We Should Use Both Medicare Advantage for All and Medicaid as a Package to Cover Everyone and We Should Do it Now

A growing number of people want to set aside all of our current health care financing approaches as a country and set up Medicare For All as a Canadian-like single-payer system to cover every American and pay for our care.

When we spend $3 trillion a year on health care and still have 30 million people without insurance, the possibility of covering everyone using the most direct and simple approach has some obvious appeal.

That Medicare for All approach being proposed to Congress today would be funded with a half-dozen taxes that would include making income tax more progressive and inheritance tax levels significantly higher than they are now.

If we have enough political momentum and enough alignment as a nation to actually replace everything in our health coverage world with a national Medicare for All system that is financed by those new taxes, then we should seriously consider going even further, and spend the same amount buying better coverage and better care for everyone by setting up a Medicare Advantage program for everyone and using that approach and program to cover all Americans.

Medicare Advantage has better benefits, better care coordination, better quality reporting, and a higher level of focus on better care outcomes and better care connectivity than standard Medicare.

Standard Medicare buys care entirely by the piece. Buying care entirely by the piece rewards bad care, bad care outcomes, bad health, and inefficient care connectivity.

Buying care by the piece prevents caregivers from building the tool kits necessary to create team care, and it does not support care information connectivity processes and care connectivity infrastructure.

Medicare Advantage buys care by the package instead of by the piece because the Medicare Advantage program pays plans by the month for each patient rather than paying for each incident and each piece of care.

Medicare Advantage plans have strong incentives to reduce medical complications and to improve both care quality and patient health because they don't profit more for bad outcomes and expensive and unnecessary care. Standard Medicare pays for care volume by the piece and not for care outcomes, care quality, or care connectivity, and it is clear that we will not make significant improvements in population health, care quality, care connectivity, or care availability as long as we only pay for pieces of care, and not for any of those care delivery enhancements.

We should be on the cusp of a golden age for care delivery in America, with a wide range of new patient-focused tools providing better and far more patient-focused care, and we will not reach that golden age as long as we continue buying care by the piece with very confusing and contradictory financial incentives in place for our caregivers.

People are unhappy with the high cost of health insurance today, and with the fact that deductibles are growing at a painful rate for consumers. Caregivers and providers of pharmaceuticals and care-related technology are raising their prices at an increasing rate because there is nothing built into the way we buy care today to prevent those price increases from happening — and that will result in people being even more unhappy with their health care insurance, coverage situations and costs.

Both anger and dissatisfaction levels with both care and coverage for millions of Americans are destined to grow.

When we understand those issues, it makes sense that a growing number of people want to move away from all of those problems by simply covering everyone with Medicare. Medicare For All has growing support with a growing number of people, and that support should grow even more over the next year or so as insurance prices inevitably continue to rise because of the care price increases, and as deductible levels for insurance plans grow to painful levels in response to those surging prices.

The combination of premium increases for insurance and unit care price increases for care will make people increasingly unhappy with their care costs at multiple levels, and that will increase support for Medicare for All to resolve those issues.

This problem is going to grow — not disappear. Millions of unhappy and even angry people will want those cost and coverage issues solved. Both Medicare for All and a single-payer health care financing model of some kind seem to be a good way of solving them for a growing number of people.

The biggest problem that the Medicare for All proposal faces in its current form is that the people who are proposing it in Congress today plan to pay for it with a combination of taxes that will make income taxes more progressive, and that will increase several wealth related taxes.

Getting agreement to pass those taxes will not be easy. It will clearly be difficult to persuade Congress to pass the half-dozen taxes proposed to fund the current Medicare For All proposal. Passing those taxes will not happen in this session of Congress and it is hard to imagine that package of taxes passing from any Congress in the immediate future that does not have a super-majority vote in the U.S. Senate.

That does not mean that we need to give up as a nation on universal coverage, however.

