SPLINTER

HEALTHCARE

The Only Guide to 'Medicare for All' That You Will Ever Need

Timothy Faust

Photo: Getty

Healthcare has claimed its prime spot in the great zodiac of policy issues in the 2020 Democratic presidential primary. As it should: Tens of thousands of Americans die a year from lack of health insurance, and in total, nearly half

of American adults under 65 are either uninsured or underinsured, meaning they have insurance plans which don't cover what they need at prices they can afford.

In the coming weeks, Rep. Pramila Jayapal (D-WA) is set to release a new "Medicare for All" bill. I'm generally inclined to distrust the policy gestures of elected officials, but I've read a detailed overview of the bill from Jayapal's office and I'm happy to say that this bill is astonishingly strong, and should become the baseline for federal legislation toward single-payer healthcare. (I'll discuss why in a minute.)

But Jayapal's bill joins a crowded mess of at least eight other healthcare policies being bandied about among Democrats. I couldn't fault anyone for

matter?

The Problem

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The problem of American health finance—not *care*, but finance—can be expressed in two complementary points:

- It is extremely profitable to charge a sick person as much as possible, so long as someone is footing the bill.
- It is *not* profitable to insure people who are sick or who are likely to

The policy wonks maintain a fantasy that they are important. They are wrong.

Staring down these problems are the corporate dorks and the feckless policy dweebs whose policy prescriptions, whose wildest visions, continually place corporations in charge of our healthcare, and ensure that American public money subsidizes them for failing at it. If you hear 2020 candidates talk about the rot of American healthcare, look out if they float a "pragmatic policy solution" or talk about plans named something like "Medicare Extra As A Service... For You!" (If they're polite, perhaps they will at least say they support "Medicare for All" before announcing they'd be open to keeping the feet of private insurance companies on our throats).

These pathetic programs, which usually revolve around a "public option," are what happens when politicians understand the need for a massive change but lack the moral imagination to do anything but genuflect to existing structures. They are, in reality, corporate bailout packages which do very little for you, but quite a bit for the Aetnas and the Sacklers and the Joe Manchins.

On the other hand, you have federal single-payer, often called "Medicare for All." Healthcare plans in the single-payer mold pool all the money currently spent on healthcare to insure every person in America. By pooling this buying power into one giant public insurer (the *single* payer), "Medicare for All" has much more leverage to determine prices through negotiation. It can say, "*oh,*

It's cheaper, it's nicer, it's better, and it lets you go to the doctor without paying anything. Yet a lot of inadequate policies are attempting to crib the name—including, paradoxically, the one advanced by Bernie Sanders.

Fundamental Components of Single-Payer

A delegation of seniors at the 1964 Democratic Convention.
Photo: AP

"Medicare for All" is a misnomer. If anything, true single-payer would be a significant improvement and expansion of Medicare, which has all kinds of loopholes, exclusions, and out-of-pocket costs.

Here is what a health policy must have to truly be a "single-payer" or "Medicare for All" program.

A single, mandatory risk pool

spending comes from 5% of the population. Many people who need expensive healthcare will only need it for a short period of time (e.g. a car accident or hip surgery). As a result, the larger the risk pool grows, the more able it is to sustain itself (at a significant discount relative to our fragmented private-insurance model). If rich people or people who are currently not in need of healthcare are permitted to, say, take their contributions *out* of the risk pool and spend it on a private option, the risk pool weakens (and, in turn, becomes less able to negotiate lower prices).

South Africa is a good counterexample. There, citizens may withdraw from the public healthcare option and enroll in private insurance instead. As a result, one-sixth of the population—the privately insured—spends just under half of South Africa's health expenditures. These people are disproportionately wealthy and white. Meanwhile, the public insurer can't

negotiate prices and covers a disproportionate amount of sick people. Private carveouts from the national risk pool has virtually reenacted healthcare apartheid in South Africa.

When people ask about the "future of private insurance alongside public healthcare," they refer to a combination of three things:

- Duplicative basic insurance, which covers the core functions of healthcare, like primary care, the emergency department, or surgery;
- Supplementary insurance, which covers things not addressed by public insurance, like how pharmaceuticals are treated in some countries; and
- Complementary insurance, which offers bells and whistles on top of the

and is therefore unjust. The last option, complementary insurance, is also revolting to me (imagine The Wing but for one-person hospital rooms). I'm not sure to what extent it's possible to prevent rich people from forming clubs to buy special rich-people things, but it is unacceptable to let that luxury spending be used to dilute or splinter the risk pool.

Comprehensive coverage

"All care for all people" must also mean "all care." Whatever care a person needs—medical, dental, mental, vision, reproductive, long-term, and more—must be covered. Playing "catch-up" with other countries is not enough: we are capable of, and should, provide a higher standard of care than any currently-existing single-payer program on the globe. Generally, care eligibility is determined by "medical necessity," because the health finance world lives in utmost terror of someone who gets recreational heart surgery. I don't disagree with the rule, though I would add a specific pathway for people seeking trans healthcare, who would otherwise need a clinical

diagnosis of some type of disorder to get the healthcare they need—a situation which results in some trans people dropping out of the healthcare system.

