

RESEARCH BRIEF

Does One Medicare Fit All? The Economics of Uniform Health Insurance Benefits

Based on BFI Working Paper No. 2019-132, [“Does One Medicare Fit All? The Economics of Uniform Health Insurance Benefits,”](#) by Katherine Baicker, Dean and Emmett Dedmon Professor, UChicago’s Harris School of Public Policy; Mark Shepard, assistant professor, Harvard Kennedy School of Government; and Jonathan S. Skinner, professor of economics, Dartmouth

KEY TAKEAWAYS

- ✓ The US looks very different now from 1965, in ways that make having a single Medicare program for everyone less efficient and less financially sustainable.
- ✓ First, medical innovation means that expansive coverage is much more expensive than it used to be. Second, higher tax rates make it costlier to finance additional benefits. Last, income inequality is rising, and people with different incomes may want to devote a different share of resources to health care.
- ✓ Those trends seem likely to continue, so that covering everyone with a uniform generous insurance plan will be increasingly challenging.
- ✓ An alternative to a single, generous public benefit would be to provide a more basic universal benefit to everyone—one with good financial protection and coverage for services with substantial health benefits, but with limited or no coverage for expensive, lower-value services. Higher income people could pay to add on coverage of those lower-value services.

When politicians and policymakers worry about the cost of health care, the affordability of prescription medications is often front and center. Given the present focus on prescription drug costs, it may surprise some readers to learn that medications were not included in the original Medicare program enacted in 1965; there were not enough expensive drug treatments to concern policymakers. Indeed, it was nearly 40 years until drug benefits were finally included in Medicare coverage in 2006.

That anecdote points to one of the challenges facing policymakers as they grapple with proposals to extend government-sponsored health insurance to all. Technological advances have broadened the services available to people (the US, for example has more MRI machines per person than any other country¹), but technology has also dramatically increased the cost of health care. There are so many more options for patients and doctors to consider in 2020

¹ There are nearly 38 MRI machines per million people in the US vs. about 10 per million in Canada. [statista.com/statistics/282401/density-of-magnetic-resonance-imaging-units-by-country](https://www.statista.com/statistics/282401/density-of-magnetic-resonance-imaging-units-by-country)

Wealthier households not only drive better cars, live in bigger homes, and eat at fancier restaurants, but they can also spend more on health care. With greater income inequality, having a single, uniform health insurance plan for everyone “fits” the population less and less well. Higher income households might opt for a generous, comprehensive benefit – but that would eat up an enormous share of overall resources available to lower income households.

than in 1965, and many are not cheap. How, then, in a world of limited resources and seemingly unlimited health care wants, should policymakers think about the tradeoffs in designing public insurance coverage that is both comprehensive and affordable?

That is the fundamental question that Katherine Baicker, Dean and professor at UChicago’s Harris School of Public Policy, Mark Shepard of Harvard, and Jonathan S. Skinner of Dartmouth set for themselves in their new paper, “Does One Medicare Fit All? The Economics of Uniform Health Insurance Benefits.” Their answer is that, while one Medicare might have fit all back in the 60s, it fits much more poorly now. Rather, they point to the advantages of a scaled-down public insurance program—one that covers many but not all services, and that gives people the option to “top up” the basic public plan with more comprehensive private coverage.

What price, health care?

Imagine a world where government-subsidized housing is a right guaranteed to all citizens. In this world, not only does everyone get a place to live, but every home is a mansion. Sounds unlikely. Such a program would probably be cost-

prohibitive—but even if it were possible, there would be very little left for society to direct toward other programs like food stamps or energy assistance. People receiving government-subsidized housing might prefer to have a more modest home coupled with help putting food on the table.

The same holds for health care. To say that health care is a right begs the question: how much health care is a right? If Medicare for all means extending the generous, comprehensive benefits accorded to current Medicare recipients to every citizen, that would place an enormous financial strain on the country’s ability to pay for both health care and many other public services. However, there are alternative ways of extending public insurance protection that would be more fiscally sustainable. The authors make a case for considering a more basic universal health insurance benefit—one with great financial protection, but that does not cover services that have low health benefit but very high cost. Anyone who wanted to purchase a plan that covered such services could “top up” the basic public policy with a more comprehensive, “mansion-like” private plan.

The authors’ proposal stems from the context of three important secular changes since the introduction of Medicare in 1965:

1. **Technology:** Medical technology has advanced by leaps since 1965, improving health care and extending lives, but at increasing costs. For example, a heart attack in 1965 that would have killed a patient can now be treated, and that life extended, but with an average hospital stay costing \$20,000. The upshot is that while rich and poor could afford similar health care in 1965 because treatment was simpler and less expensive, the cost of providing everyone with that treatment has skyrocketed as medical technology has evolved.
2. **Taxes:** While top tax rates have fallen since the 1960s, average overall marginal tax rates have increased. These increasing marginal tax rates come at a cost that goes beyond the actual revenues raised: they change the decisions and investments made throughout the economy, exerting a drag on economic activity (dubbed deadweight loss). As marginal tax rates have risen, the economic toll to financing new health benefits has mounted.

