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The Meaning of "Medicare-For-All"

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THE MEANING OF "MEDICARE-FOR-ALL"

By Isaac D. Buck†

ABSTRACT

Medicare-for-All proposals are heralded for the guarantee of additional coverage they provide, moving health insurance in the United States from nearly universal to completely universal. Indeed, if Medicare is known for something, it is the guarantee of access to health insurance it provides. Since its inception, the Medicare program has provided universal coverage to Americans aged 65 and older—a population that is both expensive to cover and often most in need of high-quality health care. But Medicare is more than that. While Medicare has become the program that guarantees coverage to an entire subset of American citizens, it has also served as a platform for innovative policy designs intended to address the health care cost crisis. From Accountable Care Organizations (ACOs), to the Merit-Based Incentive Payment System (MIPS) within its Part B, to its formidable fraud and abuse tools like the False Claims Act, Medicare has been important not only because of the example it has provided in achieving insurance universality, but also because it has provided a space for law, policy, and medicine to innovate. Specifically, it has

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served an important role in making American health care delivery more standardized, efficient, and equitable. An expansion of the program could extend its efficiencies on a universal or near-universal basis, with positive impacts for millions of American patients. This piece makes the argument that the real upside of the implementation of such "Medicare-for-All" proposals, however unlikely politically, may not be the coverage gains they promise, particularly because the Affordable Care Act's exchanges have secured such extensive growth in coverage for millions of Americans. Instead, the value of "Medicare-for-All" proposals may be their ability to universally extend Medicare's cost-containment policies, many of which are unknown to the general public or at least not fully understood. It is this impact—the expansion of Medicare's regulatory regime to cover millions more Americans—that may be the most important consequence of the push for "Medicare-for-All."

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I. INTRODUCTION

Policy debates around "Medicare-for-All" proposals impact domestic political discourse in 2020. Although new on specifics, these debates constitute a new iteration of the same discussion that has continued for more than 50 years, focusing on the appropriate roles of private industry and government action within the public sphere. Different from the debates that occurred a generation or two ago, these discussions are infused with the lessons and realities of the Patient Protection and Affordable Care Act of 2010 (ACA), the most important piece of health care legislation since the mid-1960s.

Perhaps it is surprising that these debates have become so prevalent, given that the ACA's passage was a mere ten years ago. A number of characteristics of the debate—from the stylizing of the proposals as "Medicare," to the regulatory impact such new proposals would have on the delivery of American health care, to their temporal proximity to the massive coverage-securing ACA—are noteworthy. But beyond the political branding involved and regardless of implementation, the popularity and focus of the plans do tell policymakers something: ten years ago, the ACA expanded health insurance, and now America is clamoring for *better* health insurance.

While the national narrative has focused on insurance access through "Medicare-for-All," this piece argues that it is the regulatory impact of Medicare expansion that would have a more profound effect on American health insurance. This article takes the position that it is not the impact of universal insurance that is dispositive, but rather, the expansion of the modern regulatory state, applying to millions of additional Americans, that may have the largest impact on Americans' health insurance and access to care.

This piece makes this argument in three sections. It first analyzes the regulatory impact of "Medicare-for-All" proposals.[1] Second, it presents the regulatory impact that expanding Medicare to a much larger swath of the American populace—and universally in the case of a mandatory program—would have on the standardization,

[1] The chief focus of this article is on "Medicare-for-All" proposals that would seek to cover all Americans in a single, universal, mandatory pool.

efficiency, oversight, and leverage of relationships. From expanding powerful health care fraud and abuse statutes, to extending its standard-setting and innovation-incentivizing character, to reducing administrative costs and hospital charges, Medicare's expansion could inject efficiencies into a system largely dominated by private insurance companies currently lacking them. Third, this piece summarizes the challenges and unknowns that may result from the proposals. While expanding Medicare to provide insurance for a larger swath of the American population would seem to bring positive spillover regulatory effects, its overall impacts remain unknown.

II. "MEDICARE-FOR-ALL" IS A POLITICAL SIGNAL

The popularity of Medicare—America's seminal public health insurance program—is not in doubt.[2] Instead, today, the relevant polling is for "Medicare-for-All," an amorphous set of policy prescriptions and delivery reforms that have been highlighted on the 2020 presidential campaign trail over the last year.[3] The fact that such proposals are growing in political popularity is as much a part of the story as the content and policy prescriptions within the proposals themselves.

The political popularity of traditional Medicare must be responsible. Seniors, of whom most are Medicare beneficiaries,

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[2] *See* Dan Mangan, *Medicare, Medicaid Popularity High: Kaiser*, CNBC (July 17, 2015, 3:00 AM), https://www.cnbc.com/2015/07/16/medicare-medicaid-popularity-high-ahead-of-birthday.html (noting that 77 percent of respondents "considered Medicare to be a very important government program"). *See also* Sarah Kliff, *When Medicare Launched, Nobody Had Any Clue Whether It Would Work*, WASH. POST (May 17, 2013), https://www.washingtonpost.com/news/wonk/wp/2013/05/17/when-medicare-launched-nobody-had-any-clue-whether-it-would-work/ ("Medicare is, these days, an incredibly popular program. Americans overwhelmingly oppose cutting it. No politician would consider repealing it. Most think providing health insurance to all Americans over 65 is worth the (sic) both the trouble and the cost.").

[3] *See* John Tozzi & Danielle Parnass, *Your "Medicare for All" Questions, Answered*, BLOOMBERG (July 31, 2019), https://www.bloomberg.com/news/articles/2019-03-29/how-medicare-for-all-could-mean-change-for-everyone-quicktake ("What would Medicare for All Mean? That depends on who's talking.").

consistently rate the coverage and quality of their health insurance positively.[4] Three-fourths of all Americans have called Medicare "very important," with majorities stating that it "should remain as it is."[5] Given the contentiousness that existed at its inception, it is a marvel that Medicare has become such a stable and popular program.[6] It occupies a position of cultural primacy, and has even become meme-worthy.[7]

Primarily during the presidential primary of 2020, candidates used the political popularity of the Medicare program to introduce new single-payer or public option health care proposals. A number of national figures and candidates for president, from progressive politicians like Senators Bernie Sanders (I-VT) and Elizabeth Warren (D-MA), to more centrist former candidates like Kamala Harris (D-CA) and Cory Booker (D-NJ), to newcomers like South Bend, Ind., Mayor Pete Buttigieg adopted the language of Medicare in an effort to sell new health care proposals throughout 2019. As a political matter, these are savvy decisions.[8]

But these moves beg important substantive questions—the most important of which focus on how closely related these new proposals are to the Medicare program as Americans know it. In other words,

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[4] *See* Justin McCarthy, *Most Americans Still Rate Their Healthcare Quite Positively*, GALLUP (Dec. 7, 2018), https://news.gallup.com/poll/245195/americans-rate-healthcare-quite-positively.aspx.

[5] Ken Walsh, *The Politics of Medicare and Medicaid, 50 Years Later*, U.S. NEWS & WORLD REP. (July 30, 2015, 12:01 AM), https://www.usnews.com/news/articles/2015/07/30/the-politics-of-medicare-and-medicaid-50-years-later.

[6] *See* Kliff, *supra* note 2 (quoting news headlines that state "Selling Elderly on Medicare Is Not Easy," "A.M.A. Criticizes Medicare in Ad; Says It Would Be "Beginning of Socialized Medicine," and "Medicare Staffers Having Hard Time Enrolling Those Who Need It The Most").

[7] *See* Bob Cesca, *Keep Your Goddamn Government Hands Off My Medicare!*, HUFFPOST, https://www.huffpost.com/entry/get-your-goddamn-governme_b_252326 (last visited Dec. 6, 2017).

[8] *See* Akilah Johnson, *Medicare-For-All Is Not Medicare, and Not Really for All. So What Does It Actually Mean?*, PRO PUBLICA (Sept. 6, 2019, 1:23 PM), https://www.propublica.org/article/medicare-for-all-is-not-medicare-and-not-really-for-all-so-what-does-it-actually-mean ("how politicians talk about the issue matters, with 63% responding favorably to the terms 'Medicare-for-all' and 'universal health coverage.' Those positive feelings begin dissipating when it's called a 'single-payer national health insurance system,' dropping to 49%.").

is Medicare the right platform for these proposals, or is it merely a political branding decision? And, if, in the wake of the near-decade-long implementation and multiple near-death experiences of the ACA,[9] these proposals are addressing a compelling societal problem, what, specifically, is that problem? If the ACA experience is a prologue to an effort to instantiate a federal health care program that guarantees universal coverage, those proposing "Medicare-for-All" should be ready for a long fight.

