Medicare for All

An Economist's Case

Laurence Seidman

This article makes an economist's case for extending Medicare to cover all Americans. First, Medicare for All would achieve universal coverage and portability. Second, Medicare for All would eliminate health insurance distraction for business managers, entrepreneurs, and job seekers, thereby improving the productivity of the U.S. economy. Third, Medicare for All would use an internationally proven method to reduce the huge gap between medical-care costs in the United States and those in other economically advanced countries: payer bargaining power. Fourth, Medicare for All is easy to explain and may therefore prove politically feasible.

ONLY IN THE PAST DECADE have American advocates of single-payer national health insurance started calling their proposal "Medicare for All" (Bernstein and Bernstein 2007; Conyers 2011; Kennedy 2007; Morone 2002). I believe that use of the name "Medicare for All" will come to be seen as a turning point in the American effort

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to achieve universal single-payer national health insurance.

Medicare is an American program that has been operating for half a century. Medicare has five decades of experience resolving numerous practical administrative problems. Since its beginning it has contracted with private insurance companies to perform administrative functions such as bill processing and payment, but *not* insurance functions such as selecting enrollees and setting premiums. Most Americans are familiar with how Medicare operates, either as covered seniors or as children of seniors who sometimes accompany their parents when they go to the doctor or hospital. They are familiar with the free choice of doctor and hospital, and the lack of waiting times or waiting lists, under Medicare. Medicare's fee schedules for hospitals and doctors, which have been in effect for the past two decades, have not generated waiting lists or excessive waiting times, and Medicare fees have been sufficient to enable patients to obtain high-quality medical care.

Medicare for All would be a single-payer program that covers all Americans, and the analysis and arguments of advocates of single-payer national health insurance (e.g., Geyman 2008, 2010; Woolhandler et al. 2003b) apply to Medicare for All. A single-payer bill has been introduced many times in Congress, including in the 2011–12 session (H.R. 676; Conyers 2011), and has always obtained a significant number of congressional sponsors. Using the name "Medicare for All" makes clear that single-payer national health insurance would be an extension of a long-running American program for all Americans, not a brand-new program or a foreign program with which Americans have no personal experience.

Medicare for All would eliminate patient cost-sharing so there would be no need for private Medigap policies or for Medicaid to pay medical bills. Medicaid would continue to pay for nursing homes for people with low income and low assets. The elimination of Medicaid payment of medical bills would substantially reduce state Medicaid spending and Medicaid's fiscal burden on state governments. Everyone would pay at least some of the taxes earmarked for Medicare for All so that there would be no free riding—everyone would make a financial contribution.

Medicare for All would eliminate private health insurance premiums and replace them with a set of taxes earmarked for Medicare for All. Most business firms and individuals would pay roughly the same dollar amount but send it to a different address—to Medicare for All instead of to a private health insurance company. The set of taxes earmarked for Medicare for All would consist of the following: the Medicare payroll tax, a value-added tax (VAT), a Medicare for All income tax surcharge on the 1040 personal tax return, and a set of health taxes (on tobacco, alcohol, and pollution) that discourage activities harmful to health.

Under Medicare for All, as under Medicare, individuals would be free to go to fee-for- service doctors and hospitals or to an organization of doctors that charges an annual price per enrollee rather than fee for service. Medicare for All would negotiate fees charged by doctors and hospitals, and the price per enrollee charged by an organization of doctors. Medicare for All would also negotiate drug prices with drug companies.

After paying their earmarked taxes to fund Medicare for All that has no patient cost-sharing, individuals can choose to pay for medical services outside of Medicare for All, just as individuals, after paying taxes to fund elementary and secondary public schools that charge no tuition, can choose to pay private school tuition for their children.

This article makes an economist's case for extending Medicare to cover all Americans. There are four main arguments. First, Medicare for All would achieve universal coverage and portability. Second, Medicare for All would eliminate health insurance *distraction* for business managers, entrepreneurs, and job seekers, thereby improving the *productivity* of the U.S. economy. Third, Medicare for All would use an internationally proven method to reduce the huge gap between medical-care costs in the United States and other economically advanced countries: *payer bargaining power.* Fourth, Medicare for All is much simpler to explain to people and to operate than either the current "system" of private insurance or plans (like the Affordable Care Act of 2010) that try to work through private insurance. This

simplicity may make Medicare for All more politically feasible than alternatives that are inevitably complex and hard to explain because they try to work through private insurance.

Medicare for All Would Replace Premiums with Taxes

Medicare for All would eliminate premiums and replace them with a set of taxes earmarked for Medicare for All. Rather than funding it with a single tax at a high rate, I recommend using a set of taxes, each with a moderate rate. This approach is likely to impose less efficiency loss on the economy than a single tax with a high rate because public finance economists have shown that the efficiency loss from a tax generally rises with the square of the tax rate (Seidman 2009). Moreover, a set of taxes often spreads the burden more fairly across the population than a single tax that might especially burden one group while imposing little or no burden on others.

Several of the taxes I recommend are already in place in the United States, and several would be new. One tax currently in place is the Medicare payroll tax (currently 1.45 percent on the employer and 1.45 percent on the employee—a combined rate of 2.90 percent on all wage income). The tax that would be new to the United States is the VAT, which is used successfully by virtually every economically advanced country. Many U.S. economists have recommended a U.S. VAT (Hines 2007; Seidman 2004), and several analysts have recommended that a VAT be enacted and earmarked for universal health insurance (Burman 2009; Morone 2002).

