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Is Medicare for All the Cure-all?

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"Our current dysfunctional health care system is designed to make huge profits for insurance companies and drug companies, rather than provide quality care for every man, woman and child," says Senator Bernie Sanders (I-Vt.). The solution, he claims, is his much-touted Medicare for All Act of 2019, introduced in April with the support of 14 cosponsors. In his press release announcing the legislation, he asserts that it "would ensure that Americans could go to the doctor of their choice and get the care they need, when they need it, without going into debt." Sanders goes on to declare that Medicare for All will give Americans the kind of nationalized healthcare that "every other major country on earth" guarantees its citizens, and that it will save money while guaranteeing the "right" of healthcare for every man, woman, and child in this country.

Sounds great — everyone getting what they need for free — so why doesn't universal healthcare have universal support? Is there a downside? Under Sanders' plan, will healthcare that today costs too much and delivers too little, suddenly cost less, cover everyone, and provide more generous benefits?

Critics are quick to point at the price tag. Independent studies expose massive costs of Medicare for All, be it Sanders' bill or U.S. Representative Pramila Jayapal's House version: at least $32 trillion in its first decade, and as high as $60 trillion by some estimates. How do you put amounts such as these in perspective? Consider that our national debt *which we can't afford* is pushing $23 trillion, exceeding our annual GDP by around $3 trillion. Here's another disquieting thought: Annual federal tax revenues are roughly equal to conservative estimates of Medicare for All yearly costs.

Taxes will necessarily rise, says Sanders. But he claims Medicare for All will save money by eliminating out-of-pocket expenses such as insurance premiums and deductibles, while ensuring that no American will go without proper care, including dental, vision, and long-term care. Though he has suggested possible ways to pay for this utopia (including hiking income taxes as high as 52 percent), he refuses to provide clear financials. When CNBC's John Harwood pressed him, Sanders sniffed, "I don't think I have to do that."

His fellow Democratic presidential hopeful Elizabeth Warren is more transparent. A co-signer of Sanders' bill, she estimates the plan will cost a staggering $52 trillion in its first decade. That averages $5.2 trillion per year, compared to current annual national health expenditures of $3.5 trillion, which includes out-of-pocket spending, according to the U.S. Centers for Disease Control. Incredibly, Warren claims that we need only tax the rich. "My plan won't raise taxes one penny on middle-class families,"

the Massachusetts senator tweeted. "In fact, we'll return about $11 TRILLION to the American people" in out-of-pocket savings. But her math seems flawed. Taxing away fully *half* of the incomes of the top five percent of earners — those making approximately $200,000 a year or more — would gain the federal government roughly $950 billion in tax revenues. That number about equals the government's yearly spending deficit, a deficit that is already propelling the country toward national insolvency and hyperinflation — in other words, toward poverty for most Americans. Not only can the country not afford new socialist programs, it can't afford the ones it has now.

Even adding the intended tax increases she plans to put on corporations and business and financial transactions would probably be a non-starter. (Apparently she forgets that there is such thing as a trickle-down effect.)

The Committee for a Responsible Federal Budget (CRFB) tabulated preliminary expectations of how expensive Medicare for All would be, offering several unpalatable options to pay for the program. Using an estimate of $30 trillion in costs over the next decade, CRFB determined that a 42-percent national sales tax could cover it, *until the new tax demolishes consumer spending*. Or instead of the national sales tax, imposing an extra 25-percent income surtax on everyone, including low-income earners, might pay the bill. A more straightforward approach would impose a premium of $7,500 *per individual* per year, but if you exempted welfare recipients, the head tax would rise to $12,000. CRFB also estimates that doubling the payroll tax on both employers and employees would raise the needed funds. Alternatively, the federal government could slash non-health spending by 80 percent, including drastic cuts to Social Security and the military, or it could borrow funds and double the national debt over a decade.

These numbers explain why leftists such as former vice president Joe Biden ridicule Sanders' camp, questioning its credibility and calling Warren's figures "mathematical gymnastics." Even Nancy Pelosi says she's "not a big fan" of Medicare for All, acknowledging concerns about how to pay for it. And while the Democrats vying for the White House all support a "public option," most aren't crazy about obliterating jobs in the private health-insurance industry and forcing all Americans into a single, government-run system whether they like it or not.