At base, one inquires as to whether these proposals constitute either political signaling that featured a catchy slogan in the middle of a campaign, or serious substantive policy proposals that provide clear prescriptions for America's health care troubles with popular policy solutions.[10] Certainly, the first challenge is determining the structure and content of each of the proposals. As part of this effort, the persistent policy incoherence[11] around various "Medicare-for-All" proposals is summarized below.

A. Policy-Based Incoherence

For the policy wonk, there are two particularly interesting characteristics of the focus on "Medicare-for-All" as a cure to what ails American health care financing. The first relates to the timing of the proposals. The second is substantive, and seeks to find out what these proposals contain and how they are likely to achieve their goals. Both questions begin by asking what problem the proposals seek to solve.

First, the timing of the "Medicare-for-All" cacophony is noteworthy. Americans are ten years removed from the passage of

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[9] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012); King v. Burwell, 574 U.S. 988 (2015). *See also* Chris Riotta, *GOP Aims to Kill Obamacare Yet Again After Failing 70 Times*, NEWSWEEK (July 29, 2017, 6:53 PM), https://www.newsweek.com/gop-health-care-bill-repeal-and-replace-70-failed-attempts-643832; Emmarie Huetteman, *McCain Hated Obamacare. He Also Saved It*, NBC NEWS (Aug. 27, 2018, 12:21 PM), https://www.nbcnews.com/health/obamacare/mccain-hated-obamacare-he-also-saved-it-n904106.

[10] *See* Melanie Mason, *Beyond the Slogan, "Medicare for All" Vexes Democratic Presidential Candidates*, L.A. TIMES (Feb. 10, 2019, 4:00 AM), https://www.latimes.com/politics/la-na-pol-medicare-for-all-presidential-20190210-story.html.

[11] *See* Johnson, *supra* note 8.

the ACA, which itself took generations to pass and implement,[12] and is still being challenged in court.[13] The ACA's survival—long under threat—is still not free from doubt.[14]

Nonetheless, the party of Barack Obama has now decided to push for fully universal health care coverage—policy designs that the party's most popular figure avoided in favor of his carefully-constructed technocratic marvel in the ACA.[15] It is all the more complicated to consider that the party has turned toward "Medicare-for-All," stylizing new proposals on the nation's quintessential insurance-granting health care insurance program to the nation's elderly, when the major positive accomplishment of the ACA *was* securing coverage expansions.[16]

Indeed, the push for "*Medicare*-for-All," as opposed to bolstering the ACA, seems to be an interesting branding decision. Medicare, known for its insurance universality for America's senior citizens, is clearly a smart political platform on which to base yet another fight over health care reform, but may not be the right analog for the policy construction, particularly because the ACA did so much to secure coverage gains.[17] In other words, fighting to secure additional

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[12] *See* Jonathan Oberlander, *Long Time Coming: Why Health Reform Finally Passed*, 29 HEALTH AFFS. 1112 (2010), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.0447.

[13] *See* Texas v. United States, 945 F.3d 355 (5th Cir. 2019), *reh'g denied en banc*, 949 F.3d 182 (5th Cir., 2020) *cert. granted sub nom.* California v. Texas, 140 S.Ct. 1262 (Mar. 2, 2020); Land of Lincoln Mut. Health Ins. v. United States, 139 S.Ct. 2744 (2019) (granting writ of certiorari).

[14] *See* Texas, 945 F.3d 355.

[15] *See* Matthew Sheffield, *It's Still Obama's Party: Former President Easily Tops List of Who Best Represents Democrats*, THE HILL (Apr. 2, 2019), https://thehill.com/hilltv/what-americas-thinking/436953-its-still-obamas-party-former-president-tops-list-of-who-best.

[16] Reed Abelson et al., *What Happens if Obamacare Is Struck Down?*, N.Y. TIMES (July 9, 2019), https://www.nytimes.com/2019/03/26/health/obamacare-trump-health.html (noting that 21 million people "could lose health insurance" if the Trump administration's effort to get the law declared unconstitutional was successful).

[17] *See Key Facts about the Uninsured Population*, KAISER FAM. FOUND. (Dec. 13, 2019), https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/ (noting that the number of uninsured Americans dropped from 46.5 million Americans to below 27 million Americans between 2010 and 2016). *But see* Dan Witters, *U.S. Uninsured Rate Rises to Four-Year High*, GALLUP (Jan. 23, 2019), https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx (noting that uninsurance rate dropped from 18 percent to about 11 percent between 2013 and 2016, but has risen to 13.7 percent at the end

access gains seems to be a noteworthy political choice, given the fact that the number of uninsured has dropped in the last ten years under the ACA.[18] At the very least, one may inquire as to whether the underlying popular desires that are driving these new proposals are best addressed by building on a program that provides universal access to health coverage, or, instead, should focus on shoring up other, more feeble components of the ACA.

Secondly, substantively, the generalized term "Medicare-for-All" seems to have an incoherence problem.[19] In the summer of 2019, the Democratic candidates for president—at the time more than two dozen—had fractured their support along the spectrum of different definitions and understandings of "Medicare-for-All."[20] The candidates split into three general camps: (1) some candidates were in favor of a more classic version of "Medicare-for-All," (2) others did not support "Medicare-for-All" but instead were supportive of insurance expansions, and (3) a middle group was in favor of at least "Medicare for some."[21] Even as the candidates split into these three general groups, important differences among the politicians in each camp remained.[22]

Specifically, some candidates in the 2020 presidential election argued for "Medicare-for-All" in the most literal sense, emphasizing

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of 2018).

[18] *See* Rachel Garfield et al., *The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the Uninsured Amidst Changes to the Affordable Care Act*, KAISER FAM. FOUND. (Jan. 25, 2019), https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-many-people-are-uninsured/ ("Before the ACA, the number of uninsured Americans grew over time, particularly during economic downturns. By 2013, the year before the major coverage provisions of the ACA went into effect, more than 44 million people lacked coverage." And by 2017, that number was about 27 million).

[19] *See* Johnson, *supra* note 8 (noting that Medicare has "worked, more or less, because of the government's ability to set payments to health care providers." "When you say Medicare-for-all, there are eight different flavors…. It's an advertising slogan; it's not a scientific concept.").

[20] Alice Miranda Ollstein, *Medicare for All*, POLITICO (Sept. 29, 2019), https://www.politico.com/2020-election/candidates-views-on-the-issues/health-care/medicare-for-all/.

[21] *Id*.

[22] *Id*.

access to insurance and excluding choice.[23] This was most prominently represented by Senator Bernie Sanders, whose plan would have barred other options and mandate that all Americans belong to one plan.[24] This plan was called "significantly more generous" than other countries' government-run plans, as it includes dental, vision care and prescription drugs.[25] In Senator Sanders' plan, consumers had no out-of-pocket spending—so no copayments and no deductibles—and the plan was paid for by tax revenue.[26]

Other candidates submitted plans styled as "Medicare 'for all who want it,'" emphasizing choice.[27] Mayor Pete Buttigieg was the most well-known for this type of plan, which would have enrolled uninsured individuals, grown subsidies under the ACA, and given those with employer-based insurance the option of buying into the plan.[28] Buttigieg would also have added additional consumer protections such as protecting against surprise billing and additional charge caps for care.[29]

Some candidates were positioned between choice and access. Senator Kamala Harris' plan,[30] which had also been styled as "Medicare Advantage for All,"[31] maintained private insurance and allowed for a ten-year transition period before all Americans were

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[23] *See also* Danielle Kurtzleben, *Kamala Harris Releases 'Medicare for All' Plan With a Role for Private Insurers*, NPR (July 29, 2019, 6:00 AM), https://www.npr.org/2019/07/29/746051105/kamala-harris-releases-medicare-for-all-plan-with-a-role-for-private-insurers (noting that Senator Harris' plan differed from Senator Sanders' plan, "under which any insurance that duplicates the coverage provided by his Medicare-for-All system would be banned.").

[24] *See* Sarah Kliff, *Bernie Sanders's Medicare-for-All Plan, Explained*, VOX (Apr. 10, 2019, 11:00 AM), https://www.vox.com /2019/4/10/18304448/bernie-sanders-medicare-for-all.

[25] *Id.*

[26] *Id.*

[27] Dylan Scott, *Pete Buttigieg's Medicare-for-All-Who-Want-It Plan, Explained*, VOX (Sept. 19, 2019, 8:55 AM), https://www.vox.com/2019/9/19/20872881/pete-buttigieg-2020-medicare-for-all.

[28] *Id.*

[29] *Id.*

[30] *See* Kurtzleben, *supra* note 23.