It should be recognized that when taxes are levied on business firms (such as the VAT or the payroll tax), people bear the tax burden. If businesses raise prices in response to paying taxes, consumers bear some burden. If businesses pay lower wages in response to paying taxes, workers bear some burden. If businesses pay smaller dividends or profits to investors or owners in response to paying taxes, then investors or owners bear some burden. Everyone would bear some burden from the earmarked Medicare for All taxes levied on businesses.

Virtually everyone would be "paying for"—bearing some burden of—Medicare for All earmarked taxes that are levied on business firms. There would be no free riders.

Raising the payroll tax above its current 2.90 percent would be simple to administer and require no new legislation other than raising the number 2.90 to a higher value. It would require no new tax administration. By contrast, a VAT would require new legislation and new administration. But there has been so much practical experience administering a VAT in other economically advanced countries that it would be relatively easy for the United States to get a VAT up and running. A VAT would increase the prices of most goods and services, and economic analysis shows that most of the tax burden would fall on consumers. Because of the effect on prices, a VAT should be phased in gradually over several years. Using both the Medicare payroll tax and a VAT would prevent free riding under Medicare for All because everyone would bear some burden through either lower take-home pay or higher prices and would therefore be making some financial contribution to Medicare for All.

The new Medicare for All income tax surcharge on the 1040 personal tax return would be easy to implement. Congress would have some design choices. The Medicare surcharge would be t percent (e.g., 1 percent) of either of three items already reported on each taxpayer's 1040 personal income tax return: total income, adjusted gross income, or taxable income. The Medicare surcharge would be t percent of either all income or income up to a ceiling of Z dollars (for example, $100,000). Every household or individual filing an income tax return would therefore be subject to some Medicare for All income tax.

It should be noted that many low-income working adults currently file an income tax return in order to obtain the Earned Income Tax Credit (EITC), so these adults would pay the Medicare for All surcharge. They would still have an incentive to file, as long as their EITC is greater than their Medicare for All surcharge, as it surely would be (for example, if the Medicare surcharge were 1 percent of income, a household with $20,000 of labor income would owe a Medicare

surcharge of $200, which would be much less than the EITC it would receive by filing). Adults with no income would not owe any Medicare for All income tax (and generally would not file an income tax return because they would not be entitled to an EITC). Even these adults would still bear some tax burden for Medicare for All through the higher prices of goods and services due to the VAT (and possibly due also to the payroll tax).

Some health taxes (on tobacco, alcohol, and pollution) are already in place, and some would be new. The United States has long had excise taxes on tobacco and alcohol; their revenues would now be earmarked for Medicare for All. The United States has generally used regulation rather than taxes to deter pollution. Most economists, however, have argued for pollution taxes as a more desirable way to deter pollution (Hines 2007; Seidman 2009). A set of pollution taxes would require new legislation.

Here is a rough estimate of how much the new earmarked taxes would need to be as a percent of the gross domestic product (GDP). Today U.S. medical costs are 18 percent of GDP; by contrast, no other country exceeds 12 percent. Suppose that Medicare for All aims to cut the six-percentage-point gap in half, so that U.S. medical costs are 15 percent of GDP. If Medicare for All succeeds in using its payer bargaining power (as explained below) to achieve its medical cost target of 15 percent of GDP, then Medicare for All taxes would need to be 15 percent of GDP. Spending by Medicare, Medicaid, and other government health programs is currently about 6 percent of GDP (U.S. Congressional Budget Office 2012, 49, table 3-1), so *new* earmarked taxes would need to be roughly 9 percent of GDP.

To put this 9 percent of GDP number in perspective, in 2007 (before the Great Recession caused a plunge in tax revenue), U.S. taxes (federal, state, and local) were about 30 percent of GDP. Thus, taxes would rise by 9 percent of GDP from 30 percent to 39 percent (federal taxes would rise by 10 percent of GDP while state taxes would fall by 1 percent of GDP due to the reduction in state Medicaid expenses), which would still leave U.S. taxes as a percent of GDP slightly lower than the average of the economically advanced Organization for Economic Coopera-

tion and Development (OECD) countries (roughly 40 percent) and far below the Scandinavian countries (roughly 50 percent).

At the same time, U.S. medical costs would be three percentage points of GDP lower every year (15 percent instead of 18 percent of GDP), so goods and services other than medical care would be three percentage points of GDP higher every year (85 percent instead of 82 percent of GDP). Each year Americans would enjoy three percentage points of GDP more goods and services other than medical care while still having the highest medical-care spending in the world (15 percent of GDP when all other countries spend 12 percent of GDP or less).

Once Medicare for All taxes are in place, political resistance to raising the rates of these earmarked taxes would provide a powerful force for containing the rise in medical costs under Medicare for All. The earmarked tax rates voted by Congress would in effect set a global budget for Medicare for All—a limit on total national medical costs.

Some opponents of Medicare for All have claimed that current Medicare is "going bankrupt" and that Medicare for All would be "even more bankrupt." But the term "bankruptcy" does not apply to government programs like national defense, Medicare, or Medicare for All. No one claims national defense is "going bankrupt" even when defense expenditures rise sharply during a war like World War II, and no one should claim that Medicare or Medicare for All would "go bankrupt." The expenditure of government programs is limited to the taxes government raises plus the funds government borrows. In the case of a program like Medicare for All that would use only earmarked taxes, spending would be limited to earmarked tax revenue; if earmarked taxes are 15 percent of GDP, then expenditures would be 15 percent of GDP.

