact policies or programs to safeguard access to important public benefits. Examples include local libraries, police and fire departments, public schools, national parks, and emergency medical services including the 911 system. The second economic concept is insurance. The goal of insurance, whether it is home, life, or auto insurance, is to protect individuals from catastrophic costs. The mechanism of insurance is to distribute risk among a group of people, called a risk pool. It is critical to distinguish insurance as a financial mechanism from our care delivery system that is made up of hospitals and clinics, doctors and nurses, as well as the services they provide.

As a nation, we are at a crossroads with regard to health care financing. Thus far, we have been unable to guarantee access to insurance for all Americans, and finding affordable care is a worsening problem for our patients. The cost of private insurance is outpacing overall inflation.<sup>4</sup> National health spending is growing more quickly than our gross domestic product (GDP), approaching 20% of GDP.<sup>5</sup> Under the current administration, uninsurance rates have begun to increase again.<sup>6</sup> The leading cause of bankruptcy is still medical expenses, despite the Affordable Care Act.<sup>7</sup> If these aggregate metrics haven't moved voters

---

From the Department of Community Health and Family Medicine, University of Florida, Gainesville, FL.

to demand a change, increasing media coverage of patient struggles including stories of aggressive debt collection and legal action against patients by hospitals have increasingly drawn public scrutiny, and with it, political will for reform.<sup>8</sup>

Despite these dramatic statistics, many Americans are worried about the disruption that a transition to a single-payer plan would entail. These concerns will increasingly be stoked by opponents if the movement progresses. Fear of short-term losses including jobs and profits in a deeply entrenched trillion-dollar health industry are not hard to understand. Even among proponents of single-payer proposals, there is justifiable concern about the transition. If the implementation phase of a new national plan is poorly managed, the political momentum toward universal coverage could be compromised, setting back similar proposals for years to come.

Regardless of which health care platform you support, we should all be prepared for any national legislation that comes out of this presidential election to be held up in a prolonged congressional battle, and if passed, go on to face opposition that will seek to interfere with a smooth implementation process. This is, after all, how the democratic process currently works. And as long as the debate goes on, our patients will continue to experience high levels of medical debt and financial stress, which can translate into poorer health outcomes. Prolonged uncertainty will further increase this stress. If broad national legislation cannot move forward, those of us on the frontline can forge ahead by identifying and advocating for focused strategies at the local, state, or federal level that would still allow critical pieces of reform to move forward, ideally with bipartisan support.

If we return to the policy questions of (1) how to distribute risk across populations, and (2) how to protect individual Americans from medical debt, we can see there is an incentive to build larger and more diverse risk pools that can guarantee some basic minimum of financial protection to the general public. This might lead to the creation of a national risk pool, such as that proposed in Medicare for All, or the ACA's individual mandate. However, there are incremental policy approaches to risk distribution and protecting individuals from financial loss worth considering.

In 1971, economist Martin Feldstein wrote, "our present system of financing health care provides inadequate protection, encourages

inefficient use of resources, and accelerates the inflation of medical costs."<sup>9</sup> Sound familiar? Under Feldstein's proposal, termed Universal Catastrophic Coverage, or Major Risk Insurance, the government would extend catastrophic coverage to all Americans. For costs above an income-based cap, coverage is guaranteed. Below this cap, supplemental private insurance could operate, and local health care markets could compete to provide elective and primary services. Although Feldstein's proposal doesn't attempt to fix every problem of the health system, it illustrates how a more targeted policy approach might work. This same logic could apply at the local or state level. For example, New York City owns and operates a public insurance option that could be strengthened and expanded to distribute risk over a larger municipal population.<sup>10</sup> Likewise, New Jersey's State Health Benefits Program that created a single risk pool for all state, local, and school district employees could be expanded by including employers and ultimately extending such a public plan to individuals.<sup>11</sup> Whether it is through regional or national public insurance options, Medicare for All, or universal catastrophic coverage, it is clear that voters are ready for a new approach to health insurance. As family physicians we should advocate to protect our patients and all Americans from financial hardships that result from the care we provide. As we consider policy solutions that are acceptable to the public and that offer some level of protection against medical debt for all Americans, we can begin to shift the national conscience towards the idea of a basic guarantee to all people with regard to health care.

At the frontline of American medicine, family physicians are poised to play a unique role in advocating for reform. Our political diversity gives us the opportunity to move beyond partisan politics and take a more objective approach to our advocacy efforts. The most basic oath we took as physicians—*primum non nocere*—demands that we get informed and engaged to help fix a financial system that has the potential to harm the same patients we wake up every morning to serve. It is our professional duty to move beyond our political comfort zones toward a vision of a healthier economy and more efficient and equitable health financing system.

**CORRESPONDENCE:** Address correspondence to Dr Lisa R. Chacko, PO Box 100237 Gainesville, FL 32610-0237. 352-273-5159. lchacko@ufl.edu.

## References

1. Hersh E, Goldenberg M. Democratic and Republican Physicians Provide Different Care on Politicized Health Issues. *Proceedings of the 2016 National Academy of Sciences*. 113 (42): 11811-11816.
2. Hindsdale J; Council on Medical Service. CMS Report 2-A-19: Covering the Uninsured Under the AMA Proposal for Reform (Resolution 108-A-18). Chicago: American Medical Association; 2019.
3. American Academy of Family Physicians. Health Care for All: Moving to a Primary Care-Based Health System in the United States. <https://www.aafp.org/about/policies/all/health-care-for-all.html>. Leawood, KS: AAFP; 2019. Accessed December 5, 2019.
4. Kaiser Family Foundation. Kaiser Family Foundation Employer Health Benefits 2019 Annual Survey. <https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/>. San Francisco, CA: KFF; 2019. Accessed December 5, 2019.
5. Sisko AM, Keehan SP, Poisal JA, et al. National Health Expenditure Projections, 2018-27: Economic And Demographic Trends Drive Spending And Enrollment Growth. *Health Aff (Millwood)*. 2019;38(3):491-501.
6. Berchick E, Barnett J, Upton R. Health Insurance Coverage in the United States: 2018. Report No. P60-267. Suitland, MD: US Census Bureau; 2019.
7. Himmelstein DU, Lawless RM, Thorne D, Foohey P, Woolhandler S. Medical Bankruptcy: Still Common Despite the Affordable Care Act. *Am J Public Health*. 2019;109(3):431-433.
8. Kliff S. With Medical Bills Skyrocketing More Hospital Are Suing for Payment. *The New York Times*. <https://www.nytimes.com/2019/11/08/us/hospitals-lawsuits-medical-debt.html>. Published Nov. 8, 2019. Accessed January 8, 2020.
9. Feldstein M. A New Approach to National Health Insurance. *Public Interest*. 1971;23(Spring).
10. MetroPlus Health Plan. About Us. <https://www.metroplus.org/About-Us/overview> Accessed December 5, 2019.
11. New Jersey Treasury. Health Benefits Information-Active Employees. <https://www.nj.gov/treasury/pensions/hb-info-active.shtml>. Accessed December 5, 2019.