[31] *See* Matt Bruenig, *The Real Costs of the U.S. Health-Care Mess*, THE ATLANTIC (Aug. 8, 2019), https://www.theatlantic.com/ideas/archive/2019/08/best-democratic-health-plan/595657/.

enrolled into her "Medicare for All" program.[32] Instead of eliminating private health insurance, Senator Harris required private insurance to "adhere to 'strict' requirements on costs and benefits."[33]

Still, others seemed to reject the stylized "Medicare for All" debate, like former Vice President Joe Biden's plan, which was called the "Affordable Care Act 2.0"[34] and "radically incremental."[35] His plan includes the adoption of a public option that would be accessible to tens of millions of Americans.[36] He would also bolster the ACA's tax subsidies, "uncapping" them for those who make higher incomes.[37]

B. The Rhetoric of Medicare

The fact that multiple candidates seized on the terminology, and, specifically, the "Medicare" name itself, is striking. It demonstrates Medicare's value as a powerful political force, and has, once again, shown the importance of political terminology and branding.[38] Even

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[32] *See* Tucker Higgins, *Kamala Harris Unveils "Medicare for All" Plan That Won't Kill Private Insurance*, CNBC (July 29, 2019 2:20 PM), https://www.cnbc.com/2019/07/29/kamala-harriss-medicare-for-all-plan-keeps-private-insurance.html ("The plan does not go as far or as fast as the one proposed by Sen. Bernie Sanders, which Harris has co-sponsored in the Senate.").

[33] *Id.*

[34] Dan Diamond, *Biden Unveils Health Care Plan: Affordable Care Act 2.0*, POLITICO (July15, 2019, 1:10 PM), https://www.politico.com/story/2019/07/15/joe-biden-health-care-plan-1415850 (noting, in a campaign ad, Joe Biden saying, "I understand the appeal of Medicare for All…But folks supporting it should be clear that it means getting rid of Obamacare. And I'm not for that.").

[35] *See* Julie Rovner, *Biden's "Incremental" Health Plan Still Would Be a Heavy Lift*, KAISER HEALTH NEWS (July 22, 2019), https://khn.org/news/bidens-incremental-health-plan-still-would-be-a-heavy-lift/.

[36] *Id.*

[37] *Id.*

[38] *See Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage*, KAISER FAM. FOUND. (Jan. 30, 2020), https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/ (in a survey, 63 percent had a positive reaction to "universal health coverage" and "Medicare-for-all," while only 49 percent had a positive reaction to "single-payer health insurance system", and 46 percent had a positive reaction to "socialized medicine").

candidates' plans that had very little to do with the Medicare program seized on its public relations value.[39]

Presidential candidates used the rhetoric of Medicare—and specifically, the language of access guarantees—to tout health care proposals.[40] Senator Elizabeth Warren called Bernie Sanders' "Medicare-for-All" plan "the best way to give every single person in this country a guarantee of high-quality health care."[41] Warren also said that "[p]eople will have access to all of their doctors, all of their nurses, their community hospitals, [and] their rural hospitals."[42] Indeed, the rhetoric of these proposals matches Americans' responses to polling questions that "universal coverage" is the top priority of a national health plan.[43] Further, as polling on an "'optional' Medicare-for-All" is "slightly more favorable across parties than a government-administered public option," this may go a long way to explain the terminology used by various political candidates.[44]

Even candidates and former candidates who were not proposing single-payer-based health care plans followed suit, drawing on the language of access. Senator Kamala Harris's plan, which had been referred to as "KamalaCare," argued for expanding Medicare "to all Americans and give everyone access to comprehensive health care."[45] But, according to reporting, the "proposal skimp[ed] on myriad

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[39] *See* Scott, *supra* note 27.

[40] *See* Johnson, *supra* note 8 (quoting John McDonough, Harvard Public Health Professor, as arguing "[i]t's an advertising slogan; it's not a scientific concept.").

[41] Dylan Scott, *How Elizabeth Warren Has Stayed Out of the "Medicare-for-All" Fray*, VOX (Sept. 16, 2019 4:10 PM), https://www.vox.com/policy-and-politics/2019/9/16/20869090/elizabeth-warren-2020-medicare-for-all-voxcare.

[42] William Saletan, *"Medicare for All" Is Not a Winning Platform*, SLATE (Sept. 13, 2019. 10:02 PM), https://slate.com/news-and-politics/2019/09/medicare-for-all-not-winning-platform-biden-warren.html.

[43] *See Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage*, *supra* note 38 (noting that 89 percent of those asked said that "universal coverage" was very important and nine percent that it was "somewhat important" to a national health plan, much higher than the 38 percent who said the elimination of private health insurance companies would be "very important", and 29 percent would be "somewhat important").

[44] *Id*.

[45] Dan Diamond & Christopher Cadelago, *Kamala Harris' New Health Plan: "Medicare for All" – With Private Insurers*, POLITICO (July 29, 2019, 6:00 AM), https://www.politico.com/story/2019/07/29/kamala-harris-medicare-for-all-1438631.

details, including the plan's cost."[46] Candidate Julian Castro, the former U.S. Secretary of Housing and Urban Development, also supported "Medicare-for-all,"[47] and said "[t]here is no reason, as many folks have pointed out, that in the richest nation on earth, anybody should go without health care."[48]

Mayor Pete Buttigieg, who called his plan "Medicare for All Who Want It," described his proposal as guaranteeing that "every American has access to affordable coverage either through private insurance or a public alternative," and for those who could not get an affordable private option, citizens could "get a plan that is."[49] His proposal provided for a public plan that could compete with private plans and "naturally lead to Medicare-for-all."[50] Further, the plan capped marketplace premiums for a larger group of individuals who purchased plans on the individual exchange.[51] In addition to bolstering the ACA, the architecture of this plan mostly contemplated constructing a "public option,"[52] which is a policy prescription that was suggested by Democratic presidential candidate Hillary Clinton in 2016.[53] Mayor Buttigieg's use of the term "Medicare" was

[46] *Id*.

[47] Rose Minutaglio, *Julian Castro Is Running for President in 2020. Here's Where He Stands on 9 Important Issues.*, ELLE (June 25, 2019), https://www.elle.com/culture/movies-tv/a27073125/julian-castro-presidential-election-2020-issues/.

[48] Emily Birnbaum, *Julian Castro: 'We Should Do Medicare for All in this Country'*, HILL (Jan. 8, 2019, 9:24 AM), https://thehill.com/homenews/campaign/424289-julian-castro-we-should-do-medicare-for-all-in-this-country.

[49] *See* Pete Buttigieg, *Here's a Better Way to Do Medicare-For-All*, WASH. POST: OPINIONS (Sept. 19, 2019, 5:00 AM), https://www.washingtonpost.com/opinions/2019/09/19/pete-buttigieg-heres-better-way-do-medicare-for-all/.

[50] *Id*.

[51] *Id*.

[52] *See* Dan Diamond, *How Pete Buttigieg Would Expand Health Coverage*, POLITICO (Sept. 19, 2019, 5:49 AM), https://www.politico.com/story/2019/09/19/pete-buttigieg-2020-health-care-plan-1502581 ("The plan formalizes proposals the South Bend, Ind., mayor has touted in the campaign, like building on Obamacare and creating a new 'public option' to compete with private insurers.").

[53] *See* Alan Rappeport & Margot Sanger-Katz, *Hillary Clinton Takes a Step to the Left on Health Care*, N.Y. TIMES (May 10, 2016), https://www.nytimes.com/2016/05/11/us/politics/hillary-clinton-health-care-public-option.html (Hillary Clinton is quoted as saying, "I'm also in favor of what's called the public option, so that people can buy into Medicare at a certain age.").

noteworthy, as the universal program for seniors may have little to do with his plan that injected a proposed public option and bolstered the ACA's structures. In other words, Buttigieg's "Medicare for All Who Want It" may have had very little *Medicare*—in all its mandatory, automatic, and universal glory—in it.

In the late spring of 2019, among those Americans who noted that health care was an important issue, the most common response when asked what specific topics should be discussed within presidential debates was "lowering the amount people pay for health care."[54] This observation—that Americans are not necessarily fervent about expanding coverage, but are intent on controlling cost—may be a natural response to some of the shortcomings of the ACA. As a result of this observation, it is worthwhile to examine what the ACA failed to deliver, and why the arguments in favor of "Medicare-for-All" plans have been met with enthusiasm: it is because the ACA failed to deliver on cost control goals.

