COMMENTARY

Pharmacists need to participate and pay closer attention to the Medicare for All discussion

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A R T I C L E   I N F O

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Abstract

It has been a decade since the Patient Protection and Affordable Care Act (ACA) was signed into law. The ACA’s reception remains mixed, despite its moderate success in increasing insurance coverage, and discussions of health care reform have not abated. Among ongoing efforts to reform or repeal the ACA, “Medicare for All” appears in several prominent policy proposals. Public opinion polls from across the United States have demonstrated the growing popularity of reform proposals, which has encouraged legislators to be stronger advocates for such changes. Between 2017 and 2020, the 115th and 116th U.S. Congress introduced more than a dozen legislative proposals aimed at health care reform. Unfortunately, the variety and nuance of these legislative proposals have resulted in considerable confusion and division across the nation among health care providers and patients regarding definitions and implications of Medicare for All. This commentary aims to improve pharmacists’ understanding of Medicare for All, discuss the possible impact of Medicare for All on pharmacy practice, and serve as a call for U.S. pharmacists to participate in advocacy and reform of the health care system in which they practice. We argue that only through proactive participation in legislative advocacy will the pharmacists’ role in patient care continue to evolve. This brief commentary is divided into 5 major sections: (1) support for Medicare for All, (2) definitions of existing Medicare for All policy proposals, (3) estimation of the impact of Medicare for All proposals on the health care system, (4) the pharmacist perspective on the impact of Medicare for All, and (5) recommendations for pharmacy practice and advocacy.

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Although health care reform in the United States has commanded considerable national attention since the passing of the Patient Protection and Affordable Care Act (ACA) in 2010,1 original discussions about reform are much older. Health care reform conversations date back at least to the 1930s when the Committee on the Costs of Medical Care called for the United States to provide comprehensive medical care to the entire population.2 Since then, universal health care in the United States has been championed, most prominently, by Presidents Franklin Roosevelt, Harry Truman, Lyndon Johnson, and Bill Clinton. Although not successful in achieving national coverage, these efforts led to meaningful reform, including the creation of Medicare and Medicaid in 1965 and the ACA in 2010, among others.2,3 The ACA aimed to achieve universal health insurance coverage in the United States by expanding both private and public coverage.4

Within the last decade, the Supreme Court ruled that the state Medicaid expansion was optional (11-393, Supreme Court),5 and Congress has rolled back the penalty on the individual mandate (H.R. 1, 115th Congress).6 Among legislative pushback, rising premiums, and other factors, the ACA fell short of achieving its goal of universal coverage, although the rate of uninsured fell to a low of approximately 8.8% in 2016.4,7 Despite increased coverage, the United States still falls behind many other nations in terms of health care quality, accessibility, and cost, and awareness of these health system deficits is increasing.8 Case reports of pharmaceutical industry price-gouging, rising out-of-pocket costs, and increasing public attention on health inequities have advanced legislative discourse and support for health care reform. Public dismay with the health care system has been further exacerbated by the United States’ coronavirus disease response.9 A global health crisis has now become a political and social one in the United States.

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Growing public support for health care reform tends toward expansion of government-provided health benefits. One of the most-discussed types of government payer models is Medicare for All (M4A). A 2020 nationally representative survey conducted by the Kaiser Family Foundation found that 56% of the respondents had favorable views about M4A, and 68% had favorable views of a “public option,” which offers individuals an option to buy into Medicare coverage.10 Another nationally representative online survey, conducted by the Urban Institute, found that 28% of the respondents opposed M4A, and 21% opposed a public option, with a plurality of respondents expressing ambivalence about both M4A (41%) and the public option (45%).11 Growing public support has translated into a variety of health care reform bills proposed in Congress.