Does Medicare Work?

Medicare for All supporters answer such arguments by pointing to generally high satisfaction ratings with seniors on Medicare: 80-90 percent according to the National Institutes of Health. Actually, "[Sanders'] plan doesn't look like Medicare at all," answers Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons (AAPS). "It appears he hardly knows anything about Medicare." She points out that unlike premium-free Medicare for All, seniors pay premiums for Medicare Part B (for doctor visits and non-hospital expenses) and Part D (for medications). Medicare Part C, which covers dental, vision, and supplementary needs, is entirely privately funded. Only Medicare Part A for hospital treatment is premium-free for most, but that doesn't mean it is "free." Part A is primarily funded by payroll taxes, which many believe Big Brother holds in trust so they will receive proper care in their old age. In reality, their taxes immediately vanished down the Medicare drain to help pay today's retirees' medical bills.

The theory is that tomorrow's workers will continue paying Medicare bills into the future, but Medicare is already going broke. AAPS reports that the current worker/retiree ratio is 2.5:1. "Already that is not

enough, so the IOUs in the 'trust fund' are being redeemed from general tax revenues," explains Orient in an op-ed on the AAPS website. "That fund will soon be gone … as Baby Boomers are flooding into the system. It would vanish in a nanosecond if we loaded in everybody."

Indeed, the 2019 Medicare Trustees report admits the Part A trust fund will be depleted in 2026. Though it predicts the separate trust fund covering Parts B and D will stay afloat thanks to out-of-pocket premiums, beneficiaries' pockets are sure to feel a pinch. The trustees say that fund costs will grow from 2.1 percent of GDP last year to 3.7 percent in 2038.

Pepperdine University Economics Professor Gary Galles reports the total unfunded Medicare mandate was recently estimated at $48 trillion, not accounting for factors such as higher medical cost inflation rates and ever-lower birth rates. If today's taxpayers can't foot the current bill, what are we to expect when Medicare for All *eliminates the age threshold and collects no premiums*?

Though the current system is indeed unlike Medicare for All, Orient describes how it can offer insights into what's coming. In its early days, Medicare paid the bills for hospitalizations, encouraging long hospital stays and as much care as possible. To curb skyrocketing bills, this fee-for-service policy ended in the mid-1980s when Medicare implemented Diagnostic Related Groups (DRGs), with pre-determined payments based on historical averages. Suddenly, short hospital stays with the least amount of care became more profitable; the name of the game in industry jargon is to discharge patients "quicker and sicker." Readmissions became common because patients didn't receive all the care they needed on the first visit. Then Medicare introduced the Two Midnight Rule in 2013, which means that if a Plan A hospital inpatient gets discharged before his second midnight, he is reclassified as a Plan B outpatient with a hefty bill for services rendered. If he stays fewer than three midnights, he can't expect rehab, either.

Medicare for All would likely operate by similar rules, and it is reasonable to believe the system would inherit the waste and corruption synonymous with Medicare. Consider the recent $1.2 billion fraud case, the largest healthcare scam in U.S. history according to federal prosecutors, involving 24 physicians and owners of medical equipment companies. The latter bribed doctors with kickbacks to prescribe unnecessary treatments to patients, some of whom they never saw, and then hid the profits in international shell companies.

Researchers at the Johns Hopkins Bloomberg School of Public Health reported in October's *JAMA Internal Medicine* that medical fraud costs the federal government $30 to $140 billion annually. Taxpayers are cheated, but patients are the victims hardest hit. The study found that those under the care of professionals who commit fraud are more likely to experience adverse effects or death. It estimated that fraud and abuse contributed to 6,700 premature deaths in 2013 alone.

Fraud aside, Medicare is rife with flaws. *Forbes* reported in March that improper payments — not *fraudulent* payments, but *errors* — made within Medicare and Medicaid soared from $64 billion in 2012 to $85 billion last year. More than 20 percent of Medicare patients in long-term care facilities suffer serious or permanent harm or even death, according to a 2018 report from the Health & Human Services Office of Inspector General. HHS ruled more than half of the events preventable and due to substandard care or medical errors. Even privately run Medicare Advantage (Part C) — supplementary plans that enroll Medicare-eligible patients — get a thumbs down. Government Accountability Office reported in 2017 that patients disproportionately drop these, citing dissatisfaction with medical care or

difficulty accessing preferred providers.