C. Responding to the Shortcomings of the Affordable Care Act

The fact that the Democratic presidential primary spent so much time on health care policy demonstrates that the ACA did not solve what ails American health care financing. Indeed, ten years removed from the messy policy debates of the ACA, platforming "Medicare-for-All" proposals would seem to suggest that President Obama's chief domestic achievement may not have sufficiently solved the American health care cost crisis.

Perhaps the most dogged problem that continues to haunt American health care under the ACA is its pricing problem. Still, the ACA individual market has stabilized since its inception and most average premiums were down or flat in 2019 across the United States.[55] This was a huge turnaround from the early years of the

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[54] *See* Ashley Kirzinger et al., *KFF Health Tracking Poll – June 2019: Health Care in the Democratic Primary and Medicare-for-All*, KAISER FAM. FOUND. (June 18, 2019), https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-june-2019/ (noting that 28 percent focused on lowering the cost of care and 18 percent said "increasing access to health care").

[55] *See* Bob Bryan, *Here's How Much Obamacare Premiums Will Increase in Every State*, BUS. INSIDER (Nov. 2, 2018, 8:46 AM), https://www.businessinsider.com/obamacare-premium-increases-by-state-trump-effect-2018-11.

ACA.[56] Even though this suggests an optimistic outlook for the cost of care, major cost control challenges remain.

The high-cost problems are most acute for those who purchase health insurance on the ACA exchanges but who do not receive premium assistance tax credits to help defray the costs of health care premiums.[57] These individuals have sought to avoid pay increases so as to continue to hold on to key subsidies that make their exchange-purchased insurance affordable.[58] But it is not just the population of people who do not get tax subsidies under the ACA that is suffering. Those who receive insurance through their employer, about 50 percent of total Americans,[59] have experienced cost increases.

According to Kaiser, the average American family of four paid nearly $8,000 on health care in 2018.[60] This included premiums of about $4,700, and cost-sharing that exceeded $3,000.[61] This was up 67 percent over ten years before.[62] At the same time, the average employer spent more than $15,000 to insure a family of four, which was up 51 percent from 2008.[63] On all three metrics—out of pocket spending, premium contributions from employees, and premium

[56] *See id.* (showing premium increases from 2014-19 as high as 200 percent in multiple states).

[57] For extensive coverage of this population and how it has fared under the ACA, *see* Isaac D. Buck, *Affording Obamacare*, 71 HASTINGS L.J. 261 (2020), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3364502.

[58] *Id.*

[59] *See Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND. (Oct. 17, 2019), https://www.kff.org/other/stateindicator/totalpopulation/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort% 22:%22asc%22%7D.

[60] Darla Mercado, *Here's Why Your Workplace Health Insurance Is So Expensive*, CNBC (Aug. 19, 2019, 3:27 PM), https://www.cnbc.com/2019/08/19/heres-why-your-workplace-health-insurance-is-so-expensive.html; *see* Matthew Rae et al., *Tracking the Rise in Premium Contributions and Cost-Sharing for Families with Large Employer Coverage*, PETERSON-KAISER HEALTH SYS. TRACKER (Aug. 14, 2019), https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/?utm_campaign=KFF-2019-HealthCosts&utm_medium=email&_hsenc=p2ANqtz-_72_RHB9Twe8BpbqOg28rdlGqxq_SBgV6rB-kbC4PuYMItIOSxHQLmh_D3OH4GOnUKZXa8&utm_source=hs_email&hsCtaTracking=04848753-3235-436e-a0de-ae8238ad00ad%7Cc1097ae0-0521-4e9a-8e45-e5a87f67af4a.

[61] *See* Mercado, *supra* note 60.

[62] *See id.*

[63] *See id.*

contributions from employers—the cost of health care has substantially increased – from totaling about $10,000 annually in 2003, to well over $22,000 annually in 2018.[64]

According to another Kaiser study, deductibles are up 162 percent in employer-based insurance since 2009, which drastically outstrips worker wage growth of 26 percent which occurred during the same period.[65] Now, nearly 30 percent of all workers are enrolled in a health insurance plan that has an annual deductible of more than $2,000 for single coverage.[66] In 2009, only *seven* percent of those in employer-based insurance single coverage plans had annual deductibles over $2,000.[67]

These trends are nothing new. The United States outspends every other country on earth on health care, accounting for more than $10,000 annually per capita, which is about double the average of peer countries worldwide.[68] The United States' expenditure on health care as a percentage of GDP has reached 18 percent.[69] America spent $3.65 trillion on health care in 2018, with private insurance spending rising 4.5 percent, and prescription drug spending up 3.3 percent.[70] Unfortunately, price growth is likely to increase over the next eight years.[71] Spending growth in Medicare over the next eight years is likely to approach 7.5 percent, largely because of an enrollment boom.[72]

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64 *See id.*

65 *See Employer Health Benefits Survey*, KAISER FAM. FOUND. (Sept. 25, 2019), https://www.kff.org/report-section/ehbs-2019-summary-of-findings/.

66 *See id.*

67 *See id.*

68 *See* Bradley Sawyer & Cynthia Cox, *How Does Health Spending in the U.S. Compare to Other Countries?*, PETERSON-KAISER HEALTH SYS. TRACKER (Dec. 7, 2018), https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-average-wealthy-countries-spend-half-much-per-person-health-u-s-spends.

69 *Id.*

70 *See* Erik Sherman, *U.S. Health Care Costs Skyrocketed to $3.65 Trillion in 2018*, FORTUNE (Feb. 21, 2019, 8:16 AM), https://fortune.com/2019/02/21/us-health-care-costs-2/.

71 *See* Andrea M. Sisko, *National Health Expenditure Projections, 2018–27: Economic and Demographic Trends Drive Spending and Enrollment Growth*, 38 HEALTH AFFS. 491, 495 (2019).

72 *Id.*at 493.

All of this data suggests that Americans are unhappy with health care expenditures and expenditures will likely increase even more in the years to come. This is a separate issue than just coverage, which has expanded under the ACA. But, now, it is the American insured population that faces increased costs every year, which could go a long way in explaining why "Medicare-for-All" proposals have become politically popular. If the ACA gave them insurance, Americans now want affordable insurance.

III. "MEDICARE-FOR-ALL" AS A REGULATORY TROJAN HORSE

Even though it is Medicare that is the access-guaranteeing program with broad political popularity, it is the rules and regulations that govern the Medicare program—and their universal applicability—that would lead to major changes in American health care finance and delivery. This is because Medicare has been used as a programmatic platform for many recent regulatory changes and pilots.[73] Specifically, "Medicare-for-All" would expand Medicare's potent regulatory apparatuses of efficiency, oversight, standardization, and leverage to the broader health care industry.

A. Standardization

Beyond securing coverage for a vulnerable population, the Medicare program has pushed American health care progress forward by its data collection efforts.[74] Medicare's various programs, both permanent

[73] *See, e.g.*, Jenny Gold, *Accountable Care Organizations, Explained*, KAISER HEALTH NEWS (Sept. 14, 2015), https://khn.org/news/aco-accountable-care-organization-faq/; *See also Innovation Models*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/#views=models (last visited Oct. 2, 2019) (noting that the "Innovation Center develops new payment and service delivery models in accordance with the … Social Security Act").

[74] *See* Martha Hostetter & Sarah Klein, *In Focus: Medicare Data Helps Fill in Picture of Health Care Performance*, COMMONWEALTH FUND (Oct. 9, 2019), https://www.commonwealthfund.org/publications/newsletter-article/focus-medicare-data-helps-fill-picture-health-care-performance (New requirements under the Affordable Care Act have made big changes in this area. Specifically, the Medicare Data Sharing for Performance Measurement Program will eventually allow policymakers to link policy goals to what is reflected in the

policies[75] and pilot proposals,[76] have driven medical standardization forward and constitute an important platform from which to learn about the heterogeneity of medical practice throughout the United States.[77]

Besides providing a source of information for health policy design, Medicare also plays an important standard-setting and innovation-incentivizing role.[78] As an example, the ACA created the Center for Medicare and Medicaid Innovation (CMMI) "to research optimal quality standards and payment regimes."[79] Although the White House has sought to substantially cut funding for CMMI, it has been funded through fiscal year 2019.[80] Medicaid, like Medicare, has also been lauded for how it encourages experimentation and innovation.[81]

B. Efficiency: Cost Containment for Physicians

Although it has been somewhat reshaped since the beginning of the Trump administration,[82] the Medicare Access and CHIP Reauthorization

data).

75 *See id.*

76 *Id.*; *see generally* Thomas Bodenheimer et al., *Can Money Buy Quality? Physician Response to Pay for Performance*, 3 IND. HEALTH L. REV. 445, 451 (2006).