Medicare for All would have to bargain over prices and budget caps with medical providers in order to keep Medicare for All spending from exceeding the earmarked revenues it collects. If a gap occurs, Congress would have to bridge the gap by either raising earmarked taxes or reducing medical prices and budget caps. There would be tough choices (just as there is with national defense during a war like World War II), but there would be no "bankruptcy."

Medicare for All Would Eliminate Patient Cost-Sharing

Current Medicare has substantial patient cost-sharing. As a consequence, many high- and middle-income households have bought private Medigap insurance policies to cover Medicare's patient cost-sharing, and Medicaid has had to cover it for many low-income households.

Medicare for All would eliminate patient cost-sharing. There would no longer be a need for households to buy private Medigap policies or for Medicaid to pay medical bills. Medicaid would continue to pay for nursing home care for people with low income and low assets.

Like many economists, I have been reluctant to support the elimination of patient cost-sharing. But patient cost-sharing causes two serious problems: (1) cost-sharing that does not vary with patient income overburdens moderate-income people when they obtain care; (2) cost-sharing deters necessary care (as well as unnecessary care). Let us consider each problem.

First, when cost-sharing is uniform for patients of all incomes (e.g., a $2,000 deductible or 20 percent of the medical bill), it is too burdensome for households with moderate income. This problem could be solved by income-relating patient cost-sharing. Patients would use a Medicare card at the doctor's office or hospital and at the end of the month would be billed by Medicare for a percentage of their medical cost that varies with the income reported on the previous year's income tax return (e.g., 5 percent for a low-income household, 15 percent for middle income, 25 percent for high income) with an annual ceiling that varies with income (for example, 2 percent of income for a low-income household, 6 percent for middle income, and 10 percent for high income).

The second problem, however, is harder to solve. Recent empirical literature (Baicker and Goldman 2011) has shown that patient cost-sharing sometimes deters patients from taking early medical action, such as seeking tests or adhering to prescribed medications, that would avoid much greater costs and hardships later. To deal with this problem, it would be necessary to enact a lengthy list of exceptions

to cost-sharing. Developing such a list, keeping it up to date, and basing it on medical merit rather than lobbying strength would be extremely difficult. The simplest solution to this problem would be to eliminate patient cost-sharing.

As explained below, Medicare for All would use the internationally proven method of *payer bargaining power* coupled with American tax resistance, not patient cost-sharing, to slow the rise in medical costs.

Medicare for All Would Achieve Automatic Coverage and Portability

Under Medicare for All, every *individual* would be *automatically* covered regardless of employment, health status, income, marital status, or residential location. Every individual would receive a Medicare card for life to use any time or place that individual obtains medical care. Coverage would be *automatically portable* so everyone would have the peace of mind that comes from this fact—the same peace of mind that Medicare currently provides for its enrollees.

No market of competing private insurance plans can provide this automatic coverage and portability, and therefore, no private insurance market can provide this peace of mind. Today's seniors on Medicare never worry that they will lose their health insurance should they experience a change in employment, health status, income, marital status, or residential location. By contrast, worry about losing private health insurance is widespread among Americans under sixty-five for good reason, and no private insurance market can eliminate it.

Think about what *automatic* coverage and portability means. How many Americans have changed jobs? How many families have experienced an adverse change in health status? How many have felt an adverse change in income that limits their ability to afford insurance? How many have lost coverage from their spouse's plan due to a divorce? And how many have needed or wanted to change where they live? Yet any of these changes may jeopardize their private health insurance.

Medicare for All would end the financial hardship and bankruptcies that currently result from medical bills for the uninsured and underinsured (Himmelstein, Thorne, Warren, and Woolhandler 2009). According to a study by these authors, illness and medical bills were linked to about 60 percent of all personal bankruptcies in the United States in 2007, and most of these medically bankrupt families were middle class and had health insurance with patient cost-sharing. Medical bankruptcies, and the fear of medical bankruptcies, would be eliminated by Medicare for All. It is crucial to recognize that actual bankruptcies are just the tip of the iceberg of financial hardship. Many people who suffer severe financial hardship due to medical bills manage to avoid actual bankruptcy. Thus, data on the number of actual bankruptcies due to medical bills greatly understates the number of people subject to financial hardship and anxiety due to medical bills, all of which would disappear under Medicare for All.

In the absence of government intervention, a market of competing private insurance plans would not provide automatic coverage and portability. Private insurance companies, like other private firms in other industries, try to make profits and avoid losses. When they sell insurance directly to individuals, they have a financial incentive to refuse to provide coverage unless they can charge a premium that covers that individual's expected medical cost. A former top health insurance company insider has given a disturbing account of how insurance companies maneuver to avoid people with high medical costs (Potter 2009). When an individual's health status changes adversely, the insurance company takes a loss unless it can raise the individual's premium to match the individual's higher cost.

When companies sell insurance to employers, they may be willing to cover all employees at the same premium and agree to continue coverage of employees who turn out to be high cost. But some employers prefer not to purchase insurance for their employees, so their employees have to obtain individual insurance directly from private companies that charge them a premium that matches their expected medical cost. Individuals fortunate enough to be covered by their

employer's private insurance plan know that a change of job may well mean a loss of insurance.

