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Effect on Patient Care of H.R. 1384 "Medicare for All"

by Deane Waldman, M.D., M.B.A.
Distinguished Senior Fellow

Key Points

- "Medicare for All" limits consumer choice and restricts medical facilities available to patients.
- "Medicare for All" claims to insure everyone but actually reduces access to care.
- "Medicare for All" prohibits the presence of free-market forces in health care.
- "Medicare for All" prohibits the sale of private insurance.

Introduction

Healthcare systems exist to optimize the health of individuals through timely access to necessary care (Waldman 2017a). While getting value for our spending is important, saving money *per se* is not the primary goal of healthcare, *care* is.

The U.S. healthcare system is failing the American people: Access to care is neither timely nor sufficient; and spending is dollar inefficient. Money is increasingly spent on non-value-adding activities, i.e., bureaucracy, thus taking support away from patient care.

Washington has been "fixing" healthcare since the 1965 creation of Medicare and Medicaid. It was their *fixes* that made our insurance unaffordable and our care unavailable. The Obama administration's solution was the Affordable Care Act (ACA). The ACA produced what systems thinkers call a "fix that fails or backfires": the cost of already unaffordable health insurance doubled and access to care declined despite 20 million more with insurance (Haislmaier and Badger; Merritt Hawkins; Bloomberg).

The newest "fix," H.R. 1384, is single-payer in disguise and a total takeover of healthcare by the federal government. How will Washington's latest and greatest *fix* affect patient care and our pocketbooks?

H.R. 1384

The official title of H.R. 1384 is "To establish an improved Medicare for All national health insurance program" (H.R. 1384, 1). At its outset, the bill perpetuates the false narrative that the health of Americans will improve if all are provided with taxpayer-supported health insurance.

The title of the bill implies that it is simply an extension of the Medicare program to all Americans. In fact, Section 901 (a)(1)(A) of the bill eliminates the Medicare program, and Section 701(d) liquidates the Medicare Trust, which will be insolvent by 2026 (Boards of Trustees). Thus, in seven years, Medicare will be unable to pay for hospital care for 51.2 million senior Americans and 8.8 million disabled.

Freedom of Choice

Section 103 of H.R. 1384 is titled "Freedom of Choice." The summary states, "Any individual entitled to benefits under this Act may obtain health services from any institution, agency, or individual qualified to participate under this Act" (H.R. 1384, 5). What this means in practice is that consumers can choose only among those providers the government approves, rather than those consumers might choose. Then, a consumer could wait as long as four months for a new patient appointment (Merritt Hawkins, 6). The consumer can also get in line for care at one of the limited number of facilities allowed by government where patients wait to receive a limited number of treatments the government approves.

continued

Universal Entitlement

Section 102 of H.R. 1384 is titled "Universal coverage" in the bill (H.R. 1384, 2). According to the section by section analysis of the bill put out by the Medicare for All Congressional Caucus, all U.S. residents will be entitled to receive "benefits for health care services." "Benefits" refers to insurance coverage, and the act seeks to ensure that "every person living in the United States has guaranteed access to healthcare with comprehensive benefits" (Medicare for All Congressional Caucus 2019b, 1). Under the bill, the entitlement would be for all U.S. residents without regard to citizenship and "authorizes the HHS Secretary to determine criteria of residency" (Medicare for All Congressional Caucus 2019a, 1).

No Personal Responsibility

Section 202 prohibits cost-sharing, "including deductibles, coinsurance, copayments, or similar charges" (H.R. 1384, 14). Enrollees in "Medicare for All" are not personally responsible for any costs. H.R. 1384 rejects the lessons learned from the bipartisan Personal Responsibility and Work Opportunity Reform Act of 1996. That act transformed welfare from a no-charge, unlimited entitlement to a program where receiving federal support was made contingent on an act of personal responsibility by the recipient. The effect of this cultural shift was to move many people off welfare rolls and toward self-sufficiency (Haskins; Waldman and Minjarez). H.R. 1384 makes everyone entitled to government insurance. By eliminating almost all private insurance, "Medicare for All" leaves Americans dependent on the government for health insurance coverage.

When consumers are *entitled* to health care, they have no "skin in the game." They have no incentive to make prudent choices. Therefore, they spend other people's money without restraint. The result is over-spending, precisely what we have now. Without consumers accepting the need to spend money wisely on their health care, the only way to limit expenditures is by *medical rationing*, an integral part of all single-payer systems including "Medicare for All" (Waldman 2016b).