77 Bodenheimer et al., *supra* note 76 ("Should Medicare adopt P4P, private plans and Medicaid programs could well decide to adopt Medicare's measures, which in turn would reduce the problem of lack of standardization.").

78 *See* Thaddeus Mason Pope, *Rethinking Medical Liability: A Challenge for Defense Layers, Trial Lawyers, Medical Providers, and Legislators: An Introduction to the Symposium*, 37 U. MEM. L. REV. 455, 458 (2007) (noting that Medicare has a "central role in setting standards for the health care system" and "experience in sponsoring demonstrations of health policy innovations").

79 Adam Candeub, *Contract, Warranty, and the Patient Protection and Affordable Care Act*, 46 WAKE FOREST L. REV. 45, 47 (2011).

80 *See White House Proposes Rescinding Certain CHIP, CMMI Funding*, AM. HOSP. ASS'N (May 9, 2018, 8:03 PM), https://www.aha.org/news/headline/2018-05-09-white-house-proposes-rescinding-certain-chip-cmmi-funding.

81 *See generally* Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 57 (2016).

82 *See* Joanne Finnegan, *A Break For Doctors: Trump Administration Wants to Reduce Reporting Burden Under MIPS*, FIERCE HEALTHCARE (Feb. 22, 2018, 11:51 AM), https://www.fiercehealthcare.com/practices/trump-budget-mips-quality-reporting-macra (noting the proposal from the Trump administration that would eliminate two of the four performance metrics, and easing or eliminating reporting burdens for physicians under Part B).

Act of 2015 (MACRA) has made changes to the way Medicare pays physicians who participate in the program.[83] According to CMS, in addition to ending the sustainable growth rate (SGR) formula,[84] MACRA builds in value-based reimbursement tools, "streamlines multiple quality programs," and awards providers who participate in alternative payment models (APMs) like accountable care organizations.[85]

Most relevant for the instant analysis, within MACRA, Congress established the quality payment program, which comprises the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). MIPS provides for "performance-based payment adjustment" for participating providers, and participation in an Advanced APM makes the provider eligible for additional incentive payments.[86]

Providers who are reimbursed in Medicare Part B and who are not enrolled in an Advanced APM are required to participate in the MIPS program.[87] The participating physicians' reimbursements are impacted by four performance areas: quality, promoting interoperability (which used to be referred to as "advancing care information"), improvement activities, and cost.[88] The so-called performance years— year in which providers must heed the new data collection requirements—precede "payment" years by two years.[89]

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[83] *See What's MACRA*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 14, 2019), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html.

[84] S*ee generally*, Isaac D. Buck, *Breaking the Fever: A New Construct for Regulating Overtreatment*, 48 U.C. DAVIS L. REV. 1261, 1304–05 (2015) ("The SGR, however, has never gotten off the ground. Feeling little individual responsibility, physicians have not changed their behavior to avoid the 'punishment' of declining rates.").

[85] *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *What's MACRA*, *supra* note 83.

[86] *See What Is the Quality Payment Program?*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 8, 2019), https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-PaymentProgram.html.

[87] *See MIPS Overview*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://qpp.cms.gov/mips/overview (last visited Mar. 3, 2020).

[88] *Id.*

[89] *Id.*

For example, the physician's performance data collected in 2017 impacted payments made under Medicare Part B for 2019.[90] Some Part B physicians are exempt from the requirements of the MIPS program if they qualify for low-volume exceptions, based on the total monetary value billed to the Medicare program, the total number of Part B patients they have treated, and the number of services they have provided to Part B beneficiaries.[91]

MIPS measures the four aforementioned metrics and then compares providers against one another, using the scores on those metrics to either increase or decrease their reimbursement under Medicare Part B. For performance year 2020 (payment year 2022), the maximum penalty and bonus under the MIPS program is 9 percent.[92] Interestingly, MIPS's bonuses and penalties are required to be budget-neutral,

meaning the estimated increase in aggregate allowed charges resulting from the application of positive MIPS payment adjustment factors must equal the estimated decrease in aggregate allowed charges resulting from the application of negative MIPS payment adjustment factors for the MIPS payment year.[93]

But MIPS's impact may be blunted. The Medicare Advisory Commission (MedPAC) has voted to eliminate the program.[94] The first changes, previewed in a CMS proposal rule that has since taken effect, limited the application of the MIPS program's applicability to only 36 percent of clinicians.[95] Nonetheless, the total number of providers participating in the first year of MIPS was impressive.[96]

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[90] *Id.*

[91] *How MIPS Eligibility Is Determined*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://qpp.cms.gov/mips/how-eligibility-is-determined#lowVolumeThreshold-2019 (last visited Mar. 14, 2020).

[92] AM. UROLOGICAL ASS'N, *2020 Physician Fee Schedule Final Rule Top 10 MIPS Takeaways*, https://www.auanet.org/practice-resources/patient-safety-and-quality-of-care/2020-mips-toolkit (last visited Sept. 13, 2020).

[93] CTRS. FOR MEDICARE & MEDICAID SERVS., FACT SHEET: 2019 MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PAYMENT ADJUSTMENTS BASED ON 2017 MIPS SCORES 9 (2019), https://qpp-cm-prod-content.s3.amazonaws.com /uploads/70/2019%20MIPS%20Payment%20Adjustment%20Fact%20Sheet_2018%2011%2029.pdf.

[94] Ropes & Gray LLP, *See Health Care Provisions in Bipartisan Budget Act of 2018*, LEXOLOGY (Feb. 23, 2018), https://www.lexology.com/library/detail.aspx?g=9a5a75b0-d226-4ff2-8a42-21bd67eae005.

[95] *See* Jeff Byers, *Nine Major Takeaways from the 2018 MACRA Proposed Rule*, HEALTHCARE DIVE

The Bipartisan Budget Act of 2018 changed some of the parameters around MACRA, and more specifically, MIPS.[97] Particularly, the 2018 act gives CMS discretion to add flexibility to the cost criterion, moving it from 30 percent of the overall performance score to allowing CMS to determine how much to weigh the cost factor, with guidelines of between 10 and 30 percent.[98] Other changes included removing Part B drug reimbursement from the MIPS calculation, delaying the implementation of the "performance threshold" (which is the number "providers must exceed in order to avoid payment reductions"), and reducing the base physician fee schedule update, which could impact MACRA's likelihood of awarding fee increases.[99]

Whatever the future of the MIPS program and the MACRA law, expanding the reach of MIPS and MACRA to cover all those providers who would participate in a "Medicare-for-All" program would have major impacts on the financing of health care in the United States. Because of MIPS's statutorily required budget neutrality[100] and its mandatory nature, providers participating in "Medicare-for-All" could face mandates that would force them to take account of the four performance categories. Allowing application of the law to beneficiaries beyond the strictures of the current Medicare program, and opening it up to a percentage of the 156 million who have employer-based insurance, would build a reimbursement mechanism that would reward all providers[101] based on efficiency and quality.

(June 26, 2017), https://www.healthcaredive.com/news/macra-qpp-2018-proposed-rule/445648/ ("Only 36% of clinicians will be eligible for MIPS after all exclusions, but they make up 58% of Medicare Part B charges"); *See also* Ropes & Gray, *supra* note 94 ("the Trump administration made regulatory changes that reduced the number of clinicians required to participate in MIPS").

96 *See More Than One Million Providers Participated in MIPS' First Year. Here's How They Did.*, ADVISORY BD. (Mar. 25, 2019, 8:00 AM), https://www.advisory.com/daily-briefing/2019/03/25/mips (noting that more than one million providers earned a positive payment adjustment under the MIPS formula, and that nearly 100,000 eligible clinicians participated in an Advanced APM, which was beyond CMS's participation benchmarks for the program).

97 *See* Ropes & Gray, *supra* note 94.

98 *Id.*

99 *Id.*

100 *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 93.

101 This would include those who are not exempted from the MIPS program.

C. Oversight: Fraud and Abuse Statutory Tools

In addition to cost containment efforts that force additional efficiency in the health care system, there are powerful fraud and abuse statutes that enable the federal government to return ill-gotten gains and deter providers and hospitals from seeking payments to which they are not entitled.[102] These tools protect the integrity of government programs and taxpayers, seek to lower the overall costs of health care, and ensure that the programs are administering quality care.[103]

The most powerful of these statutory tools include the federal civil False Claims Act (FCA),[104] the Anti-Kickback Statute (AKS),[105] and the Stark Law.[106] These laws provide an extensive regulatory structure that punishes and prevents hospitals and providers from overbilling, upcoding, and administering care that is of questionable medical necessity. Because of their broad reach, these laws represent substantial deterrent value and help dissuade providers from testing the limits of their application.

