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Medicare Advantage for All, Perhaps?

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The coronavirus disease 2019 (COVID-19) pandemic is forcing a much-needed questioning of the US health system. What is the right balance of authority between the federal government and the states? How should the profound inequities and gaps in the system be better addressed? Should emergency regulations, like those allowing more telemedicine and flexible funding, become permanent features of the system?

Hopefully, this reassessment will encompass a constructive conversation about the basic structure of the US health system and how it can be based on a more robust chassis. What should that guiding framework be? Although I view the system through a center-right lens, I believe a variant of the Medicare-for-all idea could prove to be a new chassis that can attract broad support.

In practice, unlike most high-income countries, the US has several different health systems for different segments of the population—each with distinctive rules, subsidy arrangements, and eligibility criteria. There is 1 system for poor individuals; an employment-based system for most working individuals and their families; and yet another for elderly individuals. Transitioning between these systems, as almost all US residents must do at some point, often means disruptions in coverage and care. Millions also continue to fall through gaps between these systems. Moreover, the amount of assistance available to individuals seeking coverage differs greatly depending on such circumstances as geography and work status.

Many progressives have responded to this patchwork by calling for Medicare to become the chassis for the whole system. However, the Medicare-for-all proposals advanced by such politicians as Sen Bernie Sanders (I, Vermont) and Sen Elizabeth Warren (D, Massachusetts) have encountered skepticism from many liberals, as well as heavy criticism from conservatives.

Concerns About Medicare for All
One objection is the enormous increase in federal expenditure that would be involved in such a switch, and although supporters point to the large savings in private expenditures, the net costs depend on many considerations and design features.

Another concern, applying to some versions of Medicare for all, is that although the Medicare benefit package is comprehensive, traditional Medicare has significant out-of-pocket costs for all but the lowest income beneficiaries (who qualify as “duals” for overlapping Medicaid coverage). This feature effectively requires seniors to purchase private “Medigap” coverage as a supplement.

A third concern is disruption. This is the other side of the coin associated with having multiple health systems in the US; Medicare for all would mean big changes for most individuals with existing coverage.

However, it is important to remember that even Medicare is really 2 distinct systems. The focus of Medicare-for-all proposals is traditional Medicare, which is a fee-for-service program with a detailed payment schedule administered by the government. But in parallel with this is Medicare Advantage, which operates differently from traditional Medicare with private plans receiving a single capitated payment for each beneficiary enrolled in their plan, adjusted according to the beneficiary’s general health condition.

Medicare Advantage as the Framework
Medicare Advantage for all could be a good starting point for a bipartisan discussion on creating a new framework for the US health system. Unlike the higher-profile Medicare-for-all approach, a Medicare Advantage-for-all approach would have several advantages. For instance:

- Medicare Advantage has wide popular support as well as broad political support. Medicare Advantage enrollment has been growing rapidly, doubling in the last decade, with the proportion of Medicare beneficiaries in such plans now exceeding 34% and rising. Moreover, Republicans as well as Democrats have supported and expanded Medicare Advantage, and the idea of making Medicare Advantage plans available to younger US residents has begun to intrigue some reformers on the right.
- The capitation system permits competing Medicare Advantage plans to offer a variety of benefits beyond a required core of basic benefits. Moreover, in contrast to traditional Medicare’s rigid and detailed payments system, it allows plans to explore different payments as a means of achieving greater efficiency and beneficiary satisfaction.
- In contrast with the design of traditional Medicare, Medicare Advantage plans are generally consistent with the growing managed care pattern in nonelderly coverage, including within the employer-based system. Today, about 90% of Medicaid beneficiaries are enrolled in some form of managed care. Meanwhile, about two-thirds of workers with employment-based plans are enrolled in health maintenance organizations or other network coverage that is similar to most Medicare Advantage plans. Medicare’s income-adjusted premiums are also broadly compatible with the structure of income-based subsidies available for plans in state health insurance exchanges, and many insurers offer Medicare Advantage and health insurance exchange plans that have similar designs. Thus, for a large proportion of households, transitioning from their existing coverage to coverage more like Medicare Advantage plans would not involve a big adjustment.
Recent changes in laws and regulations allow Medicare Advantage plans to include more nonclinical services that can influence health, such as nonurgent transportation, nutritional services, and even some simple home modifications to reduce the risk of injuries. This reflects the growing interest in addressing so-called social determinants of health.

Gradual, Not Radical
Choosing Medicare Advantage as the organizing theme for reforming the whole US system does not necessarily imply there must be radical legislation that literally replaces all existing coverage with the current Medicare Advantage program. That would be unnecessarily disruptive and regimented. Rather, it should mean gradually adapting existing forms of coverage so that over time they become very similar to Medicare Advantage, and there would essentially be no change in coverage as individuals change jobs, lose their jobs, or retire.

One step toward that outcome would be to merge state exchange plans with Medicare Advantage plans in the state. Another would be to slowly reconcile the subsidy system available for exchange plans with the tax benefits for employer-sponsored insurance, such that a similar structure of income-related subsidies would apply to everyone enrolling in insurance. Seniors would continue to receive assistance toward the cost of coverage that is reflective of the payroll taxes they paid and the national commitment to their health care, at least until there was agreement on a more comprehensive revenue and financing system, and the state-federal share of support would continue for lower-income households. A third step would be to move further toward the place of work being just a convenient location to facilitate plan selection, with employers handling the mechanics of government subsidies and payments by workers, and to move away from employers as plan sponsors.

None of these steps are small details, of course. They are major issues and would involve contentious debate. But to reach eventual agreement on big changes in society, it is necessary to have a framework in mind that is likely to command broad support and that the current system could evolve toward with minimum disruption. Medicare Advantage for all is such a framework. Medicare for all is not.

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