We will face growing levels of anger on health care cost and coverage issues, and this is a good time to look at other ways to put together a package of approaches that could cover everyone in the country with good coverage and do it with a cash-flow source we could afford and pass.

That is possible.

We could resolve the cost issues we are facing, and eliminate the anger about painfully high deductibles and frustration about badly connected and poorly delivered care, if we move past perceiving the government as a single-payer for care and instead suggest the government function as a single-buyer for care, and then simply offer Medicare Advantage coverage to everyone in the country who is not on Medicaid.

The missing link in the health care economy today is a buyer. Our country spends more than $3 trillion a year on care, and almost no one currently buys care well.

No one sets expectations for care delivery at any level. The prices we pay for pieces of care have been skyrocketing because they face no constraints from any kind of skillful and competent buyer, and because we have managed to make most care prices functionally immune from market forces.

Using Medicare Advantage would allow us to start buying care by the package, and not just by the piece, and to maintain significant control over the prices we pay for those packages.

To function well as a buyer, we need to know what we want from care. We need to determine what we want from care — and then we need to build what we want into the specifications we use to buy care.

We can use Medicare Advantage plans to achieve those specifications. We need to be very clear about our expectations for the purchase of care to mandate focus on prevention, care connectivity, care quality improvement, and care coordination — and we should turn those expectations into purchasing specifications for care teams who are paid by the package to meet patient needs, and not paid by the piece for making care worse and more dangerous.

We need to face reality as we look at how we buy care.

The fee-for-service care-payment model rewards bad care, bad care outcomes, poor health, and care delivery inefficiency.

The fee-for-service model has thousands of billing codes for pieces of care, and no billing codes for cures, better results, or better health.

Fee-for-service is rewarded for unsuccessful care and for patients suffering both chronic conditions and care complications that result from those conditions.

Medicare has been trying hard to improve buying care by the piece, but has not been successful. We should take advantage of what we are learning in those attempts to buy better care, and we should preserve the best parts of those programs as expectations for the next generation of Medicare Advantage care delivery.

We can build on the best information we have today about the best team care and the best Accountable Care Organization processes, and the very best patient centered medical home approaches that Medicare has been working on, and build all of those expectations into buying care for everyone from Medicare Advantage plans that will meet those needs for their patients and members.

We can use Medicare Advantage rather than the Standard Medicare for All fee-based payment as our primary coverage strategy, and also continue to use Medicaid as the coverage approach for our lowest-income Americans.

That approach would give coverage to everyone in American through Medicare Advantage plans that are paid by the month for each person they cover. We could fund those payments with one basic and simple tax that looks very much like how we pay for most care now.

We could use that approach to cover everyone in America, and we could do it by spending the same amount we spend now to buy insured care as a country.

We now spend $1.1 trillion a year on insured care in America. Most of our people get their coverage now in our country from that flow of money.

Instead of continuing to use that $1.1 trillion to buy care badly and ineffectively by the pieced with a wide and sometimes painful range of deductible coverage, we would collect that money using a payroll deduction tax, and we could put it into a single-buyer payment fund for health care, and we could use it to buy Medicare Advantage coverage with a one thousand dollar deductible coverage package for everyone in the country who is not on Medicaid.

We could buy one thousand dollar deductible plans for everyone under the age of 65 who are not on Medicaid. Plans would then compete. Everyone in the country could choose their health plan and their care team from the Medicare Advantage plans that would be available and competing for their business.

That is the model they use now in Germany, Switzerland, and the Netherlands. They each use Medicare Advantage-like plans and people in those countries each choose the plans they want for their coverage and care.

People in our country would have universal coverage with no premium, because the plans would be paid from the fund created by the payroll tax.

We have those coverage and collection tools in place now. We pay for Social Security now with a payroll tax.

We also pay for health care coverage in most companies with a payroll tax process that involves deductions from each paycheck from both employer and employee. So the idea of using a payroll deduction as the funding source for health coverage is already part of our reality and functionality as a nation, and the average payroll deduction now is about 14 percent.