Because Medicare is a taxpayer-funded federal program, application of the federal statutes to the Medicare program has been natural. But, if a "Medicare-for-All" program were constructed and successfully implemented, all three statutes—the FCA, AKS, and Stark Law application in health care—would extend well beyond the nearly 60 million Americans who make up the total population of Medicare and Medicare Advantage beneficiaries.[107] Assuming that a substantial

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[102] CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE FRAUD & ABUSE: PREVENT, DETECT, REPORT 4 (2019), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads /Fraud-Abuse-MLN4649244.pdf ("Although no precise measure of health care fraud exists, those who exploit Federal health care programs can cost taxpayers billions of dollars while putting beneficiaries' health and welfare at risk.").

[103] *Id.* at 17.

[104] *See* 31 U.S.C. § 3729 (2014).

[105] *See* 42 U.S.C. §§ 1320a–7b (2010).

[106] *See* 42 U.S.C. § 1395nn (2010).

[107] *Total Number of Medicare Beneficiaries*, KAISER FAM. FOUND., https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location %22,%22sort%22:%22asc%22%7D (last visited Oct. 4, 2019).

portion of the largest group of beneficiaries—those who receive health insurance through their employment—would sign up for 'Medicare-for-All" plans (or be forced into them), application of the federal health care statutes and their powerful penalties would be extended over millions of more individuals.

While the AKS applies to Medicare, Medicaid, and other "federal health care program business,"[108] and the FCA applies to any fraud on the government,[109] the Stark Law only applies to the Medicare and Medicaid programs.[110] Expanding Medicare would not only extend Stark Law application to all of those who switch from the employer-based insurance marketplace to "Medicare-for-All" (assuming some version of employer-based insurance could survive), but it would also apply to all of those who currently receive their insurance through the ACA's exchanges and elect to switch to a "Medicare-for-All" plan. That population totals about 10 million people, and adding in those who receive health insurance from "off-exchange plans" would bolster the total to about 14 million Americans.[111]

But the much larger pool of individuals—those whose shift to "Medicare-for-All" would extend regulatory coverage in a much more robust way—would be the group of Americans who currently receive health insurance through their employment and would opt, or be forced, to sign-up for a "Medicare-for-All" plan. According to Kaiser, the number of Americans with employer-sponsored health insurance totals

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[108] *See* Alexander Dworkowiz et al., *Extending VBP Models Into Medicaid Drug Purchasing: Challenges and Opportunities*, HEALTH AFFS. BLOG (May 22, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190520.247063/full/ ("the AKS is a criminal law that prohibits the payment of anything of value in exchange for referrals under Medicare, Medicaid and other federal programs").

[109] *See* Richard A. Bales, *A Constitutional Defense of Qui Tam*, 2001 WIS. L. REV. 381, 381–82 (2001) (the FCA is "the government's primary litigative tool for combating fraud against the federal government").

[110] *See A Roadmap for New Physicians: Fraud and Abuse Laws*, OFF. OF INSPECTOR GEN., U.S. DEP'T HEALTH & HUM. SERVS., https://oig.hhs.gov/compliance/physician-education/01laws.asp (last accessed Oct. 4, 2019) (noting that Stark applies to Medicare and Medicaid).

[111] *See* Rachel Fehr et al., *Data Note: Changes in Enrollment in the Individual Health Insurance Market Through Early 2019*, KAISER FAM. FOUND. (Aug. 21, 2019), https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/ (showing that individual enrollment has dropped from more than 17 million in 2015 to under 14 million in 2018).

about 156 million people, which makes up about 58 percent of the non-elderly population.[112] Interestingly, the shift away from employer-based insurance seems to have already begun, as that number is down from 67.3 percent of non-elderly Americans who were employer-sponsored health insurance beneficiaries in 1999.[113]

Nonetheless, throwing a substantial percentage (or all) of 156 million people into a federally-run "Medicaid-for-All" program would greatly expand the reach of the federal statutes that are currently more-or-less limited to America's public health care insurance programs and have no application to private insurance. At the very least, all three of the statutes—the FCA, AKS, and Stark Law—would likely have an impact on the regulation of American health care by simply expanding applicability of those statutes over a wider swath of American health care delivery. By expanding the pool of individuals over which these statutes govern, the statutes themselves become more powerful tools and have a greater deterrent value. As a result, those providers and jurists that have lamented the reach and complexity of the Stark law may represent only the tip of the iceberg in a new "Medicare-for-All" regime.[114]

First, and perhaps most importantly because of the size of its penalties, expanding the application of the False Claims Act (FCA) to the health care delivery of substantially more Americans would expand its potency. In fiscal year 2018, resolutions by the Department of Justice (DOJ) totaled more than $2.8 billion, including settlements and judgments.[115] Of the $2.8 billion recovered, $2.5 billion related to the health care industry, with 2018 marking "the ninth consecutive year that

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[112] *Id.*

[113] *Id.* ("The share has declined markedly over the last two decades, with the greatest percentage reductions among people with incomes under 400 percent of poverty ($85,320 for a family of three in 2019).").

[114] *See* United States *ex rel.* Drakeford v. Tuomey Healthcare Sys., 792 F.3d 364, 395 (4th Cir. 2015) (Wynn, J., concurring) ("This case is troubling. It seems as if, even for well-intentioned health care providers, the Stark Law has become a booby trap rigged with strict liability and potentially ruinous exposure—especially when coupled with the False Claims Act.").

[115] *See Justice Department Recovers Over $2.8 Billion from False Claims Act Cases in Fiscal Year 2018*, DEP'T OF JUST., OFF. PUB. AFFS. (Dec. 21, 2018), https://www.justice.gov/opa/pr/justice-department-recovers-over-28-billion-false-claims-act-cases-fiscal-year-2018 [hereinafter *DOJ Recovers Over $2.8 Billion in 2018*].

the Department's civil health care fraud settlements and judgments have exceeded $2 billion."[116]

Most of these recoveries went back into federal coffers, but Medicaid programs have been bolstered by DOJ's FCA recoveries as well.[117] Since 1986, the government has recovered more than $59 billion in civil FCA case resolutions.[118] Extending FCA application over millions more of Americans—and particularly because of its exorbitant penalties[119]—would likely achieve important regulatory results.[120]

Second, application of federal criminal statutes, such as the AKS, would also be extended to the same population. The AKS is an intent-based statute that currently applies to federal health care program beneficiaries, but can also be used to deter inappropriate business relationships from taking root within health care delivery for those currently outside of the ambit of the federal health care programs.[121] While other criminal statutes do govern health care fraud and abuse that occurs in the private insurance industry,[122] extension of the broad reach of the AKS would likely have a notable influence on American health care delivery.[123]

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116 *Id.*

117 *Id.*

118 *Id.*

119 *See* Isaac D. Buck, *Caring Too Much: Misapplying the False Claims Act to Target Overtreatment*, 74 OHIO ST. L.J. 463, 495, 505–10 (2013) [hereinafter Buck, *Caring Too Much*].

120 Interestingly, extending application of the FCA and other federal health care fraud statutes over the health care delivery of millions more Americans would also likely require the hiring of additional health care fraud prosecutors, which would likely lead to more recoveries. As has been noted, between 2009 and 2011, the government recovered $7.20 for every dollar spent on health care fraud prevention and prosecution. *See* Kelly Kennedy, *Fight Against Health Care Fraud Recovers $4.1B*, USA TODAY (Feb. 14, 2012, 8:48 PM), http://www.usatoday.com/news/washington/story/2012-02-14/sebelius-holder-announce-health-care-fraud-money/53097474/1.

121 *See* 42 U.S.C. § 1320a–7b (2010).

122 *See* 18 U.S.C. § 1347 (2010). *See also* Jeffrey S. Baird & Erica L. Beacom, *Defrauding Commercial Insurers: Criminal Liability*, MEDTRADE (Mar. 30, 2019), https://www.medtrade.com/news/billing-reimbursement/defrauding-commercial-insurers-criminal-liability/ ("Contrary to common belief, arrangements within the private, third party payor sphere are not immune from federal government scrutiny or enforcement.").

123 *See DOJ Recovers Over $2.8 Billion in 2018, supra* note 116 (". . .the Department continued to place great importance on enforcing the safeguards contained within the Anti-Kickback Statute (AKS).").

Finally, application of the Stark Law would also have an impact. The Stark Law prevents physicians who participate in the Medicare program from self-referring Medicare patients for designated health services without falling under a regulatory exception.[124] Stark applies—most directly—to "eliminate any financial motivation for physicians to send patients for unnecessary testing that could raise overall health care costs."[125] Stark has likely influenced health care entities' decisions to link a physician's pay to their efficiency and services provided.[126] Hospitals have been found liable under the Stark Law due to bonus structures that are based on productivity and profit.[127] An expansion of Stark application would impose additional strictures around self-referrals in American health care that currently are not universally applicable.