Definition and variations in current M4A proposals

Although support for health care reform through a transformation in the structure of Medicare coverage continues to grow, there is considerable disagreement surrounding the meaning and implications of M4A. Navigating this changing landscape is challenging for working pharmacy professionals, potentially limiting meaningful participation and advocacy on issues that can uplift the profession. Table 1 provides a concise summary of the various health care reform bills introduced recently within Congress.12 Although it is unlikely that 1 of these bills will be voted into law, understanding the structure and scope of each proposal may help promote understanding of the issues surrounding health care reform. The simplest, and possibly earliest, definition of M4A comes from the bill proposed by Vermont Senator Bernie Sanders that calls for a single-payer system in the United States that replaces all private insurance with a tax-financed, comprehensive program that automatically enrolls U.S. residents into an insurance plan without premiums or coverage limits and with minimal cost-sharing.13 This version of M4A is often referred to as the “pure” M4A and is likely the least politically feasible currently.14 More bipartisan-friendly models of health care reform involve limited Medicare coverage expansions and can be classified under “Medicare for More”—a term used in previous literature.15 Medicare for More, also referred to as “hybrid” M4A, borrows concepts from the single-payer model without replacing the existing infrastructure for private insurance.14 Table 1 contains several current Medicare for More—modelled proposals, all of them employing what is popularly referred to as a “public option,” where individuals who are not currently Medicare-eligible can buy into Medicare coverage (sometimes called Medicare Part E or Medicare-X) through the insurance marketplace. These options have greater support among lawmakers than other M4A options, and were notably included in President Joe Biden’s 2020 campaign platform.14,16 Despite their shared foundation, public-option proposals exist along a spectrum of public inclusion, with some bills proposing a Medicare buy-in option for all or some groups of individuals and others including automatic buy-in with opt-out options. Other lesser-known health care reform bills (S. 489/H.R. 1277 in Table 1) employ an expansion of the Medicaid program instead of Medicare.12,14 This proposal offers a buy-in similar to the public option, but interested individuals would be enrolled into state-based Medicaid programs instead of the federally administered Medicare program. This “Medicaid buy-in” would set up the U.S. health insurance system to more closely resemble that of Canada. Although the Medicaid buy-in may not be as well-known as the M4A proposals, the increasing enrollment of states in the ACA’s Medicaid expansion, the popularity of Medicaid expansion ballot initiatives,17 and the flexibility in implementation of the system from state to state may potentially make this a highly feasible option.

Impact of potential M4A proposals on the health care system

Estimates from the RAND Corporation project that under the “pure” M4A model, U.S. national health expenditure would total $3.89 trillion in the first decade, which represents an increase of 1.8% over the current framework.18 Although the estimated total change in spending may be minimal, detailed analysis shows an expected decrease in private-sector spending on health coverage accompanied by compensatory increases in public health care spending of more than 200%.18 The increase in public spending, under existing proposals, would be funded by new taxes replacing individual premium payments to private insurers.19 These cost estimates must be interpreted with caution owing to a large amount of uncertainty surrounding the impact of M4A on health care use and
spending. The most direct impact of the M4A model would be the establishment of a monopsony—a system where the U.S. government would be the sole payer for all health care services. A monopsony would result in large purchasing power that may directly affect prices for all health care services. With greater bargaining power, the U.S. government could feasibly decrease prices for health services and health-related products, such as provider reimbursements, hospital charges, and prescription medications. Although capping health services prices may rein in ballooning health expenditures, the impact of such cost savings on other aspects of innovation and care may be harder to predict. In addition, the pure M4A model would immediately extend coverage to all Americans, which has the potential for reducing disparities in health outcomes and improving key indicators of health. Despite potential benefits, some authors have expressed concern that a pure M4A model that retains the existing reimbursement structure for providers and hospitals may lead to reduced revenue and potential shutdown of several hospitals, particularly in rural areas with already diminished health care access.