If we used that same Social Security payroll tax process to raise the health care money — and if we capped the maximum taxable income for each person at the same $136,000 per year level that we use now for Social Security — it would take a 15 percent payroll tax to generate that same $1.1 trillion we spend now on insured care to create a care-purchasing fund for the country that would do a far better job of purchasing insured care.

We would pay that money out to health plans on a monthly lump-sum basis for each person who chooses to get their care from each plan, just like the Medicare Advantage plans are paid now for their senior members.

Buying care by the month instead of by the piece creates huge flexibility in the ways we can pay for and deliver care.

We could take advantage of huge opportunities to make care more patient focused, more efficient, more effective, and less expensive if the health plans were paid a lump sum each month for each patient. We can create purchasing specifications that require the plans to make the improvements we want in the delivery of care that we know are available to us.

There is a wide range of low-hanging fruit waiting to be harvested if we decide to do a better job of purchasing care.

We could cut chronic disease by a third if we focused on making that happen, and if we required the plans to make those objectives performance expectations for their care. Two-thirds of health care costs today in our country are from chronic diseases — and fee-for-service Medicare does almost nothing to prevent those diseases.

We could cut the number of people with chronic conditions significantly if we reserve care plans and care support tools for each person and each disease. There are major opportunities for success in each of those areas that are not being worked on today, and those processes would become immediate benefits to people with that coverage.

We could also reduce asthma attacks, congestive heart failure crises, and strokes if health plans were paid to reduce those care delivery expenses, and given the financial cash flow to make those reductions happen. The opportunities to reduce care costs by making care better are obvious and easy to achieve.

Care sites now profit significantly from each asthma attack — and there are millions of those attacks.

About half of those attacks can be prevented if that were part of the expectations, specifications, and financial reality for each plan.

We could also cut administrative costs in many provider sites by a third or more if the Medicare Advantage plans were required by their contracts to reduce those costs.

The benefit package provided by the plans to everyone would be better than the average benefit package we see today. The one thousand dollar deductible plan would improve benefits for most insured Americans as part of that universal coverage package, because the average deductible this year is about fourteen hundred dollars. Many people have deductibles much higher than that now.

We should also administer deductibles far more effectively.

We should require each of the plans to give all patients easy to use information about the price for each piece of care that can be used by each patient before the deductibles are met — to introduce market forces and informed decision making to those care decisions for the first time.

Most insured people in America would be able to keep their current insurance plan and caregiver relationship, because all of the major insurers have significant Medicare Advantage programs now, and all of those plans would already have both experience and linkage to our insured patients.

This approach of using a payroll tax to fund care would be particularly useful for the largest growing segment of the workforce — the people with multiple employers — because this approach creates funding for the coverage from each employer, but frees the link to health coverage from any single employer status.

The percentage of the 15 percent tax that would be paid by the employer and employee would be determined in each worksite. Most employers today pay about 70 percent of the premiums for health insurance — so it is not unreasonable to expect some similar cost sharing patterns in the future.

Just like Social Security deductions, there would be a higher share of the deduction paid by the self-employed, but employers of part-time employees could choose to compete for employees by paying a higher percentage of the amount.

That tax and approach could cover everyone.

That would include self-insurance approaches. Self-insured companies meeting those benefit standards could be allowed to remain self-insured, and everyone else would be enrolled in a plan paid by that tax or in Medicaid.

That entire strategy would be relatively easy to follow.

All the key pieces to run that program and make that transition to Medicare Advantage for Everyone are in place today. We have the ability to collect payroll tax deductions now, and we use that process with every paycheck.

We now have the ability to pay the plans by the month based on the age and sex of those who choose them, and that payment already happens for millions of people on Medicare Advantage for Seniors every month.

Medicaid programs are now in place in every state, and states are doing increasingly well in administering those plans.

The government would not be a single-payer for health care with the Medicare Advantage approach, but would become a single-buyer for care.