Everybody's (Not) Doing It

Sanders and his ilk turn a blind eye to such problems, arguing that nationalized healthcare works for all other major nations. "America is a health-care outlier in the developed world," reads *The Economist*, "the only large rich country without universal health care."

On the contrary, "there are very few single payer systems in the world," Orient told AnneMarie Schieber in a Heartland Institute podcast in April. "Almost all have a parallel private insurance system for people who can't get what they need under the government funded system."

However, two systems that come close to universal, single payer are Health Canada and Britain's National Health Service. In fact, in Canada, if the government provides a particular service, Canadians are not allowed to seek it in the private sector. This is the system that Sanders has repeatedly held up as a paragon of his Medicare for All vision. How is socialized medicine working out for them?

"Waiting for treatment has become a defining characteristic of Canadian health care," notes the Fraser Institute. "Specialist physicians report a median waiting time of 21.2 weeks" from referral to treatment. Even routine diagnostic procedures are hard to come by. In 2017, Canadians waited 4.1 weeks for a CT scan, 10.8 weeks for an MRI, and 3.9 weeks for an ultrasound. Had he lived in Canada, Bernie might still be waiting for the emergency heart stents he received in early October, assuming he survived.

No wonder Canadians bolt to the United States for care. That has been going on for years. In 2010, Newfoundland's Premier Danny Williams made headlines when he came to the United States for the heart surgery he couldn't get at home. According to the Fraser Institute, Canadians increasingly choose the United States for healthcare.

So do Brits who can afford it; Mick Jagger had heart surgery in New York this past April. Little wonder, since delays across the pond can be life-threatening, a fact that James Schmitz learned the hard way. Several years ago Schmitz, now a member of the Young Leaders Program at The Heritage Foundation, had to turn down a job in London. "As an epileptic, I needed a steady supply of anti-seizure drugs and visits to the doctor about every three months," he explains. When he learned there was no way around a nine-month wait time to see a neurologist, he regretfully packed his bags and returned to the States. "Health care should not be a reason to have to leave a modern, First World country," he opined.

Despite his disappointment, Schmitz is fortunate that Medicare for All was not the law of the land. Otherwise, he would have had no recourse.

Skyrocketing Costs

However, like most Americans, Schmitz pays dearly for the care he gets. Sanders blames the free market for skyrocketing costs, but why is healthcare a stand-out among all other service industries also subject to free market forces?

Financial author John Steele Gordon pinpointed the culprit in a 2018 address to Hillsdale College:

Whenever one segment of an economy exhibits, year after year, inflation above the general rate, and when there is no constraint on supply, then either a cartel is in operation or there is a lack of price transparency — or both, as is the case with American medical care.

Gordon's "Short History of American Medical Insurance" exposes why our country's healthcare costs are out of control, and the role government — not the free market — plays in the debacle. The story begins in the 1920s, when hospitals began offering modified insurance plans to improve weak cash flows. For a modest annual premium, subscribers were guaranteed a certain number of days of care. While the point was to protect against unexpected medical expenses, the result was that subscribers began frequenting hospitals — not for emergencies or serious illness — but for minor conditions that would have cost much less to treat elsewhere. This predictable "use it or lose it" reaction generated steady demand for hospitals.

Their plans — which were not insurance at all, but pre-payment plans — covered services no matter the cost, so consumers lost all incentive to shop around. Indifferent to costs, subscribers bought more medical services than ever before. Prices (not costs) naturally began to rise due to increased demand and lack of price competition.

Since the IRS classified hospitals as charities, their clever marketing devices were tax exempt and free from regulations or reserve fund mandates, giving them an artificial, government-imposed advantage over private insurance. To compete, the latter began copying hospitals' pre-payment models, covering everything up to a pre-set quota. This is foreign to the true concept of insurance, designed to cover only large or catastrophic losses. For example, auto insurance covers collisions and accidents, not routine oil changes and radiator flushes. Gordon explains the result:

Hospitals came to be paid almost always on a cost-plus basis, receiving the cost of services provided plus a percentage to cover the costs of invested capital. Any incentive for hospitals to be efficient and reduce costs vanished.

