Medicare For All would mean worse care for all

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May 4, 2022

Senate Budget Committee Chairman Bernie Sanders (I-Vt.) has announced that as early as next week, his committee will hold a hearing "on the need to pass a Medicare for All single-payer program."

Sanders gets an "A" for passion, but an "F" in compassion.

The non-partisan Congressional Budget Office has cautioned that Sanders' Medicare for All bill would create "a shortage of providers, longer wait times, and changes in the quality of care."

Indeed, the non-partisan Medicare Payment Advisory Commission has warned since at least 2003 that Medicare's approach to health care quality "is largely neutral or negative." Enrolling 330 million people in the program would only make the problem worse.

Thankfully, there is a (potentially bipartisan) way to reverse Medicare's negative impact on quality: Apply "public option" principles not to the private health insurance market but to Medicare, where this traditionally Democratic idea would dramatically increase choice and competition.

Since 1965, Medicare has paid providers more for low-quality care than for high-quality care. For example, in 1995, Utah's Intermountain Health Care reduced mortality by improving how it treated pneumonia. Medicare rewarded those quality improvements by paying Intermountain *less*.

In 1999, Duke University developed a better way to treat congestive heart failure. Medication adherence increased. Hospitalizations fell. Resource use fell by half. Again, Medicare (and private insurers with similar payment rules) responded by reducing payments. Duke eventually had to shutter the program for lack of funds.

In 2002, Whatcom County, Washington improved glucose management for diabetics and stabilized congestive heart failure patients, saving $3,000 per patient. The county ended up shuttering the program for the same reason Duke did.

Need more evidence?

In 2009, Medicare *reduced* payments to Texas' Baylor Medical Center after the system cut heart-failure readmissions in half with no increase in mortality. Hospitals can nearly *double* net revenues if a Medicare patient develops post-operative complications. Medicare pays hospitals nearly $3,000 more per patient when low-quality care leads to more post-acute care and

readmissions. Medicare paid a large urban hospital system more when it allowed urinary-tract or bloodstream infections than when it prevented them.

It doesn't have to be this way.

In the mid-1990s, Group Health Cooperative of Puget Sound improved diabetes care with an "average cost savings [] of $685-$950 per patient per year." Group Health's different payment rules—which markets developed a century before Congress enacted Medicare—allowed it to *profit* from those quality improvements.

What Sen. Sanders doesn't get is that medicine is so complex, no single payment system can promote all aspects of health care quality. Locking in *any* single set of payment rules—as a single-payer system by definition must—will always reward low-quality care and penalize progress.

Competition drives providers to improve all dimensions of quality—even those their own payment rules discourage. Improving care across the board requires letting all varieties of payment rules compete on a level playing field.

Public-option principles demand exactly that: a level playing field where consumers are the ultimate arbiters of quality and efficiency. Public-option supporters want a new government program to be one of the competitors.

But there's no need for a new program. Traditional Medicare is a government-run plan that already competes against private insurers. Economist Mark Pauly explains that Medicare "is essentially a risk-adjusted voucher program" that lets enrollees choose between a public option and private Medicare Advantage plans.

That playing field, however, is anything but level. Congress bars certain plans, encourages excessive coverage, and penalizes high-quality coverage. It further violates public-option principles by offering larger subsidies to healthy enrollees if they choose Medicare Advantage, and to sicker enrollees if they choose traditional Medicare.

Public-option principles demand eliminating all such distortions. Most important, they require that each enrollee's subsidy neither rise nor fall depending on which health plan, or how much coverage, he or she chooses. Only one type of subsidy can do that: cash.

Public-option principles *require* that Medicare mirror Social Security, which gives enrollees cash and trusts them to spend it. In 2022, Medicare will spend enough to give each enrollee an average cash subsidy of $12,100. Income- and risk-adjustment would give poorer and sicker enrollees thousands more to ensure they could afford coverage.

Enrollees would spend that money better than government bureaucrats do. Evidence shows that cost-conscious patients force providers to reduce prices and that when seniors control their health decisions, even those with cognitive limitations make good choices.

While Medicare for All would condemn generations to low-quality care, applying public-option principles to Medicare would improve health care through choice and competition. It's a Democratic idea even Republicans can love.

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