That single-buyer approach is what most European countries use now to create universal coverage. Switzerland, Germany, and The Netherlands all use payroll taxes to create a single-buyer fund, and then they use the payroll tax collected in each country to buy care from health plans for people who choose each plan.

Bismarck invented that single-buyer model over a 130 years ago. He did not want government health care, but he wanted Universal Coverage for Germany — so he used health plans that function much like Medicare Advantage plans to provide the care.

More than 100 of the health plans he created still exist, and all Germans still select their own plan for their care from those competing plans.

That universal coverage plan for Germany is not a single-payer system. Canada actually does use a single-payer system for care. All of those other countries function as single-buyers.

We could do the same thing to create universal coverage here if we create that care purchasing fund, and use it to buy care from Medicare Advantage plans, and then pay the plans by the month for each person who chooses them.

We need the health plans to be paid to transform care. We need to use that $1.1 trillion to get the care and health that we want and need as a country — and we need to create specifications for the plans that will cause us to achieve those goals.

We will not achieve those goals without changing the way we buy care.

We could and should be on the cusp of a golden age for health care delivery. We should have connected care, team care, and continuously-improving care supported by the best technology and the most current science as our reality today.

That level of better care for a country will not happen unless we pay for it, and unless we make that package of services and improvements a requirement for the way we buy care from the plans.

Many of the most innovative new tools invented in the health care technology world are not used today because Medicare and other payers do not pay for them, and because the patients in America do not have access to the data they need about their own care to get the best use from those tools.

There are more than ten thousand new health care apps available for sale today — and they perform at far lower levels than patients would like, because they are not supported by data about the patients.

We should change that situation with the way we buy care.

We need to require each of the plans to give patients complete electronic data about their own care in ways that will support electronic care support tools, and that will lead to innovations in both connectivity and improvements in care.

The truly innovative new care-delivery tools and patient-support tools will not become part of the care experience of Americans until we make access to those tools part of the way we buy care.

We need to become an intelligent buyer of care to create the context for all of the new care support tools to be used.

We can make that care connectivity and the use of those tools part of the specifications that we create as a smart buyer for the Medicare Advantage plans.

The barriers that exist now for better care are hard to understand at some levels, but that world of better care will not exist for most patients in America if we fail to use our purchasing tool for care in a very intentional way to create those benefits.

We will never reach that golden age of care delivery if we continue buying care entirely by the piece with no one paying to make those tools and improvements a reality for people who need care.

Not only will we not see those improvements, we will see a continuation of the horror stories about unconnected care for our sickest patients who need care connections the most, and we will see the cost of care increase.

We need to understand how much unhappiness we are very close to triggering in health care as a country. Prices are going up for pieces of care — and that will cause an explosion in premium levels that will make people very unhappy. Deductibles will get higher and over-all health care premiums will increase at an alarming rate if we do not change the way we buy care.

We are now on the cusp of another painful explosion in care costs. The care delivery infrastructure is anxious about the future, and a wide range of care sites are currently cranking prices higher to alleviate their concerns, and to maximize their current and future streams of revenue.

We are about to see an explosion in the unit costs of care in many areas of the health care delivery infrastructure — and that will result in an explosion in health insurance premiums because insurance premiums, for any group, are always the average cost of care for the insured.

When those costs go up and premiums follow, our only response with the approach we use to buy care today will be to increase deductibles for insured people.

People hate large premium increases and people hate having their deductibles going to very high levels. We need to recognize how much damage those trends might create and how much of a political crisis could result in the immediate future, because we have already significantly politicized the health care debate, and those particular factors will increase the anger level of people who believe that political actions are making the problems worse.

We are at high risk of seeing significant and growing anger as premiums go up and deductibles get worse.

Most people who buy health insurance and who now pay high premiums will discover that their next levels of deductibles will be so high that they will never actually receive any payment personally from their insurance plan, because they will never meet their deductible.