Advocates of a system of private health insurance claim it can achieve universal coverage. They offer two alternative approaches. Under the first, no attempt would be made to force private insurance companies to do what they do not want to do. Companies would be free to reject individuals with preexisting conditions, drop individuals who develop a high-cost medical problem, or charge each individual a premium that varies with that individual's expected medical cost. But the government would make last-resort insurance available at a normal premium to every high-cost individual. It would do this by either providing subsidies to private insurance companies to enroll high-cost individuals at a normal premium, or covering these individuals itself.

Under this first approach, however, coverage and portability would not be automatic. A high-cost individual might initially be rejected by a private insurance company or offered a very high premium. The individual would then have to apply to qualify for last-resort insurance. There would be a delay processing the application, and the individual might ultimately be rejected. Even if accepted, a person with moderate income would need an adequate subsidy from the government to enable her to afford the normal premium. By contrast, under Medicare for All no application process or subsidy is necessary. Every person is automatically covered by Medicare for All.

Under the second approach, the government would try to force companies to enroll everyone who applies at a normal premium regardless of preexisting conditions or high medical cost. This is the approach of the Affordable Care Act (ACA) enacted in 2010. When it goes into effect in 2014, it will try to make insurance companies do what they do not want to do: enroll high-cost individuals at a normal premium. In an effort to reduce the company resistance and maneuvering that has been documented by insurance insider Potter (2009) and others, the ACA would try to implement "risk adjustment." Under risk adjustment, the government would give financial compensation to companies that enroll an unusually high

number of high-cost individuals. Without adequate risk-adjustment, companies would seek subtle ways to discourage the enrollment, and encourage the disenrollment, of high-cost individuals. Risk adjustment, however, has already been attempted in the Medicare Advantage program and the Medicare Drug program, and several studies have found that it is very difficult to achieve successful risk adjustment. For example, Brown, Duggan, Kuziemko, and Woolston (2011) find little evidence that risk adjustment has worked in the Medicare Advantage program.

Analysts, and even advocates, do not expect the ACA, which relies on regulation of private insurance companies and risk adjustment, to come even close to covering the entire population; millions will remain uninsured or underinsured. There will certainly be no *automatic* coverage and portability, and therefore no peace of mind. In contrast to people sixty-five and over who are automatically covered by Medicare, a substantial minority of people under sixty-five will continue to lack health insurance, and many people under sixty-five will continue to worry about losing their private health insurance.

Medicare for All Would Eliminate Distraction for Business Managers and Job Seekers

Under Medicare for All, business managers, entrepreneurs, and job seekers would no longer be distracted by health insurance. Managers and entrepreneurs would concentrate exclusively on their business, and job seekers would choose to switch jobs without considering health insurance. Removing the distraction of private health insurance would lift the productivity and efficiency of the economy.

Under today's private health insurance market, most managers and entrepreneurs must devote substantial resources and time to handling their employees' health insurance. They must select private insurance plan options for their employees and continually monitor plan performance, employee satisfaction, and plan changes (in premiums, service coverage, and patient cost-sharing). Large firms

must establish benefits departments to handle their private health insurance business.

The health insurance burden is especially severe on managers of small businesses. The premium charged by private insurers will usually vary with the average medical cost of the small group of employees. If one employee's family develops a chronic costly medical problem, the insurance company will usually raise the premium to cover the higher medical cost for as long as the high-cost employee remains with the firm. This places the business manager in a difficult ethical situation. Instead of being able to concentrate exclusively on business, the manager must worry about the medical costs of employees and their dependents.

The potential private health insurance burden discourages entrepreneurship and small business creation. Consider someone who is deciding whether to work for an established large business firm or start up her own small business. If she works for the large firm, it will provide her health insurance and she will not have to take care of anyone else's health insurance. But if she becomes an entrepreneur, she must immediately confront the problem of whether to provide health insurance for her employees. If she does not, she may be unable to attract the best employees, and she must also obtain and maintain individual health insurance for herself. The alternative is to search the private health insurance market even before she begins to operate her new business and continue to bear this burden of managing health insurance for as long as she stays in business.

Now consider the burden on each job seeker. An immediate question is whether a potential employer provides health insurance and the specifics of the employer's health insurance policy. Once a job seeker is employed, leaving the job would entail losing the employer's health insurance. As a consequence, some employees experience "job lock": They decide not to switch jobs because of the health insurance loss such a switch would provoke (Madrian 1994). Workers who would be more productive and/or more satisfied if they switched jobs are deterred from switching because of concern about health insurance. Switching from low- to high-productivity jobs is deterred by concerns about health insurance.

Eliminating the health insurance distraction of business managers, entrepreneurs, and job seekers would improve the productivity of the economy. Instead of burdening managers and workers with responsibility for obtaining health insurance, Medicare for All would take care of health insurance so that managers and workers can concentrate on economic productivity.

Medicare for All Would Eliminate Marketing Costs and Reduce Administrative Costs

Marketing costs are substantial under a private health insurance system. How many ads have you seen by private health insurance companies? These ads are costly and the cost is built into the premiums that these companies charge and that people bear. These costs disappear under Medicare for All, as do the costs of enrolling or cancelling people in private insurance plans and negotiating contracts with providers.