### The pharmacist perspective

Consideration of the M4A impact from the perspective of pharmacy practice is prudent for pharmacists wishing to advocate for their own best interests. First, the pure M4A model would result in increased health insurance coverage and lower out-of-pocket costs, which can grow the care-seeking population and increase the affordability of pharmaceutical care across the United States. Implementation of M4A would also likely result in decreased costs for brand-name drugs because a single government payer would have more leverage and bargaining power with drug manufacturers than what is offered by our current fragmented system. Theoretically, this increased drug affordability may improve medication compliance, ultimately leading to decreases in hospitalization expenditures. These cost savings also conceivably would affect hospital drug expenditures as well. National drug cost—control measures may lead to a standardized national formulary, which could eliminate or limit the amount of pharmacist time wasted in navigating diverse, convoluted formularies; prior authorization requirements; and other administrative burdens to get a patient the medications that they need. Aside from reduced drug expenditures, a single-payer system may redesign current reimbursement structures for pharmacies, lead to broad changes in pharmacy incentive program design, and can result in the elimination of restrictive direct and indirect remuneration (DIR) fees as well as preferred pharmacy networks. A single-payer system could also restructure the current role of pharmacy benefit managers (PBMs), decreasing pharmacy overhead and potentially improving medication accessibility for patients. Finally, when one reflects on the last 10 years within the pharmacy profession, including the expansion of pharmacy services within the ambulatory community space, this progress has largely occurred under the Centers for Medicare & Medicaid Services and Veterans Health Administration systems, both federally funded health entities. It is possible that, under M4A, the pharmacy profession can expand advanced clinical service offerings to a greater number of practice settings and evolve to better meet patient needs.

The potential benefits presented here may be most likely with a pure M4A model. However, this information can be extrapolated to estimate the impact of other M4A proposals.
presented earlier. In the case of a hybrid model, the impact is more likely to be modest and will depend on the structure, design, and uptake of the public option. Other health care reform options such as the Medicaid buy-in could potentially lead to similar benefits as the pure M4A model but will ultimately depend on the specifics of the implementation.

**Recommendations for pharmacy practice**

The pharmacy profession has a mixed record on self-advocacy. Broad pushes for large reforms within the profession, such as government recognition of pharmacists as health care providers, have sometimes been few and slow. Even the push to advocate for PBM regulation has been reactive rather than proactive. Within the swell of health system transformation, although opportunity and public opinion align, pharmacists—regardless of political persuasion—can and should be active participants in forging the structure of the new health care system and the profession’s future within that system. The potential impact of M4A mentioned from the pharmacist perspective—including PBM restructuring, DIR reform, and other initiatives—are not directly included in the legislation and can only be realized with continued advocacy and increase in awareness of the issues affecting the pharmacy profession. There is some evidence that such advocacy is already in place within the pharmacy profession, but there is a need for sustained, long-term efforts to remedy this problem. First, there is a need for education of pharmacists with respect to the scope and impact of health care reform along with a need for advocacy. This education must come in the form of continuing pharmacy education providers and professional organizations and an emphasis on topics related to health care reform in their curricula. Second, state and local organizations, including boards of pharmacy, must call practicing pharmacists to action in participating in legislative advocacy for health care reform at the state and national levels. Third, professional pharmacy organizations should actively advocate for the profession through more focused budgeting and fundraising to help grow a grassroots movement around health care reform. Notably, the pharmacy profession has little direction for advocacy within the health care system, so pharmacy organizations must call pharmacists to action in participating in legislative advocacy for health care reform at the state and national levels. Fourth, schools of pharmacy need to ensure that all future pharmacists receive adequate training about the evolution of the profession in the context of evolving health care reform. Fifth, there is a critical need for additional research in pharmaceutical health policy that ties in pharmacist capability with the goals of patient care, affordability, and accessibility. Models of the impact of health care reform on pharmacist-led services and reimbursement in all settings of care are needed to better understand and advocate for the best policies. This research can be made possible through specific awards and grants with requests for proposals that advance this area of research. Finally, pharmacists should be encouraged to be patient advocates, not just within the walls of the health care institution but also in the community, through leadership positions and elected office.

There is a history of successful pharmacists in elected office in the United States, including the office of the Vice President—it is time to leverage this leadership to continue to evolve this profession. To secure our future in patient care, we must define the role of “pharmacist” for ourselves. With this in mind, we return to the Oath of a Pharmacist, which calls us to “embrace and advocate changes that improve patient care.” Health care reform is one such change to advocate for—patients’ well-being, health outcomes, and the future of our profession may be at stake.

**References**


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