More and more often the consumer of healthcare was not the purchaser. Hospitals and physicians no longer competed for patients based on price, but on referrals. Prices (not costs) soared, while consumers became habituated to using the services without knowing what the provider was paid, unlike any other market industry.

Uncle Sam further exacerbated the problem by implementing wage controls during World War II. Prevented from rewarding employees with pay raises, companies competed for talent by offering fringe benefits, including health insurance. The IRS ruled associated costs as tax-deductible business expenses, and the National Labor Relations Board subjected health benefits to collective bargaining. Once unions latched onto that, companies had no choice but to offer insurance. Gone were cost-effective, custom-tailored individual plans, and an additional degree of separation was inserted between the healthcare consumer and purchaser. Moreover, since individual companies contain relatively small pools of insureds (compared to regional or national populations that help keep the price of other insurance down — e.g. life, home, auto), unless a company has very healthy employees, premiums are much higher since insurers base rates on the claims they expect to incur.

Americans now spend 15 percent of our nation's GDP on healthcare, as compared to 3.5 percent in 1930. We can't blame that entirely on modern advancements. "Don't believe for a second that the high prices are because of high-tech medical care. It's a lie," warns Mark J. Perry writing for American Enterprise Institute. "High-tech increases productivity and lowers costs everywhere."

This unprecedented hyperinflation was already on a fast track when Medicare and Medicaid barged onto the scene in 1965. Structured like the old hospital plans, the two systems suddenly launched

millions of medically high-risk Americans onto the government dole in the largest wealth transfer in our nation's history. As taxpayers shouldered the medical bills of these millions, Gordon relates the incomes of medical professionals roughly doubled in the 1960s. Government became the "largest single source of funds for virtually every major hospital in the country," with enormous power over hospital policy decisions. "As a result, these decisions were increasingly made for political, rather than medical or economic, reasons."

By 1970, these programs demanded five percent of the federal budget, according to CRFB. As other measures were added and the population aged, that portion increased to 20 percent by 2000. Enter ObamaCare, and 28 percent of federal dollars were spent on healthcare in 2017. Current trends point to 33 percent within the next decade and 40 percent by 2040. "In dollar terms, major federal health spending has grown by 230 percent since 2000, while economy-wide prices have only risen 40 percent, and the economy has only grown by 90 percent," reads the CRFB report *American Health Care: Health Spending and the Federal Budget*.

Is Healthcare a Right?

Despite these disastrous results of government interference in the medical market, the leftist push for universal, single-payer healthcare forges ahead, as even conservatives argue for socialized medicine with their calls to "repeal and replace" Obama-Care. Their rationale: "Healthcare is a right!" The mantra is printed on placards and repeated ad nauseam by talking heads looking to slam the door on objections to socialized medicine.

"Healthcare is not a right," any more than are food, clothing, shelter or anything else that people need to live, argues Charles Scaliger for The New American. Though each of these is absolutely necessary and proper for people to have, labeling any of them as a "right" is simply a demand for "legal entitlement to cheap or free stuff."

The same tactic has been used throughout the bureaucratic labyrinth — education, housing, welfare, agriculture, etc. The invariable argument is, "We have a right to it!" The invariable result is that taxes climb to pay for all the "free stuff," governmental power expands, and quality of the finished product suffers. (Cases in point: Do you want to live in subsidized housing? Would you prefer your children attend public rather than private school? When you go to the doctor, is a public health clinic your destination of choice?)

Just because you want something cheap or free doesn't mean you have a right to it. Your rights cannot infringe on someone else's; in layman's terms, you do not have a right to make your problem into someone else's problem. Using government as an intermediary doesn't make it okay either. Scaliger explains that while some rights (such as the right to trial by jury) impose obligations on private citizens (e.g., jury duty), the benefit more than offsets the personal expense (in this example, the benefit of limiting judicial power).

Therefore, the litmus test for determining whether healthcare is a right is simple: Does it impose costs that are not offset by limiting government's power? Hardly! It costs plenty for everyone involved and sparks a huge expansion of bureaucratic overreach. Let's look at the list.