Medical provider administrative costs would be substantially reduced. Most doctors and hospital administrators justifiably complain about the significant staff costs they incur because their patients are covered by numerous different insurance plans that each have different payment and coverage rules. Under Medicare for All, all patients would be under one insurance plan. Administrative costs have been much lower under Canada's single payer system than under the U.S. multiple private insurance system (Cutler and Ly 2011; Woolhandler, Campbell, and Himmelstein 2003).

The costs of processing bills submitted by doctors and hospitals to the insurer would remain. The bills would now be submitted to Medicare for All instead of to numerous private insurance companies, but Medicare for All would do what Medicare has done for half a century: contract with private insurance companies to process bills submitted by doctors and hospitals. There would, however, be no billing or collecting from patients, thereby achieving a substantial reduction in administrative cost.

Medicare for All Would Reduce the Huge Medical Cost Gap

Is it possible for the United States to stop being an extreme outlier in medical cost as a share of GDP? Let's take a practical approach. We observe that for several decades the United States has been an *extreme outlier* among high-income countries with respect to two numbers. Health spending as a percentage of GDP and health spending per capita have each been *much* lower in all other high-income countries than in the United States. As mentioned earlier, the U.S. medical cost is 18 percent of GDP, while no other country exceeds 12 percent (OECD 2012). This six-percentage-point gap is huge. Although many Americans may want the United States to have a higher medical cost percentage than any other country, it is doubtful that most Americans would want the gap to be so large. The practical response to this gap should surely be to ask: What have other high-income countries been doing that we have not? Maybe we will decide that what they have been doing is unacceptable for us. But explaining why these two numbers are so much lower for all other high-income countries is surely a first step.

For several decades, virtually all high-income countries have used payer bargaining power to limit the rise in prices paid to medical providers. Payer bargaining power has been used to limit prices set by hospitals and drug companies and fees set by doctors, and to set budgets—total spending caps—for hospitals, drugs, and doctors (White 2009). Some countries have exercised payer bargaining power through a government national health service (e.g., Britain); others, by having government be the single payer of private medical providers (e.g., Canada); and others, by having the government coordinate private insurers into a united bargaining unit, sometimes called an "all-payer" system (e.g., Germany).

None of these high-income countries has used any of the methods that have dominated the recent health-care cost-containment debate in the United States. None has used a "consumer-driven" strategy in which households get private insurance with high deductibles that will supposedly make them active shoppers who discipline medical providers on price and quality just as cost-conscious consumers discipline

providers of other goods and services. None has used a "premium-support" strategy in which the government gives households vouchers to buy insurance from private companies that will somehow discipline medical providers on price and quality. None has relied on generating competition among medical providers or among private insurance companies as the method of health care cost containment. Instead, these countries have all used payer bargaining power to negotiate prices and budget caps.

So a practical policy response would be to seriously consider using the same method that has been used in other high-income countries: payer bargaining power. Payer bargaining power is an internationally proven method of achieving a lower percentage of GDP for medical costs.

But won't this method lead to waiting lists, shortages, and poor quality? Not if payer bargaining power is applied *moderately*. To understand why, we need to understand the price explosion that has occurred in U.S. medical markets under its private insurance system.

100 Percent Insurance Generates a Massive Rise in Medical Prices in the Absence of Regulation

What happens if insurance pays 100 percent of the bill? Figure 1 provides the answer. With 100 percent insurance, the demand curve would be a vertical line: No matter how high a price is charged by the medical provider (doctor, hospital, or drug company), the patient's demand is the same as it would be if the price charged were zero. With a normal supply curve *S*, at first glance it might seem that the market would move to point *G* and stay there. But this is not so.

After the market reaches point *G*, price continues to climb up *D* without limit unless insurers or government regulators stop it. Why does price keep climbing? Because with 100 percent insurance, patients no longer care about the price that their own medical provider charges when they seek medical care and choose among medical providers. Providers know this. In a market without 100 percent insurance, the force limiting each supplier's price increase is the worry that it will cause some patients to switch to another supplier with a lower price.

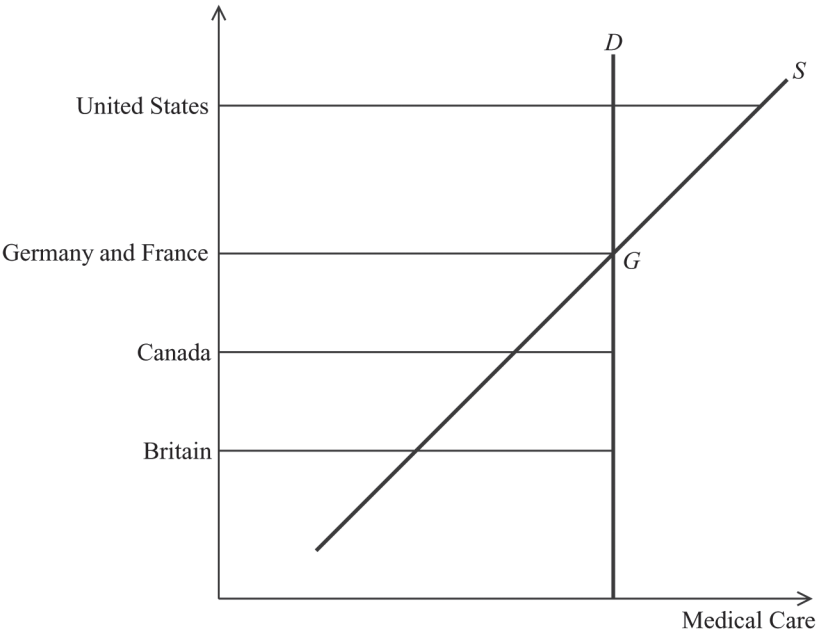

Figure 1. Medical Prices with 100 Percent Insurance

But 100 percent insurance completely destroys this usual force. Hence, unless insurers stop it, the price gradually shoots up from point *G* up the *D* line like a rocket ship (Seidman 2009).