Worth special mention is the coverage of all elder care, long-term care (LTC), and home-and community-based services (HCBS). Long-term care affects most families in America: two-thirds of seniors will require some sort of living assistance, while people with disabilities often need help maneuvering around their homes and lives. The American system for dealing with this is utterly broken.

Medicare refuses to cover long-term care, and thus the problem is shunted to either private insurance or Medicaid. Private insurance often refuses to cover

together and gives elders the care they need without shredding their savings or forcing their children to quit their jobs to take care of them.

Healthcare or assistance given to a person in their home—usually referred to as "home or community based services"—is equally essential. For people with disabilities, life without HCBS can be a dystopia of regulations and misery. If home health isn't available from a state Medicaid program, people with disabilities are often removed from their homes and families and sent to die in structurally negligent nursing homes under the care of deeply overworked and underpaid caregivers privately contracted out to the state. And even if HCBS *is* offered, its means-testing restrictions can be brutal and oppressive. Disabled couples with too much money in the bank—$22,000 in New York, plus a max of $1,233 in monthly income—often need to spend down or divorce to qualify. In New Jersey, a person who needs home health is only eligible for the program if they have less than $2000 in the bank—and

I've spoken with people who have a $2000-a-year income cap. (This also presumes the person receives as many caregiver hours as they need, which is not often the case).

LTC/HCBS are fundamental to healthcare—fundamental to the basic dignity of personhood, even—yet for some reason they have been bandied around as if they were auxiliary "maybe" components of various healthcare bills. This is utterly unacceptable. Meanwhile, the field is becoming increasingly corporatized. There will be 1.2 million home health aides by the year 2020, and in states like Iowa and Arkansas, where some state legislators literally work directly for nursing home companies, we're seeing private long-term care providers (corporate nursing homes, basically, regardless of whether

Standards, payment, and oversight at the federal level.

This one's quick. The federal government must set minimum standards for care and guarantee prices and payment. When states can pick and choose what care they offer, their smaller budgets and inability to deficit spend gives them a financial incentive to cut costs and save money, and people die.

Local implementation and flexibility

That said, healthcare is *local*. Healthcare needs in Brooklyn, Boston, Birmingham, and Butte are all different from each other. Keeping the delivery of single-payer funding as close to the ground as possible lets it be more responsive to both the needs of the people and democratic pressure. Let a San Francisco health agency use funds to put people in homes; let a rural Iowan one spend on transport services to bring people in rural areas to their dialysis appointments.

There are many more things a single payer can do, or should do; or tools it can build for itself. But only a program with these basic principles qualifies as single-payer, or the "Medicare for All" name.

Current Bills

Rep. Pramila Jayapal speaks at a rally against the Republican healthcare bill in 2017.
Photo: Getty

There are at least six bills with confusing names currently floating around Congress. Among them: Rep. Rosa DeLauro (D-CT) and Rep. Jan Schakowsky (D-IL)'s "Medicare for America Act"; Sen. Brian Schatz (D-HI) and Rep. Ben Ray Lujan (D-NM)'s Medicaid buy-in bill; plus policy guidelines from the Urban Institute ("Healthy America") and the Center for American Progress ("Medicare Extra for All"). Just the other day, 368 members of Congress signed a letter sponsored by lobbyist group America's Health Insurance Plans (AHIP) praising the Medicare Advantage plan, which opens the door to privatization of the system. Almost all of these plans are a variation on the public option and each one fails to meet the principles I've just laid out, since they ultimately they seek to sustain the private insurance market, which is like trying to dig your way out of quicksand with a bucket.

This leaves only two bills worth considering: Bernie Sanders's "Medicare for All" bill in the Senate and Pramila Jayapal's upcoming House version, The Medicare for All Act of 2019.

Bernie's bill comes close, but it isn't there yet. (I've said as much before.) It satisfies three of the four pillars of single-payer. What it lacks is comprehensive coverage. Specifically, Sanders has a lousy plan for elder and long-term care. His bill delegates long-term care to state Medicaid programs —the same process which currently results in the medieval policies causing all this abuse and misery. When insurance companies and other corporations build for-profit nursing homes and then win contracts to administer Medicaid, they just pack their halls with any available body, and reward local

have a "Medicare for All" bill—he has a segregated healthcare bill which inflicts unnecessary and preventable harm on people with disabilities.

Jayapal's bill, though, appears to meet all of the criteria for a proper single-payer plan. It includes long-term care with a preference toward home health. It sets guidelines for care but lets doctors overrule them. It is, by all accounts, the first actual robust single-payer bill of the post-ACA era. If you are looking for a bill to call "Medicare for All," this is the one. It must not be permitted to be weakened.

The bill is not perfect. Early commentators fretted when they noticed it dropped a requirement for all providers to become not-for-profit companies in order to be eligible for single-payer payment. This is understandable—we want to "remove profit from healthcare," after all—but less compelling to me, as "non-profit" is merely a tax designation. Non-profits like the $8 billion Cleveland Clinic, the 78-hospital Ascension health system, or the

University of Pittsburgh Medical Center are all non-profits with incredible histories of grift and fraud—UPMC, to me, is best known for opening food banks for the employees it underpays.