The authors' proposal stems from the context of three important secular changes since the introduction of Medicare in 1965.

Technology

Medical technology has advanced by leaps since 1965, improving health care and extending lives, but at increasing costs.

Taxes

While top tax rates have fallen since the 1960s, average overall marginal tax rates have increased ... As marginal tax rates have risen, the economic toll of financing new health benefits has mounted.

Income Inequality

Income inequality has risen substantially in the US. Wealthy households, on average, have access to more and better products and services than lower-income households ... With greater income inequality, having a single, uniform health insurance plan for everyone "fits" the population less and less well.

3. **Income inequality:** Income inequality has risen substantially in the US. Wealthy households, on average, have access to more and better products and services than lower-income households. This means that wealthier households not only drive better cars, live in bigger homes, and eat at fancier restaurants, but they can also spend more on health care. With greater income inequality, having a single, uniform health insurance plan for everyone "fits" the population less and less well. Higher income households might opt for a generous, comprehensive benefit—but that would eat up an enormous share of overall resources available to lower income households. Forcing such a generous plan on low-income households would make them worse off than a combination of a less generous plan alongside more generous other social insurance programs. Forcing a more basic plan on high-income households, on the other hand, would prevent them from spending resources on health care that they value, and might in fact slow the development of new, life-saving medical technologies.

In the context of these trends, the authors' model shows that a uniform public health insurance benefit is increasingly costly—and that a move to a more basic benefit coupled with the option for higher-income households to top up, and with some of the savings from reduced public

health program spending reallocated to other safety net programs, could leave both higher- and lower-income households better off. This is, in fact, more similar to the health systems seen in many developed countries than the moniker "single payer" would suggest. Such a plan could be a higher-value, more sustainable alternative to many proposals that seek to expand the current Medicare program.

Conclusion

On July 9, 1965, in a statement following Senate passage of the Medicare amendment to the 1935 Social Security Act, President Lyndon Johnson extolled Medicare's benefits, but also presaged its future financial challenges:

*"This bill is sweeping in its intent and impact. It will help pay for care in hospitals. If hospitalization is unnecessary, it will help pay for care in nursing homes or in the home. And wherever illness is treated—in home or hospital—it will also help meet the fees ... Its benefits are as varied as the techniques of modern treatment themselves."*²

² [cms.gov/About-CMS/Agency-Information/History/Downloads/CMSPresidentsSpeeches.pdf](https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/CMSPresidentsSpeeches.pdf)

Those “techniques of modern treatment” have evolved beyond, perhaps, even the imaginations of those who welcomed Medicare in 1965, and with that technical evolution has come a steep increase in costs.

Today, there is an important ongoing debate about access to affordable health care for all citizens. The key challenge is how to design public health insurance benefits in a way that both provides broad access and is financially sustainable. Baicker et al. point to the advantages of a “basic” public insurance plan that covers care of sufficiently high value, but not care with low health benefit and a high price tag; leaving people who could afford it with the option to augment the public plan with a private insurance plan that covered such lower value services. Social Security is somewhat analogous, with many higher income households supplementing their Social Security payments with their own private savings.

Of course, such a plan would not come without real concerns. First, lower-income households would likely consume less health care than higher-income households under such a plan, raising issues of equity. Imposing an expensive public insurance benefit on lower-income households can leave them worse off than having those funds available for a variety of uses—but there are no guarantees that the political process would result in savings from lower spending on public health insurance being devoted to other public

safety net programs. Second, designing a public insurance plan with coverage limitations based on the value of care raises the crucial question of how and by whom those limitations would be determined—surely a fraught process. That said, our current choice of covering virtually all services through Medicare not only makes it more difficult to extend that coverage to a broader population, but also will become increasingly untenable as technology evolves and the population ages.

The authors’ model shows that a uniform public health insurance benefit is increasingly costly — and that a move to a more basic benefit coupled with the option for higher-income households to top up, and with some of the savings from reduced public health program spending reallocated to other safety net programs, could leave both higher- and lower-income households better off.

READ THE WORKING PAPER

NO. 2019-132 · NOVEMBER 2019

Does One Medicare Fit All? The Economics of Uniform Health Insurance Benefits

bfi.uchicago.edu/working-paper/2019132

ABOUT OUR SCHOLARS



Katherine Baicker

Dean and Emmett Dedmon Professor, Harris School of Public Policy, University of Chicago

harris.uchicago.edu/directory/katherine-baicker



Written by David Fettig, BFI Senior Writer and Editor