Note that a vertical demand curve per se does not cause a price rise—only a vertical demand curve caused by 100 percent insurance does that. Suppose, instead, that a vertical demand curve is caused by consumers' strong natural preference for a product, so that as the price rises, consumers continue to demand the same quantity. With a "natural" vertical demand curve, each consumer still prefers a lower price; if one supplier offers a lower price than another for the same quality product, consumers will switch to that supplier. With a "natural preference" vertical demand curve, the market would, as usual, stay at point *G* (the intersection of supply and demand) because each supplier would limit price for fear that consumers would switch to other suppliers. But when the vertical demand curve is caused by 100 percent insurance, each supplier can raise prices without fear that consumers will switch, so the price rises.

The price rise would occur even if patients must pay a fixed-dollar

copayment or modest deductible before the 100 percent insurance kicks in. As long as the dollar copayment or deductible does not vary with the price the provider charges, a patient is not deterred from going to a medical provider no matter how much the provider raises the price charged to the patient's insurer. Thus, even if there are copayments or modest deductibles, 100 percent insurance would raise prices unless insurers stop it.

Of course, the insurers paying the bills will try to stop the price rise under 100 percent insurance. When insurers receive bills from medical providers, they usually refuse to pay the providers' prices. When the provider charges $500 for a particular service to an enrolled patient, the insurer announces that its "allowable" charge for that service is $200, and that is all it will pay. The provider usually accepts the "allowable" charge of a large insurer with many enrollees. But the ability of an insurer to stop rising medical-provider prices depends on its share of the market.

Suppose that an insurer with a small share of the market tries to set its allowable charge well below the provider's charge. The provider will tell the small insurer that unless its allowable charge is substantially raised, the provider will not treat its enrollees. Enrollees will complain to their employers that they cannot use the providers that they prefer unless the employer switches insurance companies. Because other insurance companies are available, employers will switch. To prevent the loss of enrollees, the insurer with the small market share will have to raise its allowable charge substantially. Thus, because many competing private insurers are in the market, no single insurer will have sufficient bargaining power to significantly hold down allowable charges.

One way to improve payer bargaining power over medical providers would be either to have insurers merge or to have the government coordinate insurers to bargain with providers as a single unit. The merger strategy, however, would create a small number of very large private insurers that would have undesirable monopoly power over consumers, enabling the few large insurers to get away with charging high premiums. Government-regulated unified bargaining between

insurers and medical providers has been reasonably successful in several countries (e.g., Germany). But this still leaves all the other disadvantages of a private insurance system in place.

By contrast, Medicare for All is both the simplest way to achieve payer bargaining power over medical providers while at the same time eliminating all the other shortcomings of a private insurance system.

The Impact of Single-Payer Bargaining Power on Medical Markets

High price, not high quantity, is the main reason that U.S. medical expenditure—which equals price times quantity—is so high. That is the conclusion of an empirical study of OECD countries by health economists Anderson, Reinhardt, Hussey, and Petrosyan (2003) in their article "It's the Prices, Stupid: Why the United States Is So Different from Other Countries." They analyze the split between price and quantity in 2000, presenting comparisons of different quantity measures including doctors, nurses, hospital beds, hospital admissions, and hospital days. In most of these, the quantity per capita in the United States was below the OECD median. They conclude that prices, not quantities, are the drivers of cross-national differences in health spending and that a major cause of the difference in prices is the difference in the bargaining power of the payers of medical providers. They emphasize the difference between the United States and other OECD countries in the degree of bargaining power on the buyers' side of markets for medical care:

> Although the huge federal Medicare program and the federal-state Medicaid programs do possess some monopsony power, and large private insurers may enjoy some degree of bargaining power as well in some localities, the highly fragmented buy side of the U.S. health system is relatively weak by international standards. It is one factor, among others, that could explain the relatively high prices paid for health care and for health professionals in the United States. In comparison, the government-controlled health systems of Canada, Europe, and Japan allocate considerably more market power to the buy side. (Anderson et al. 2003, 102)

Here is how I interpret their findings in terms of Figure 1. The United States is currently at a price well above point *G* because of widespread 100 percent patient insurance and the relatively weak bargaining power of multiple insurers. Replacing multiple private insurers with a single payer—Medicare for All—would enable the price to be brought down to *G*. If Medicare for All reduces price to *G* but no further, there would be no waiting lists. Only if Medicare for All reduces the price below *G* would waiting lists be generated. As shown in the diagram, some countries—for example, Britain, and to some extent Canada—have reduced the price too far—below *G*—and generated waiting lists. But other countries—for example, Germany and France—have reduced the price to *G* but not lower than *G* and have therefore avoided waiting lists.