D. Softer Power: Leverage

In addition to the three well-known statutes mentioned above, the Medicare program also uses its size and other penalties to exert leverage on providers. Through (1) its administrative penalty known as exclusion,[128] and (2) its simple market share, Medicare is able to force providers and entities into making changes to health care delivery through softer administrative power and economic leverage. Through the power of exclusion and greater control on prices, Medicare can exert this softer leverage on the providers and entities that participate in the program.

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[124] *See Physician Self-Referral*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 5, 2015, 10:59 AM), https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/.

[125] Ayla Ellison, *15 Things to Know about Stark Law,* BECKER'S HOSP. REV. (Feb. 18, 2017), https://www.beckershospitalreview.com/legal-regulatory-issues/15-things-to-know-about-stark-law-021717.html.

[126] *See id.*

[127] Tuomey Healthcare System was found liable in 2015 for violating the Stark Law, and was assessed a $237 million penalty. The Tuomey contracts were paying doctors "a base salary based on the prior years' production, with substantial productivity bonuses equal to nearly 80% of aggregate compensation". *See* Scott Becker & Holly Carnell, *The Tuomey Case: 12 Key Points*, BECKER'S HOSP. REV. (July 16, 2015), https://www.beckershospitalreview.com/legal-regulatory-issues/the-tuomey-case-12-key-points.html [hereinafter Becker, *Tuomey Case: 12 Points*].

[128] *See* 42 U.S.C. § 1320a–7 (2010).

Exclusion. Because the ability to participate in the Medicare program is so important to hospitals and providers, the exclusion penalty has been referred to as the "death penalty."[129] Exclusion is particularly potent, given the percentage of expenditures that Medicare provides in the United States.[130] Because of this leverage and providers' fears of exclusion, Medicare exclusion has become a potent tool available to the Department of Health and Human Services (HHS) to bring about policy change.[131] The power of exclusion is a unique remedy available to the Medicare program, in that it demonstrates the leverage that the program has over the participating providers and entities. An implemented "Medicare-for-All" proposal would supercharge the power of this exclusionary penalty, as excluded providers would be unable to administer health care to *any* patients, not just a Medicare subset.

Controlling Prices. Shifting millions of Americans to a single-payer system could save the health care system a substantial amount. A 2019 study concluded that generally, the public payers of Medicare and Medicaid "have done a better job at controlling spending than private payers have."[132] Specifically, from 2006 to 2017, spending per enrollee

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[129] *See* Robert Pear, *Trump Administration Invites Health Care Industry to Help Rewrite Ban on Kickbacks*, N.Y. TIMES (Nov. 24, 2018), https://www.nytimes.com/2018/11/24/us/politics/trump-health-care-kickbacks-medicare-medicaid.html ("A health care provider who violates the anti-kickback or self-referral law may face business-crippling fines under the False Claims Act and can be excluded from Medicare and Medicaid, a penalty tantamount to a professional death sentence for some providers."); *see also* Rodney A. Smolla, *Off-Label Drug Advertising and the First Amendment*, 50 WAKE FOREST L. REV. 81 (2015) ("The impact of exclusion from federal reimbursement for programs such as a Medicare and Medicaid is catastrophic for many entities—a health care reimbursement death penalty."); *see also* Buck, *Caring Too Much, supra* note 119 at 506–07.

[130] *See* Juliette Cubanski et al., *The Facts on Medicare Spending and Financing*, KAISER FAM. FOUND. (Aug. 20, 2019), https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/ ("Medicare spending was 15 percent of total spending in 2018, and is projected to rise to 18 percent by 2029."). *See also* Christian D. Humphreys, *Regulation of Physician Self-Referral Arrangements: Is Prohibition the Answer Or Has Congress Operated on the Wrong Patient*, 30 SAN DIEGO L. REV. 161, 165 (1993) (noting that Medicare spending was as high as 40 percent of overall health care expenditures in the early 1990s.).

[131] *See* OFF. OF INSPECTOR GEN., U.S. DEP'T HEALTH & HUM. SERVS., *List of Excluded Individuals and Entities*, https://oig.hhs.gov/exclusions/exclusions_list.asp (last updated Sept. 6, 2019) (providing downloadable databases of excluded providers and entities).

[132] Shelby Livingston, *Medicare, Medicaid Contains Costs Better Than Private Insurers, Study Says*, MOD. HEALTHCARE (Feb. 11, 2019, 12:00 AM), https://www.modernhealthcare.com/article/20190211/NEWS/190219996/medicare-medicaid-contain-costs-better-than-

grew 2.4 percent in the Medicare program, 1.6 percent in the Medicaid program, and 4.4 percent for private insurance.[133] Specifically, according to the study's authors, "[t]he larger cost containment problems the nation faces are in the private insurance market."[134] Nonetheless, CMS has noted that Medicare is likely to experience annual spending growth that exceeds private insurance.[135]

Although up for debate, Medicare may pay less overhead than private insurance. Medicare's administrative costs have been found to amount to less than two percent of the program's total costs.[136] In 2017, Medicare's administrative costs accounted for only 1.1 percent of total spending.[137] When one includes Medicare's private plans—the Part D drug benefit plans and Part C Medicare Advantage—the total percentage of administrative overhead jumps to 7 percent.[138] Indeed, Medicare's Part D private drug plans have administrative costs that total about 11 percent.[139]

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private-insurers-study-says.

133 *See id.*

134 J. HOLAHAN & S. MCMORROW, SLOW GROWTH IN MEDICARE AND MEDICAID SPENDING PER ENROLLEE HAS IMPLICATIONS FOR POLICY DEBATES, ROBERT WOOD JOHNSON FOUND. (2019), https://www.rwjf.org/en/library/research/2019/02/slow-growth-in-medicare-and-medicaid-spending-per-enrollee.html (last accessed Oct. 1, 2019).

135 *National Health Expenditure Projections 2018-2027, Forecast Summary*, CTRS. FOR MEDICAID & MEDICAID SERVS., https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf (last accessed Jan. 19, 2020).

136 Potetz et al., *A Primer on Medicare Financing*, KAISER FAM. FOUND. (Feb. 2011), https://www.kff.org/health-reform/issue-brief/a-primer-on-medicare-financing/; *see also* Steffie Woolhandler & David Himmelstein, *Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs*, ANNALS INTERNAL MED. (Apr. 18, 2017) (Original version published Feb. 21, 2017), https://annals.org/aim/fullarticle/2605414 (noting that the administrative overhead for "traditional Medicare" was 2.2 percent).

137 *See* Austin Frakt, *Is Medicare for All the Answer to Sky-High Administrative Costs?*, N.Y. TIMES (Oct. 15, 2018), https://www.nytimes.com/2018/10/15/upshot/is-medicare-for-all-the-answer-to-sky-high-administrative-costs.html.

138 *Id.*

139 *Id.* ("All of this additional, private administrative cost is paid for by taxpayers and, through their premiums, people who use Medicare.").

This is compared to private insurers' administrative costs, which have been estimated between 12[140] and 17 percent of revenues.[141] It has been estimated that "the government's administrative costs are about $132 per person on Medicare, compared with over $700 for private plans."[142] If accurate, this means that administrative costs for private plans constitute more than five times the administrative costs associated with Medicare.[143] Eliminating these administrative costs from the health care landscape would save the system money.

Nonetheless, some of this larger budget may be due to care management or network management, which could improve quality outcomes, and would, in the long run, add efficiencies into the health care delivery system.[144] These include "nurse hotlines, case managers, network management and maintenance, customer service operations, and federal, state, and local taxes and fees."[145] Indeed, citing and crediting the percentage of administrative costs as a measure of efficiency has become contentious, with others concluding that one should examine administrative costs per beneficiary in real dollar amounts.[146] Under this analysis, Medicare has a higher administrative cost, at $509 per beneficiary, versus private insurance's number, at $453.[147]

Whether or not administrative costs are saved by adopting a "Medicare-for-All" proposal, a RAND study released in the spring of

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[140] *See* Woolhandler & Himmelstein, *supra* note 136 (noting that "private insurers' overhead currently averages 12.4 percent").

[141] *See* Diane Archer, *Medicare Is More Efficient Than Private Insurance*, HEALTH AFFS. (Sept. 20, 2011), https://www.healthaffairs.org/do/10.1377/hblog20110920.013390/full/.

[142] Frakt, *supra* note 137.

