TITLE: Medicare for All: What does it mean and what does it mean for health care access?

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STUDENT SUBMISSION: No

TOPIC/TARGET AUDIENCE: Public health professionals with clinical, policy, or academic interests in improved access to healthcare

ABSTRACT: Ten years ago, eight physicians and nurses were arrested at a US Senate Finance Committee hearing for advocating a single payer alternative to the Affordable Care Act. Today, national single payer bills are receiving hearings and have sponsors in both houses of Congress. Both the Senate and the House bills call themselves 'Medicare for All'. What do these bills really propose? And how can a universal care program pay for itself, given that the US already spends more money per person than any other nation in the world? The panel will review these efforts to create a sustainable universal health care program both nationally and in individual states, and explore a how universal health care plan could pay for expanded benefits to more people but spend less than we do now.

OBJECTIVE(S): (1) Distinguish between the two major national 'Medicare for All' bills in Congress. (2) Understand the differences between Medicare for All and other proposals to expand health care access. (3) Describe how the US could pay for expanded benefits to more people and spend less on health care than it does now.

PANEL MODERATOR: Kenneth D. Rosenberg, MD, MPH

PANEL ABSTRACT 1: Despite the implementation of the Affordable Care Act, 45% of US adults are uninsured or underinsured causing significant numbers of individuals and families to delay care due to cost or face crippling medical debt. Furthermore, our health care system remains the most expensive in the world. Other industrialized nations have universal health care systems that provide comprehensive coverage to all of their residents at roughly half the US cost. They are able to accomplish this by creating a universal program with a single set of benefits for everyone, not-for-profit financing, limiting or removing cost sharing and strictly limiting administrative costs. There is a growing consensus that adoption of a different system is needed to provide universal coverage at a lower cost in the United States. There are currently two pieces of federal legislation which would implement "Medicare for All." We will review these bills -- SB 1129 in the Senate and HR 1384 in the House of Representatives -- in detail and relate their implementation to both health outcomes and population health.

PRESENTER 1: Peter Mahr

PANEL ABSTRACT 2: Industrialized nations with universal health care plans provide better care to more people for less money than the US. Unlike most other nations, the US has a federal system that technically allows universal health care on a statewide basis. However, the US also has federal laws that make it illegal to make many of the changes that would create a

sustainable universal health care system. Congress may find it convenient to pass state-based enabling legislation (an expanded version of section 1332 waivers, inserted into the Affordable Care Act by Sen. Ron Wyden) to overcome these restrictive laws while it considers a nationwide universal health care plan. In 2018, such enabling legislation was co-sponsored by three of Oregon's congressional representatives. The bill has not been submitted in 2019. Meanwhile, proposals to expand statewide insurance coverage within Oregon include confounding terms like 'public option' and 'Medicaid expansion' that could be mistaken for national 'Medicare for All'.

PRESENTER 2: Samuel Metz

PANEL ABSTRACT 3: The United States currently funds health care in a complex and confusing manner. Many people get health insurance through private insurance companies whose incentives include denying claims to increase profits. Others receive insurance through existing single-payer systems like Medicare, Medicaid, the Veterans Administration, the military or the Indian Health Service. The Medicare for All Act of 2019 (HR 1384) would provide a standard Medicare plan for all residents at no cost to individuals -- no deductibles, minimal (or no) copays, no coinsurance. Congress would decide how to cover the costs of Medicare for All. Taxes would replace, and for most Americans be less than, the premiums and out-of-pocket expenditures for individuals and employers. There would be as much as a 50% reduction in administrative overhead as a simple eligibility and a single risk pool replaces thousands of eligibilities and risk pools. These savings would cover the cost of coverage for people who are not currently covered and it would make the new system more sustainable.

PRESENTER 3: Michael Huntington