The United States is an affluent country with a preference for high spending on medical care. Medicare has always paid doctor and hospital prices that are high enough—point *G* in Figure 1—to avoid waiting lists and to enable Medicare patients to obtain high-quality medical care, technology, and pharmaceuticals. The same would be true under Medicare for All. The aim of single-payer bargaining would be to keep prices from rising above *G* or falling below *G*. Medicare for All, like Medicare, would aim for *G*. Any signs of waiting lists or insufficient quality would be a signal that prices have unintentionally been set below *G* and should therefore be raised in order to eliminate waiting lists and restore high quality.

High-Deductible Private Insurance Versus Medicare for All

Advocates of high-deductible private insurance concede that the market has not yet worked in medical care, but they contend that the market can be made to work. They assert that the reason for the market's failure has been widespread 100 percent insurance, which has caused most consumers not to care about price and cost. They say the key to restoring the fee-for-service medical market is to give tax incentives to employers and individuals to choose high-deductible insurance instead of 100 percent

insurance. With high-deductible insurance, most consumers will pay 100 percent of the price for most of their fee-for-service medical care. Market advocates claim this change will restore the effectiveness of the market in medical care (Cogan, Hubbard, and Kessler 2011).

Before examining whether this high-deductible insurance strategy would succeed in containing prices and costs, I want to emphasize that this strategy will not achieve automatic coverage, portability, and peace of mind. Individuals who obtain their high-deductible insurance from their employer would still lose their insurance if they lose or leave their job. Individuals who obtain their high-deductible insurance directly from insurance companies would still be subjected to a pre-enrollment health questionnaire and would either be rejected or charged a high premium if they have a high expected medical cost.

High-deductible insurance advocates oppose having the government force private insurance companies to enroll everyone at the same premium regardless of preexisting conditions or expected medical cost. Instead, some advocates propose that the government pay private insurance companies a subsidy to voluntarily enroll high-cost individuals at a reasonable premium. But there would be no way to make enrollment automatic. High-cost individuals would initially be rejected and would then have to apply to demonstrate that they are likely to be high cost and entitled to a substantial subsidy. Some might still be rejected. In the meantime they might face huge medical bills.

Suppose tax incentives succeed in getting most employers to offer high-deductible insurance and most individuals to obtain such insurance. Consider two individuals, one with a high income and the other low income, who each have insurance with a $2,000 deductible and therefore must pay 100 percent of the price until they have spent $2,000 on medical care. The high-income person would be moderately deterred from obtaining medical care but would be able to afford urgent medical care, and this is exactly what the free market advocates want.

But the low-income person would be strongly deterred from obtaining medical care and may be unable to afford even urgent medical care. High-deductible insurance advocates may regret this, but they are

opposed to doing anything about it. They oppose requiring private insurance companies to vary the deductible according to the individual's income, and they oppose having the government reimburse low-income persons more than high-income persons for out-of-pocket medical costs. So their high-deductible strategy would lead the quantity of medical care to vary substantially with an individual's ability to pay.

Would the high-deductible strategy really contain medical prices and costs? In virtually all other markets, prices are posted so that consumers know in advance how much they will pay if they choose a service. High-deductible insurance advocates assume this would happen in medical care under their strategy. But would hospitals or doctors really provide prices of various services to patients in advance? Many hospital patients are literally in no position to comprehend price information. Many patients and their families are under emotional stress and time pressure and would find it extremely unpleasant to consider price information. Many doctors would find it unpleasant to spend time discussing prices with patients. It is therefore doubtful that patients would be able to play the same role in containing prices and costs as consumers do in most other markets.

Moreover, although most individuals would not exceed their high deductible, the minority of individuals who do exceed it actually account for a large share of the total medical cost incurred in a given year. These high-cost individuals would have no financial incentive to care about price once they exceed their high deductible. Although it might be possible to restrain the prices and costs incurred by these patients through government regulation, high-deductible advocates oppose such government regulation.

Premium Support for Private Insurance Versus Medicare for All

Premium support for private insurance is a key component of the ACA proposed by President Barack Obama and enacted in 2010. Under the ACA, starting in 2014 a household with moderate income will be given a tax credit to reimburse part of its expenditure on a premium

for private health insurance. Premium support for private insurance is also a key component of the conservative proposal to end Medicare as a government insurance program and replace it with a voucher program that would reimburse part of a retiree's expenditure on a premium for private health insurance.

Under premium support, the government would give each household a tax credit or a voucher to help it afford the premium charged by a private health insurance company. The household's credit or voucher would not vary with the premium of the insurance plan it chooses; if a household's credit or voucher is $5,000, and it chooses a plan with a premium of $11,000, it must come up with its own $6,000.

The premium support strategy has three serious weaknesses. It will not achieve automatic coverage and portability, ensure that all households can afford medical care, or control medical costs. Let us consider each weakness in turn.