[143] *See id.*

[144] *See id.*

[145] Glenn Kessler, *Medicare, Private Insurance and Administrative Costs: A Democratic Talking Point*, WASH. POST (Sept. 19, 2017, 2:00 AM), https://www.washingtonpost.com/news/fact-checker/wp/2017/09/19/medicare-private-insurance-and-administrative-costs-a-democratic-talking-point/.

[146] *See* Robert Book, *Medicare-For-All Would Increase, Not Save, Administrative Costs*, FORBES: THE APOTHECARY (Sept. 20, 2017, 5:03 PM), https://www.forbes.com/sites/theapothecary/2017/09/20/medicare-for-all-would-increase-not-save-administrative-costs/#783c63960ba5.

[147] *See id.*; *see also* Kessler, *supra* note 145.

2019 demonstrates a major discrepancy in the hospital rates paid by Medicare and the rates paid by private insurance.[148] The study concluded that private insurance paid hospitals 241 percent of Medicare rates.[149] Further, private-insurance-paid outpatient services were nearly three times higher than what the Medicare rates were (293 percent total), and inpatient services were paid at 204 percent of Medicare rates.[150]

The study examined nearly 1,600 hospitals and looked at claims for four million people.[151] The researchers suggested a move away from discounted pricing and toward a fixed-price reimbursement structure like the one seen in the Medicare program.[152] Transparency is not likely to address the crisis, but "employers may need state or federal policy interventions to rebalance negotiating leverage between hospitals and employer health plans."[153] According to RAND's press release, "[i]f employers and health plans participating in the study had paid hospitals using Medicare's payment formulas, total payments over the 2015-2017 period would have been reduced by $7 billion—a decline of more than 50 percent."[154]

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148 *See* Morgan Haefner, *Private Insurers Pay Hospitals 2.4 Times What Medicare Pays*, BECKER'S HOSP. REV. (May 9, 2019), https://www.beckershospitalreview.com/payer-issues/hospitals-get-241-more-from-private-payers-than-medicare-rand-says.html.

149 *See id.*

150 *See* CHAPIN WHITE & CHRISTOPHER WHALEY, PRICES PAID TO HOSPITALS BY PRIVATE HEALTH PLANS ARE HIGH RELATIVE TO MEDICARE AND VARY WIDELY 19 (2019), https://www.rand.org/pubs/research_reports/RR3033.html.https://www.rand.org/pubs/research_reports/RR3033.html.

151 *See Private Health Plans Pay Hospitals 241% of What Medicare Would Pay*, RAND (May 9, 2019), https://www.rand.org/news/press/2019/05/09.html.

152 *See id.*

153 White & Whaley, *supra* note 150 at ix.

154 RAND, *Private Health Plans Pay Hospitals 241% of What Medicare Would, supra* note 151; *see also* Shefali Luthra, *Market Muscle: Study Uncovers Differences Between Medicare and Private Insurers*, KAISER HEALTH NEWS (May 9, 2019), https://khn.org/news/market-muscle-study-uncovers-differences-between-medicare-and-private-insurers/ (noting that health spending would have been reduced by $7.7 billion if private payers would have paid the same rates as Medicare's rates).

E. The ERISA Run-Around

In addition to the substantive regulatory fixes that can be achieved through "Medicare-for-All" programs, procedural successes that focus on avoiding regulatory hurdles may follow. For example, state efforts to bring about health care reform have been particularly stymied by a legal barrier, the Employee Retirement Income Security Act of 1974 (ERISA).[155]

Through its preemption rules, ERISA provides broad, prophylactic limitations on states' abilities to pass laws that "relate to" health benefit plans.[156] A recent U.S. Supreme Court decision has made clear that states have limited ability to pass laws that relate to self-funded employer-based insurance plans, severely limiting states' abilities to contemplate health reform efforts, including establishing a single-payer program.[157] Because ERISA's preemption rules lock out states from regulating in this space, an expansion of the federally-run and organized Medicare program would avoid the reach of ERISA preemption. Such an expansion would also avoid at least one other legal block on states' efforts to regulate in this space.[158]

IV. OPEN QUESTIONS AND CHALLENGES

While the positive regulatory impacts, at least from a cost control perspective, seem seductive, there remain open questions and challenges related to the push for "Medicare-for-All." Beyond the challenge of the cost of the program to the federal coffers,[159] additional challenges range

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155 *See* 29 U.S.C. § 1001 (2014).

156 *See* 29 U.S.C. § 1144 (2006); *see also* Gobeille v. Liberty Mutual Ins., 136 S. Ct. 936 (2016) (holding that a data reporting requirement established under state law—in an effort to consider the feasibility of a single payer delivery system—was preempted and void under ERISA preemption rules).

157 *See* Gobeille v. Liberty Mutual Ins. Co., 136 S. Ct. 936.

158 *See* Ass'n for Accessible Meds. v. Frosh, 887 F.3d 664 (4th Cir. 2018) (holding Maryland's anti-gouging prescription drug pricing law unconstitutional under the dormant commerce clause).

159 *See* Ronald Brownstein, *The Eye-Popping Cost of Medicare For All*, ATLANTIC (Oct. 16, 2019), https://www.theatlantic.com/politics/archive/2019/10/high-cost-warren-and-sanderss-single-payer-plan/600166/ (observing the Urban Institute's projection that a Medicare for All plan would cost "$34 trillion in additional federal spending over its first decade in operation").

from (1) dislocation, to (2) scaling and predictability concerns, to (3) spillover effects and pushback from incumbents. All three of these impacts are explored below.

Dislocation. First, there is the chief concern that the current benefits that inure to the Medicare program are not universally transferable. For instance, should "Medicare-for-All" be implemented, the cross-subsidization that occurs from private insurance (assuming the "Medicare-for-All" plan that is adopted requires a mandatory element) would disappear. In other words, what makes Medicare so efficient now is that providers continue to participate in the Medicare program and do not have to clamor for increasing reimbursement *because* they receive such substantial reimbursements from private insurance. Eliminating private insurance would eliminate this cross-subsidy. This would likely cause tension within the reimbursement structure for "Medicare-for-All," as providers would push for increased reimbursement within the program to make up for the loss in revenue due to the evaporation of the private market.

As a result, an important caveat must be made. Because Medicare represents a percentage of overall payer mixes for most providers, it has been able to achieve certain efficiencies and standardizations. This, in turn, creates the real possibility that many of the positive impacts of the Medicare reimbursement-related rules are not guaranteed, and may be blunted due to the elimination of cross-subsidization from private payers.

Scaling and Predictability. Second, this analysis contemplates that the regulatory regime that currently governs the Medicare program would largely be retained when expanded. But, extending the Medicare program to the entire United States population could pose challenges for scaling that are difficult to identify and quantify at this stage. Put simply, expanding enrollment by more than 100 million people presents uncertainty. Indeed, perhaps it is the fractured nature of Medicare (it only covers a defined population) that allows it to retain a stricter regulatory environment. For instance, Stark Law regulations could change, and become less strenuous, in a world of "Medicare-for-All." In short, it is difficult to determine the full impact a proposed universal Medicare program would have on its regulatory regime.

Spillover Effects and Incumbent Pushback. Lastly, throughout the history of the Medicare program, dominant hospitals and providers have

been able to stymie changes that are not advantageous to their powerful constituents. These actions, mainly accomplished through political action and changing business models, allow dominant hospitals and providers to prevent or blunt regulatory changes that they wish to reject. This is an important caveat to mention as policymakers contemplate regulatory changes that could follow the construction of a "Medicare-for-All" regime because reactions by American hospitals and providers could be hard to predict. Overall, the extent of pushback and the spillover impacts of "Medicare-for-All" are likewise difficult to predict.

V. CONCLUSION

The political rhetoric surrounding "Medicare-for-All" has outstripped its policy specifics. Many of the proposed plans using the Medicare platform have very little to do with the venerable universal program that has served America's elderly for more than a half-century. Instead, it appears that the appetite for a universal insurance guarantee is more about the failure of the ACA to achieve cost control than it is to guarantee universal insurance to all American citizens.

Nonetheless, and whether ill-fitting or not, "Medicare-for-All" plans would impact American health financing by extending vast regulatory resources and rules over the entirety of American health care delivery. These regulations would apply different efficiency, standardization, leverage, and oversight standards to American health care writ large. Also, they would steer clear of the legal hurdles, most namely ERISA, that states have encountered as they have attempted to achieve health care reform in the post-ACA era. Ultimately, whether or not the proposals are politically palatable to the American populace is an open question. Nonetheless, their rise into the public consciousness indicates something valuable for future discussions of American health law and policy during the Trump era.