Suppressing Innovation

Section 614(b) reads as follows: "Payments to providers under this Act may not take into account, include any process for the provision of funding for, or be used by a provider for— (1) marketing of the provider; (2) the profit or net revenue of the provider, or increasing the profit or net revenue of the provider; (3) incentive payments, bonuses, or other compensation..." (H.R. 1384, 78). Designers of H.R. 1384 appear to presume that funds "diverted to profit" are the primary reason "tens of millions of people in the United States do not receive healthcare services" (77).

"Profit motive" is a term commonly used to describe an individual's or an organization's desire to increase wealth. In a free market, this works to the advantage of both producers and consumers. The desire to increase wealth is why buyers seek the lowest price to reduce their personal spending. Likewise, profit motive encourages sellers to compete for sales by offering products that meet consumer demands for price and quality. In a market with no government mandating certain practices, the profit motive of both the buyers and sellers ensures the highest quality at a competitive price.

Where the profit motive incentivizes *individuals* to acquire financial advantage, *governments,* especially the federal government, are motivated to gain power advantage—to extend its scope and reach (Judis). In contrast to the profit motive among consumers and sellers, politicians' drive for power leads to expansion of its bureaucracy. This usually leads to the expenditure of billions of taxpayer dollars, increased prices, and higher taxes.

According to a 1999 study, by both direct administrative spending and indirectly through regulatory compliance, the U.S. federal bureaucracy is the largest single consumer of healthcare dollars, taking at least 31 percent of all healthcare spending (Woolhandler et al., 768). If the same holds true today, Americans are being denied more than $1 trillion dollars' worth of care, not because of profit-seeking but because these dollars are diverted to federal bureaucracy (Sherman).

The U.S. is the major innovator of medical treatments and prevention (Thorpe). If H.R. 1384 is enacted, it will not continue to have that honor. The reason we create so many new medical technologies is simple: the mutual pursuit of wealth and health by consumers and producers. If the government takes that away, it will stifle future progress. There will be few new cures. Without innovation, cancer and heart failure would still be as untreatable today as they were in my grandfather's day.

No Competition

H.R. 1384 eliminates both individual and employer-supported health insurance for most health care services. Section 107 states, "it shall be unlawful for ... a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act" (H.R. 1384, 9). The list of federally mandated benefits is quite comprehensive, including "all primary care, hospital and outpatient services, prescription drugs, dental, vision, audiology, women's reproductive health services, maternity and newborn care,

long-term services and supports, prescription drugs, mental health and substance abuse treatment, laboratory and diagnostic services, ambulatory services, and more" (Medicare for All Congressional Caucus 2019b, 1). There is little or nothing left out. While H.R. 1384 "allow[s] the sale of ... supplemental coverage," it is unclear what medical services could be provided, or would be needed, under this provision (Medicare for All Congressional Caucus 2019a, 2).

Keep in mind that "benefits" actually refers to the government's *promise to provide* care, not for the actual *delivery* of care. The American people have learned painfully, in some cases fatally, that coverage on paper does not equal care (Waldman 2017b). Having *government insurance* such as *Medicaid*, Medicare, TriCare for *veterans*, or *ACA insurance* has resulted in death-by-queueing (Oversight.gov; Horton). Conversely, those without insurance generally get care albeit often through the overly expensive emergency rooms. The American people need nurses, not navigators—a new bureaucratic job created by and for the ACA; doctors, not directors; care, not coverage.

Suppressing market competition

H.R. 1384 makes it clear that the federal government does not want any competition. Prices for health care services and goods will be dictated by government, not by consumer preferences or medical needs.

Payments and Prices Determined by Fiat

Section 611, payments to institutional providers based on global budgets," mandates that "institutional providers ... be paid a lump sum" (Medicare for All Congressional Caucus 2019a, 6); that individual providers must accept a government fee schedule; and that the "Secretary [of Health and Human Services] ... negotiate prices for pharmaceuticals, medical supplies, and medically necessary equipment" (7).

Prices will be determined by government fiat. Section 616 states: "The prices to be paid for covered pharmaceuticals, medical supplies, medical technologies, and medically necessary equipment covered under this Act shall be negotiated annually by the Secretary" (H.R. 1384, 83).

Government Practice of Medicine from Washington, D.C.

By law, only medical doctors can practice medicine. Doctors have a fiduciary responsibility to a specific patient, not to a federal budget. Only doctors can recommend treatment or prescribe medications. H.R. 1384 changes that paradigm so that government bureaucrats practice medicine on people.