First, the premium support strategy will not achieve automatic coverage and portability. Individuals who obtain insurance from their employer would still lose their insurance if they lose or leave their job. Individuals with high expected medical cost who lack employment-based coverage would still face insurance companies that want to reject them or charge them very high premiums. To try to prevent these rejections or high premiums, government might try to prohibit private insurance companies from engaging in such actions. The ACA will try to do this. But it is doubtful that the ACA can succeed in preventing insurance companies from avoiding high-cost households or subtly encouraging them to disenroll, given the past maneuvering of these companies as documented by a top insurance insider (Potter 2009). The ACA will also attempt to financially compensate insurance companies that enroll a disproportionate number of high-cost people, but it is doubtful that "risk-adjustment" compensation would work satisfactorily in practice (Aaron 2011; Brown, Duggan, Kuziemko, and Woolston 2011; Van der Water 2012).

Second, as medical costs and premiums rise, Congress may fail to keep the credit or voucher large enough so that all households can afford adequate insurance. It is likely that Congress will keep the credit

or voucher large enough so that high-income households with normal expected medical costs will be able to afford adequate insurance, but less likely that it will be large enough so that low-income households with high expected medical costs can afford adequate insurance.

Third, there is no reason to believe that private insurance companies would have any more success in holding down medical costs under a premium support plan than they do today. Currently, private insurance companies would like to hold down medical costs, but without single-payer bargaining power they have not succeeded. Premium support would have no effect on their bargaining power with providers. It is true that several countries (for example, Germany) have implemented, with some success, "all-payer" bargaining under which the government requires all private insurers to unite to bargain as a single unit with medical providers (White 2009). Such "all-payer" bargaining has not been implemented in the United States, and though it might succeed in holding down medical costs, it would still leave all the shortcomings of a private insurance "system" that have been emphasized throughout this article.

Conclusions

American advocates of single-payer national health insurance started calling their proposal "Medicare for All" only in the past decade. The use of this name, I believe, will come to be seen as a turning point in the American effort to achieve universal single-payer government health insurance. Why? Opponents have argued that single-payer insurance would be a brand new program, a foreign program, a risky departure from American experience and values. They have given accounts of foreign health programs whose validity most Americans cannot judge. Although most Americans have no firsthand experience with foreign health systems, they emphatically do have firsthand experience with Medicare. Think of what this difference means.

Most American seniors are on Medicare (unless they are still working and still covered by their employer's private insurance plan).

Younger Americans know their retired parents or grandparents are on Medicare. From firsthand experience, Americans know that under Medicare each patient has free choice of doctor and hospital (except for a small minority of doctors who do not participate in Medicare). They know that Medicare has no waiting lists or waiting times that are any greater than private insurance. They know that Medicare is no more subject to rationing than private insurance. They know that most people on Medicare are very satisfied with it. When the proposal is Medicare for All, stories about foreign health systems are less relevant. Medicare is an American program that has been operating for half a century and has covered members of almost every family. The issue is no longer whether to establish a new program or a foreign program. The issue is whether to extend a successful and popular American program that has been operating and improving for half a century to all Americans.

Opponents of Medicare virtually never criticize how it is working today because they know people have firsthand knowledge and are overwhelmingly satisfied with Medicare's current performance. Opponents of Medicare focus mainly on the future. They claim that Medicare will "go bankrupt" and will therefore collapse; that it will institute rationing and end the free choice of doctor and hospital; that it will pay doctors and hospitals so little that they will be unwilling to provide patients with high-quality medical care.

In this article I have explained why neither Medicare nor Medicare for All nor national defense can "go bankrupt" or collapse. These programs will spend what Congress collects in taxes. Taxpayer resistance will limit the spending. Citizens who recognize and receive the benefits of these programs will press Congress to collect enough taxes to maintain their quality. Congress and the public will face tough choices under Medicare, Medicare for All, and national defense. But there will be no "bankruptcy" and no collapse in any of these programs.

Medicare for All would eliminate private health insurance premiums and replace them with a set of taxes earmarked for Medicare for All. Most business firms and individuals would pay roughly the same

dollar amount but send it to a different address—to Medicare for All instead of to a private health insurance company. The set of taxes earmarked for Medicare for All would consist of the following: the Medicare payroll tax, a VAT, a Medicare for All income tax surcharge on the 1040 personal tax return, and a set of health taxes (on tobacco, alcohol, and pollution) that discourage activities harmful to health. Everyone would bear some financial burden from this set of taxes—there would be no free riders under Medicare for All.

Medicare for All would eliminate patient cost-sharing so there would be no need for private Medigap policies or for Medicaid to pay medical bills. Medicaid would continue to pay for nursing homes for people with low income and low assets. The elimination of Medicaid payment of medical bills would substantially reduce state Medicaid spending and Medicaid's fiscal burden on state governments.

After paying their earmarked taxes to fund Medicare for All that has no patient cost-sharing, individuals can choose to pay for medical services outside Medicare for All, just as individuals, after paying taxes to fund elementary and secondary public schools that charge no tuition, can choose to pay private school tuition for their children.

This article offers four main arguments to make an economist's case for extending Medicare to cover all Americans. First, Medicare for All would automatically achieve universal coverage and portability. Second, Medicare for All would eliminate health insurance distraction for business managers, entrepreneurs, and job seekers, thereby improving the productivity of the U.S. economy. Third, Medicare for All would use an internationally proven method to reduce the huge gap between medical care costs in the United States and other economically advanced countries: single-payer bargaining power. Fourth, Medicare for All is much simpler to explain to people than either the current "system" of private insurance or plans (like the ACA) that try to work through private insurance; this simplicity may make Medicare for All more politically feasible than alternatives that are inevitably complex and hard to explain because they try to work through private insurance.

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