When more than 90 percent of the people who pay high premiums out of their own income literally receive no personal cash benefits from their insurers, that will trigger frustration and anger toward the insurers and the people in our government who have enabled that set of realities to be what we face as a nation.

The next couple of years could be painful and grim for health care insurance and costs in America.

Those problems exist because we buy care very badly as a country — and the care-delivery business model that we have created with that bad model has us on a path to spend even more than we are spending now on care.

We need to cap health care spending. We need the ability to have a global budget and target for care costs that has actual tools built into it that can make that global budget happen.

The missing link in American health care is clearly a buyer. We spend $3 trillion on care each year with no plan, no strategy, no expectations, and no real oversight.

We need a buyer and we need a better buying process for care that can make sure that a very real and meaningful part of that vast flow of money gets us the care we deserve and should be getting.

Using Medicare Advantage for Everyone as our buying mechanism gives us a relatively painless and functionally smooth way of achieving those goals. If we use Medicare Advantage for Everyone, we can use tools we already have in place and we can create very clear specifications that give us continuously improving care, direct access to our relevant care data, and a far more patient-focused care infrastructure.

Support for Medicare for All continues to grow. We need to build on that momentum and we need to help people who support that strategy to acquire a sense that we could do it all faster, cheaper, and in a way that channels market forces, the best science, and basic process-improvement engineering into the reality of people who receive care by using Medicare Advantage for Everyone instead.

We are on the edge of a crisis.

We know that people are going to be very angry about their coverage and care.

The political process in Washington has tried for a couple of years to come up with solutions to those problems, and has failed.

Some of the proposed solutions have been very complex and have had many moving parts.

Some of the proposed solutions have been painfully simple.

Instead of complex or simple solutions, we need a doable solution.

We need a solution we can achieve with parts we know and understand, and with a clarity of direction that will give us all peace of mind that we are focused on fixing the situation we are in with tools that can fix it.

Offering Medicare Advantage to everyone is a way of buying care well for the first time as a nation, and it gives us a solution set for all of the major concerns and issues that should succeed because all the parts work now.

This strategy of using Medicare Advantage for Everyone gives us a safety net as a nation for health care financing and coverage.

We can put this strategy on a shelf and take it off when we are ready to actually deal with the real issues in a way that has a high likelihood of success.

None of those pieces needed to implement that plan are going away. They all work now and they are all possible to do whenever we want.

That time when we will want to implement a working solution might come more quickly than many people think. There is a very high likelihood right now that Americans will be very angry later this year when insurance benefits go down, insurance premiums go up, and care prices explode in visible and inflammatory ways.

We can expect the next couple of years to be painful and grim, and we can expect people to be unhappy about all of those care-related cost issues.

When we get really sick and tired of the mess we are in, we can choose to make a couple of smart decisions, drop in a couple of key pieces that we already own, and we can fix both care financing and care delivery with one set of tools that actually work.

Most people with a high level of energy about health care reform issues and problems today have only incomplete, relatively vague, ideologically correct, but only marginally functional or operationally practical ideas about what might actually be done to make care better of more affordable.

Most people who talk about universal coverage using Medicare for All to cover everyone tend to have coverage aspirations that are not linked to politically and functionally available sources of revenue to pay for that coverage and that do nothing to improve the care they would like to fund.

This approach of buying Medicare Advantage for Everyone and paying for it with a payroll tax that is about the level companies pay now for care, can both fix care and fund the process with a tool that fits the flow of cash we use to buy care today that could be implemented in months rather than decades.

Even if no one is ready now to cover us all with this approach, it is worth understanding what might be done with this set of tools, and then putting this plan on the shelf for possible use later, when we are in enough pain that we will want to make the pain and the exploding expense levels both end by doing something that actually works to fix them.

Medicare Advantage for All Plus Medicaid.

We can cover everyone and we could do it in a year without increasing the amount we spend on care.

Worth considering.

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