Section 201 states "individuals enrolled for benefits under this Act are entitled to have payment made by the Secretary to an eligible provider for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition" (H.R. 1384, 10). By deciding what to pay and even if payment will be authorized, Washington bureaucrats effectively will decide what treatments or drugs a patient can get and what care will be denied.

Central economic planning

Sections 601, 611, 612, 613, and 614 of H.R. 1384 describe in detail the price and wage controls as well as the budget allocation process that will limit both payments to providers and available care facilities. This will directly restrict the availability of needed care.

There will be a "national health budget" and a "national fee schedule" that effectively determine patients' health care instead of being determined by their medical and surgical needs. When government controls health care, cost cutting is more important than patient care, and people die, avoidably (Waldman 2013).

The "Medicare for All" plan "entitles Program enrollees to long-term services and supports," in essence promising whatever care elders need (Medicare for All Congressional Caucus 2019a, 3). As Chris Jacobs notes, H.R. 1384 gives the federal government complete control of long-term care services and supports (Jacobs). What care elders receive and when or even if they receive it, will be decided by government actuaries and finance officers, not by patients' medical requirements. Since elder care tends to be very expensive, access to such care is likely to suffer by government limitations on funds allocated, i.e., medical rationing.

The Bureaucratic Expansion of H.R. 1384

In order to take over the practice of medicine, H.R. 1384 will "establish regional offices and appoint regional directors ... [as well as] ... deputy directors to represent American Indian and Alaska Native tribes in each region" (Medicare for All Congressional Caucus 2019a, 4). These will be added to an already incomprehensibly complex and prohibitively expensive bureaucratic structure.

Establishing numerous new bureaucracies will be very expensive. For example, the website www.HealthCare.gov cost more than $2 billion to build (de Rugy). To start up its ACA Health Insurance Exchange, CoveredCalifornia, California spent more than $1 billion (Mach and Redhead, 4). This bureaucratic "healthcare" spending is money taken away from care for Americans.

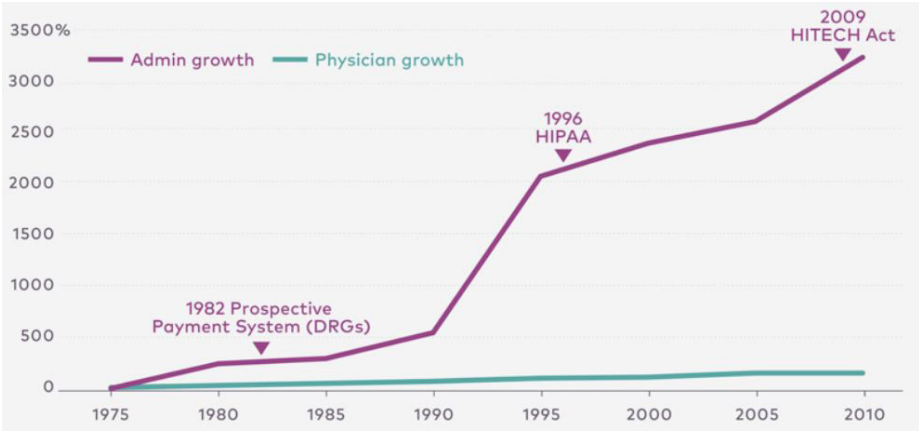
In addition to all the bureaucracy machinery to manage the activities noted above, the bill establishes a beneficiary ombudsman to "receive complaints, grievances, and requests for information ... provide assistance with respect

to complaints, grievances, and requests ... [and] ... submit annual reports" (H.R. 1384, 51-52). This too will be added to the cost basis of healthcare.

While each of the detailed actions, rules, and regulations cited above will reduce patients' access to care, the most harmful impact will come from "bureaucratic diversion" (Waldman 2017a, 89). Bureaucracy already takes a huge bite of the healthcare *pie*, more than 31-40 percent of all spending. When one adds the cost of the additional bureaucracy necessary to implement and oversee "Medicare for All", the result is more taxpayer "healthcare" dollars being diverted from care to pay for bureaucratic expansion.

Figure 1 demonstrates the growth of healthcare bureaucrats as well as physicians. From 1975 to 2010, the supply of physicians increased nearly 200 percent. Over the same period, the number of healthcare administrators increased more than 3,000 percent. The 11-year cost of the ACA through 2023 was originally estimated to be $1.76 trillion (Amadeo), but the actual cost could be somewhat lower as not all states expanded Medicaid and CHIP. Much of this spending paid for expansion of the bureaucracy—like setting up healthcare exchanges—and providing tax credits, rather than paying for health care.