A strong series of budgetary tools lets Jayapal's single-payer program keep providers on a tight leash. One tool is global budgeting, or the advance determination of the national healthcare budget, which is used to set baseline budget agreements for the year and pay hospitals in guaranteed blanket sums based on expected activity. By saying, "last year you spent $2 million dollars, and we can pretty reasonably predict that this year you'll need $2.1 million dollars for all your services," the single payer can pay hospitals fairly while minimizing the hospital's ability to rack up line items and gouge the

think it should go further in determining how funds for long-term care can and cannot be used—perhaps to guarantee a minimum hourly wage for long-term-care caregivers, alongside increased standards and oversight of LTC services.

Jayapal (and Sanders) also currently leave the Indian Health Service (IHS) alone, though the current IHS funding model is disastrous. The amount spent per-capita for Natives is a third of that spent nationally. This isn't because Native people have three times better health factors and health outcomes: men on the Sioux Rosebud reservation in South Dakota have a life expectancy of 47 years. Several factors drive this inequity:

- IHS funding is dispensed as a fixed amount of money on a predetermined schedule, and is not updated for inflation or cost increases.

- IHS hospitals in rural areas often need to contract with private providers for services outside their capabilities, which come at exorbitant rates and

receive inadequate Medicare funding.

Removing the block and comprehensively overhauling the IHS budget and permissions would be cheap and relatively simple and should be included in any Medicare for All bill. Next to prisoners, it is hard to imagine a part of the American population so explicitly wounded by racial and economic segregation in healthcare. We must reverse the gears of this misery.

Beyond the Bill

A protester is dragged out of the Capitol Building during actions against the GOP healthcare bill.
Photo: AP

But no bill, including Jayapal's, is enough. No bill, on its own, *could* be enough.

For the past hundred years, every time the insiders—the well-meaning senators, the well-meaning policy writers, the well-meaning union or nonprofit leaders—have taken on the insurance industry, they've written a bill and waved it around and tried to gin up support among the grassroots. And then they were beaten by a reactionary establishment that is capable of

outmaneuvering, outfoxing, and outgunning health reform. They lost in the ‘40s, they lost in the ‘60s, they lost in the ‘70s, they lost a few times in the ‘90s, and they lost in the 2000s.

But when these well-meaning people lose, it is not the senators or union leaders or policy thinkers who find their suffering compounded. It is the people in who live Section 8 housing; the people in prison; people whose backyards are dumping grounds for toxic waste; people with disabilities forced out of their homes; poor mothers and poor children; the people who have been denied work, care, or dignity.

The policy wonks maintain a fantasy that they are important. They rub a little lucky charm and believe their big brains and their tools and their toolkits are

And thus the wonks, even the really nice ones, are not enough. Bills, even the really nice ones, are not enough. Even a socialist president is incapable of passing single-payer by him or herself. When Jayapal’s bill—our first, best articulation of single-payer—or anything like it is passed, it will be on the backs of a massive popular movement. Policy people like to say that you pass a bill, and then you hold politicians’ feet to the fire. Sure. But first, you must build the fire.

What is the reason that the Disability Integration Act (DIA), which lets people with disabilities receive long-term care at home, exists? Not the spontaneous kindness of co-sponsor Chuck Schumer. It was the constant work of popular activist groups like ADAPT, who wrote the bill—and whom you might remember for saving Medicaid for the rest of us during the ACA repeal debates—or hero activist Ady Barkan. They pushed, they pulled, they called, they screamed, they showed up with a list of demands, and they got a bill. (Why did it stall in the House and the Senate despite bipartisan support? Because temporarily able-bodied people haven’t shown up yet).

Why is Medicaid expansion going to happen in Maine? The Maine People's Alliance launched a massive statewide campaign for minimum wage increases, won, then turned its supporters out to expand Medicaid as a ballot measure—and then to crush its ruling GOP party, infamous for its disembowelment of Maine's welfare programs, when it actively refused to comply. Their example gives hope to the people of Utah, who are watching their own successful Medicaid expansion vote be overruled by craven elected officials pushing a partial and punitive measure.

Why is Medicaid expansion going to happen in Idaho? Because of Reclaim Idaho, a grassroots popular movement which started out winning school financing in its' founders tiny ski town. It grew by driving all over the state in

This is how you build the fire. These popular movements which win material gains are the components of a giant, searing flame in which politicians will be incinerated, while new and more fearful ones line up behind them, to fill the void from among us. There will be no singular popular vertical campaign that wins Jayapal's bill or any other future bill toward single-payer, or for health justice beyond it. When it is won, it will be won by a patchwork of smaller movements: of local efforts to win power, which thread together in a great tapestry.

This is something the wonk envies, fears, and cannot understand. This is power.

Disclosure: the author works in the insurance industry. His views are his own and not those of his employer.

A Public Option Isn't Good Enough

How Did Medicare for All Candidates Fare in the Midterms?

A Preview of the Bloody Uphill Battle for Single-Payer

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