

Medicare for All: Would Reforming Private Insurance Be a Better Solution?

October 25, 2026 - Medicare for All sounds like an attractive proposition. Eliminate insurance premiums, deductibles and copayments, and guarantee healthcare coverage to every American. But is replacing the nation's private health insurance system really necessary, or would Americans be better served by fixing the problems with the system they already have?

The Affordable Care Act has already addressed one of the biggest obstacles to obtaining health insurance. Americans can purchase coverage through government exchanges regardless of preexisting medical conditions, and federal subsidies can make premiums affordable or even reduce them to zero for qualifying households. Medicaid provides another option for eligible lower-income Americans.

That doesn't mean everyone can afford coverage, but it does suggest that access to insurance and the cost of actually receiving medical treatment are two different problems.

Consider hospital coinsurance. Someone with a policy requiring 20% coinsurance could face thousands of dollars in medical bills following a hospitalization, even though they have insurance. Existing out-of-pocket maximums provide some protection, but those limits can still be financially devastating.

Why not address that problem directly? Congress could limit hospital coinsurance, replace percentage-based charges with predictable copayments, or eliminate coinsurance for medically necessary hospital care altogether. Lower annual out-of-pocket limits, perhaps tied to household income, could provide additional protection without dismantling private insurance.

Of course, those changes would need to be financed. Eliminating coinsurance could simply shift costs into higher premiums. But targeted reforms would allow policymakers to address specific problems while preserving competition and consumer choice.

Senator Bernie Sanders' Medicare for All proposal takes a much more sweeping approach. It would replace most employer-sponsored insurance, Medicare Advantage and other private health coverage with a national government-financed program. Representative Pramila Jayapal has introduced similar legislation in the House. If passed, these bills would completely eliminate consumer choice and at the same time, eliminate employer provided health plans. But there are other proposals, including a government-sponsored public insurance option, would preserve private coverage rather than replace it.

Sanders has suggested financing options that include a 4% household income tax and a 7.5% employer payroll tax. Under his earlier proposal, the first \$29,000 of income for a family of four would be exempt from the household tax.

A family earning \$150,000 would therefore pay approximately \$4,840 annually under that proposed tax. That would be in addition to regular income taxes. Whether that represents savings depends on what the family currently pays for insurance and medical care.

Readers can estimate their own costs using this formula:

$(\text{Household income} - \$29,000) \times 0.04 = \text{Estimated annual healthcare tax}$

To determine the income level at which the proposed tax would equal current annual insurance premiums:

$\text{Break-even income} = (\text{Annual insurance premiums} / 0.04) + \$29,000^{**}$

For a family currently paying \$5,000 annually for insurance, the crossover point would be \$154,000 in household income. Above that level, the proposed tax would exceed existing premiums. Below it, the tax would be lower.

These are illustrative calculations based on Sanders' earlier financing options, not a finalized tax schedule. They exclude current deductibles and copayments, potential wage changes and additional taxes that might be necessary to finance the program.

Cost, however, isn't the only concern. There is also the question of what happens when government financing becomes the dominant means of paying for medical treatment.

Canada and Britain provide some cautionary examples. Canada's median waiting time from referral to specialist

treatment increased from 9.3 weeks in 1993 to 28.6 weeks in 2025. In England, approximately 36% of patients awaiting cardiology treatment had already exceeded the National Health Service's 18-week target in January 2026.

By comparison, a 2025 American survey found an average wait of approximately 33 days for an initial cardiology appointment. The measurements are different, so they cannot establish a direct ranking, but they demonstrate why access to insurance should not be confused with timely access to treatment.

There is another potential consequence that deserves consideration: the emergence of a two-tier healthcare system.

If government reimbursement rates become unattractive to certain physicians or medical facilities, some providers might choose to leave the publicly financed system. Wealthier patients could then seek private treatment, potentially including services outside the United States, while everyone else depends on the government program.

That outcome isn't inevitable, and Sanders' legislation would restrict private insurance that duplicates government coverage. But restrictions on private insurance would not necessarily eliminate demand for privately financed care. Policymakers would need to explain how the program would maintain provider participation and prevent access from becoming increasingly dependent on personal wealth.

The concern is particularly relevant to highly specialized physicians. If a nationally financed system cannot offer competitive compensation or reasonable working conditions, it could struggle to retain some providers. Whether that would actually happen depends on reimbursement policies and how the program is implemented. But it is worth noting that some of the best doctors in Canada left for the United States after Canada nationalized its healthcare.

None of this means America's current healthcare system is working perfectly. Insurance premiums continue to rise, hospital charges can be excessive, and patients sometimes face enormous financial obligations despite having coverage.

But those problems do not necessarily justify eliminating most private insurance. Other countries, including Germany, Switzerland and the Netherlands, have achieved universal coverage while retaining substantial roles for private insurers. And eliminating competition is usually a recipe to make things worse, not better.

A more practical American approach might be to strengthen the existing insurance market, limit excessive hospital charges, reduce out-of-pocket exposure and preserve the ability of patients and physicians to make their own choices.

Medicare for All promises comprehensive coverage, but it also introduces uncertainty about taxation, provider participation and access to treatment. Having coverage is meaningless if you can't get treatment. Before replacing a system that serves hundreds of millions of Americans, Congress should demonstrate why carefully targeted reforms wouldn't accomplish the same objectives with less disruption.

Americans deserve the freedom to choose their insurance, their doctors and where they receive treatment. Reforming the existing system is the best way to preserve that freedom.