Figure 1. Growth of supply of healthcare administrators and physicians



Source: Cantlupe, "The rise (and rise) of the healthcare administrator."

Net Effect of "Medicare for All" on Access to Care

The following are the likely effects in H.R. 1384:

- Enhanced public dependence of federal government.
- Limited options for both patients and physicians.
- Elimination of profit motive and market competition.
- Federal control of prices and payments.
- Suppression of innovation.

More people will demand care. The physician shortage will be worse. Wait times to receive care will go up: Access to care will go down (Merritt Hawkins; Waldman 2016a). New, improved treatments will not be forthcoming.

The net effect of H.R. 1384 on Americans' access to timely, quality care is clear: it will go down.

The Cost of "Medicare for All"

There is no fiscal note in H.R. 1384. To date, the CBO has not scored it. Thus, we do not have an official projection of how much "Medicare for All" will cost, how funds will be distributed, how physicians will be paid, and how Washington will acquire the necessary funds. Obviously, those dollars must come from American taxpayers as well as debt placed on our children, but how many dollars will be needed?

In July 2018, Charles Blahous of Mercatus Center *calculated the cost* of single payer/"Medicare for All." He reported a cost of $32.6 trillion over 10 years. This means H.R. 1384 will nearly double current unsustainable spending on healthcare, adding $3.2 trillion to the $3.5 trillion we expended for healthcare in 2018 (Blahous, 3). Funding "Medicare for All" would consume all the money we currently expend on other national priorities such as education, military, infrastructure, security, etc. Professor Blahous estimated that paying for "Medicare for All" would *double* both federal individual as well as corporate taxes (Blahous, 21)!

To keep the cost at "only" $32.6 trillion, professor Blahous projected a 40 percent reduction in payments to physicians. H.R. 1384 would drive a large number of doctors out of clinical care and would provide a powerful disincentive to anyone considering a career as a care provider. As a result of "Medicare for All," timely care would likely become a fond memory.

A Communist Manifesto for U.S. Healthcare

Key features of H.R. 1384, "Medicare for All," appear to reassert the guiding principles of Soviet-style communism from the now-defunct Union of Soviet Socialist Republics:

- Central economic planning.
- Services and goods determined by government.
- Everyone is equal—reject class distinctions in principle, but in reality, have two classes: proletariat and government officials.
- No private property.
- No profit motive:
  - Sellers do not compete for consumer dollars.

- Buyers (patients) have no incentive to save money.
- Government deploys medical rationing and makes life-and-death medical decisions (Waldman 2018).

The "Medicare for All" bill calls to mind George Orwell's 1945 satire *Animal Farm*. The pigs were the farm's government and proclaimed, "All animals are equal, but some animals are more equal than others," referring to themselves. The principles and implementation of H.R. 1384 apply to the general American population, what was called the proletariat in the U.S.S.R., but not to federal officials. If past behavior is an indicator of future events, it seems likely that members of Congress will exempt themselves from a "Medicare for All" program as they did with Obamacare (Malcolm and Cannon).

Conclusion

H.R. 1384, "Medicare for All," offers a clear picture of what will happen to healthcare when totally controlled by Washington. Access to care will decline, spending will rise, taxes will double, and personal freedom will be traded for entitlement.

Knowing that federal healthcare through H.R. 1384 will lead to higher prices and less care, we can choose a different path. Instead of increasing federal authority over healthcare, we need to reduce Washington's role in healthcare and put decision-making where it belongs: with the people in their states. If Californians want a single-payer system and Texans want a market-based one with a safety net, they should be able to do so.

Recommendations

H.R. 1384, "Medicare for All," should be vigorously opposed. It will restrict patient choice, reduce access to care, and make the federal government the medical decision maker for all Americans.

Let the people in their states decide their own healthcare. People will get the care they need at prices they can afford. Americans will no longer be forced to waste more than a trillion healthcare dollars as in 2018 on federal bureaucracy (Woolhandler et al., 768; Sherman).

Citations

Amadeo, Kimberly. 2019. "How Much Did Obamacare Cost?" *The Balance*, March 19.

Blahous, Charles. 2018. *The Costs of a National Single-Payer Healthcare System*. Mercatus Center, George Mason University.

Bloomberg. 2018 "Since Obamacare Became Law, 20 Million More Americans Have Gained Health Insurance." *Fortune*, November 15.

Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2019. *2019 Annual Report of The Boards of Trustees of The Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Centers for Medicare & Medicaid Services and Boards of Trustees.

Cantlupe, Joe. 2017. "The rise (and rise) of the healthcare administrator." *Athena In Sight*, November 7.

De Rugy, Veronique. 2014. "How Much Did HealthCare.gov Really Cost? More Than the Administration Tells Us." *National Review*, October 1.

Haislmaier, Edmund, and Doug Badger. 2018. *How Obamacare Raised Premiums*. Heritage Foundation.

Horton, Nicholas. 2016. "Hundreds on Medicaid waiting list in Illinois die while waiting for care." *Illinois Policy*, November 23.

Haskins, Ron. 2015. Testimony before the U..S. House of Representatives Ways and Means Committee, on Challenges Facing Low-income Individuals and Families, February 11.

H.R. 1384, "Medicare for All." February 28, 2019.

Medicare for All Act of 2019 Section-by-Section. Congressional Caucus. Updated 2/25/19.

Medicare for All Act of 2019 Summary. Congressional Caucus. Updated 2/25/19.

Jacobs, Chris. 2019. "Lowlights of House Democrats' Single-Payer Legislation." *The Federalist*, March 1.

Mach, Annie L., and C. Stephen Redhead. 2014. *Federal Funding for Health Insurance Exchanges*. Congressional Research Service.

Malcolm, John, and Michael Cannon. 2017. "Congress' illegal and egregious Obamacare exemption, explained." *Washington Examiner*, September 5.

Medicare for All Congressional Caucus. 2019a. "Medicare for All Act of 2019 Section-by-Section." Last updated February 25.

Medicare for All Congresstional Caucus. 2019b. "Medicare for All Act of 2019." Accessed April 30.

Merritt Hawkins. 2017. *2017 Survey of Physician Appointment Wait Times And Medicare and Medicaid Acceptance Rates*. Merritt Hawkins.

Oversight.gov. 2015. "Review of Alleged Mismanagement at the Health Eligibility Center." Accessed February 2018.

Sherman, Erik. 2019. "U.S. Health Care Costs Skyrocketed to $3.65 Trillion in 2018." *Fortune,* 21.

Thorpe, Kenneth. 2011. "Medical Advancements: Who Is Leading the World?" *Huffington Post,* January 14. Updated May 25.

Waldman, Deane. 2013. "Cutting Healthcare Costs by Killing Patients." *American Thinker*, February 27.

Waldman, Deane. 2016a. "ObamaCare's dangerous wait lines." *The Hill*, December 5.

Waldman, Deane. 2016b. *Single Payer Won't Save Us*. Columbus, OH: Gatekeeper Press.

Waldman, Deane. 2017a. *The Cancer in American Healthcare*. Corpus Christi, TX: Strategic Book Publishing and Rights Agency.

Waldman Deane. 2017b. "More coverage doesn't necessarily translate into better patient care." *The Hill*. May 23.

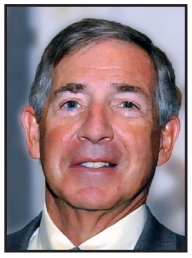
Waldman, Deane. 2018. "Great Britain offers cautionary tale on single payer." *Real Clear Health*, May 10.

Waldman, Deane, and Jennifer Minjarez. Forthcoming. *Extend Gains from Welfare Reform to Texas Medicaid*. Texas Public Policy Foundation.

Waldman, Deane, and Vance Ginn. Forthcoming. *What Should Texas DO with Medicaid? Transform Texas Medicaid*. Texas Public Policy Foundation.

Woolhandler, Steffi, Tara Campbell, and David Himmelstein. 2003. "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medecine* 349(8): 768-775.

ABOUT THE AUTHORS



Deane Waldman M.D., M.B.A., is a distinguished senior fellow on health care policy for Right on Healthcare, an initiative of the Texas Public Policy Foundation. He is a retired pediatric cardiologist and system theorist analyst for American healthcare. He has 37 years of clinical experience plus the business and administrative experience as chief of pediatric cardiology at the University of Chicago. He is also the consumer advocate member on the board of directors of the New Mexico Health Insurance Exchange.

His background and academic training include Yale, Chicago Medical School, Mayo Clinic, Northwestern, Harvard, and Anderson Management Schools. He has authored over 150 academic medical publications and more than 250 articles on both management and strategy in healthcare. Dr. Waldman is the author of *Curing the Cancer in U.S. Healthcare: *StatesCare* and the Texas Model*.

With assistance by Matt Liles, research associate.

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