Patients pay a high price for this supposedly free care. The doctor-patient relationship is destroyed and replaced by a bureaucratic middle-man dictating what and how much care the patient receives. Let's

not forget that in 2018 Congress finally axed ObamaCare's Independent Payment Advisory Board, a 15-member Medicare-rationing team that pundits dubbed "Obama's death panel" for threatening seniors' access to necessary medical care. If implemented, Medicare-for-All-appointed bureaucrats would hold sway over life-or-death decisions for all Americans.

Moreover, under the plan, patients can demand medical care free of charge, placing healthcare providers in much the same position as slaves of yesteryear, when people were forced, with government sanction, to work without proper compensation. In the slavery of socialized medicine, government forces healthcare professionals to provide products and services on its terms, usually below market value. So much for the physician's right to earn a living, and for his incentive to continue practicing.

There is a third loser in our Medicare-for-All litmus test: taxpayers, who finance all this sub-standard "free" care. In a classic case of legal theft, government uses its taxing authority to take money from one person, who earned it, and give it to someone else who did not. Congress can even punish for non-compliance. Consider the extraordinary new powers which Obama-Care granted the IRS to penalize anyone for not having health insurance.

Obviously, healthcare is not a right. Even if it were, the federal government's only proper role would be to *protect your access to it*, not *provide access to it*. Natural rights only impose an obligation on government not to interfere with them. Your right to practice religion, or to exercise free speech, or to own property, do not compel anyone else to provide anything for you. For example, the Bill of Rights protects your right to peaceably assemble, but the government doesn't rent meeting space for you. Nor does it provide the printing materials for your local paper to exercise the right to free press. And you certainly don't get a subsidy to keep and bear arms. Why should government provide healthcare?

Perhaps a more compelling question is: Do we really want healthcare provided by the government? The track rec-ord of government provision answers that question. Our payoff for the "right" to well-paying jobs is unemployment-inducing minimum wage laws; for the "right" to decent housing is dilapidated buildings and conditions that foster poverty and crime; for the "right" to education is continued U.S. student scores lagging behind other advanced industrial nations. It should be clear what will happen to individual health and the economy as a whole under Medicare for All.

Free Market Solutions

The obvious solution is not more government, but less. The good news is that taking down the cartel is not as pie-in-the-sky a goal as it seems. Five years ago, The New American senior editor William F. Jasper visited The Surgery Center of Oklahoma (SCO), a private, state-of-the-art facility in Oklahoma City that performs "surgeries for one-half, one-fourth or even as little as one-tenth" the price demanded elsewhere. Jasper describes the center's secret: a free-market approach with total price transparency. "We identify our costs, build in a marginal profit, and then display those prices," SCO co-founder Dr. Keith Smith told Jasper. "That's how every other industry works. It promotes healthy competition and keeps quality high and prices low."

SCO attracts patients from around the world and is one of several centers in the United States operating on the same model. AAPS identifies them on its website at AAPSonline.org, which also lists more than 1,300 physicians with "direct payment/cash friendly practices," a testament that patients are hoping to get government and insurance companies out of their exam rooms. Perry also mentions

services such as MediBid, a platform in which doctors bid in an auction format for your business, and Direct Primary Care (DPC), a subscription service that entitles you to "unlimited access to primary care and prevention services." Subscribers to this service need only seek catastrophic insurance coverage to pay for unforeseen medical emergencies, as DPC covers everyday healthcare needs. Such providers recognize and value conditions that lower prices in every other area of the economy: competition, completely free from government intervention. No other industry needs Trump to enforce price transparency; consumer-purchasers are the solution to our medical industry woes. When enough consumers consider cost in their healthcare spending decisions, prices will nosedive. Patients will realize that the chargemaster prices hospitals list on their statements of charges have nothing to do with actual costs but are merely scare tactics to make patients believe they must have insurance to survive, says Orient. They will once again buy insurance for its rightful end — to buffer against unforeseen catastrophe — not for every little pain or sniffle. Premiums will plunge since insurance companies will no longer pay out claims for every Band-Aid and flu shot.

The alternative means having "a gatekeeper standing at the door trying to deny you things that you really do need," warns Orient. Fortunately for us all, people prefer to be in control of their own medical decisions, so hope springs eternal for free market healthcare.

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