Improved/Single Payer MEDICARE FOR ALL and HEALTH CARE REFORM

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New Directions in American Health Care
Hofstra University
March 11, 2010

DISCLOSURES

Dr. Oliver Fein has no relevant financial relationships with commercial interests

Dr. Oliver Fein is President of Physicians for a National Health Program

PRESENTATION OUTLINE

1. **Recent history of U.S. health care reform**

2. **Challenges facing U.S. Health Care System**

3. **Comparison of Congressional Health Care Reform and single payer improved Medicare for All**

4. **What's Next?**

HEALTH CARE REFORM
OBAMA'S FATEFUL CHOICE

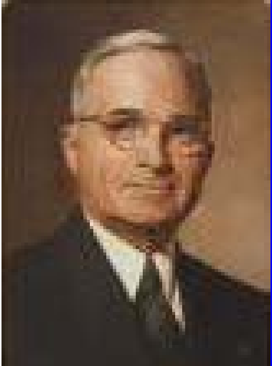
- **He did not want to "start from scratch"**

- **He had two fundamental choices:**

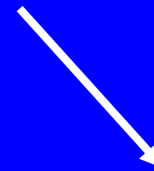
  1) to build on the public sector (Medicare)
  or
  2) to build on the private sector

- **He chose to try to reach universal coverage by expanding private insurance**

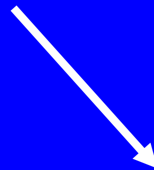
Progress(?) of US Health Reform



Employer mandate



Medicare



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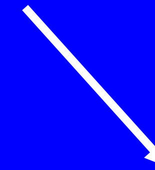
Individual mandate*



Public option**

* “each eligible individual must enroll in an applicable health plan for the individual and must pay any premium required with respect to such enrollment.” (S.1775)

** “you can choose to enroll in the new public plan”

WHAT HAPPENED TO THE PUBLIC OPTION?

The original "robust" Plan

- Open enrollment: "Medicare for everyone who wants it"
- Medicare rates, backed by the government
- 119 million members (Lewin)

The House Plan

- Restricted enrollment (only the uninsured)
- 6 million members (<2% of the population)
- Negotiated rates, self sustaining

The Senate Plan

- No public option

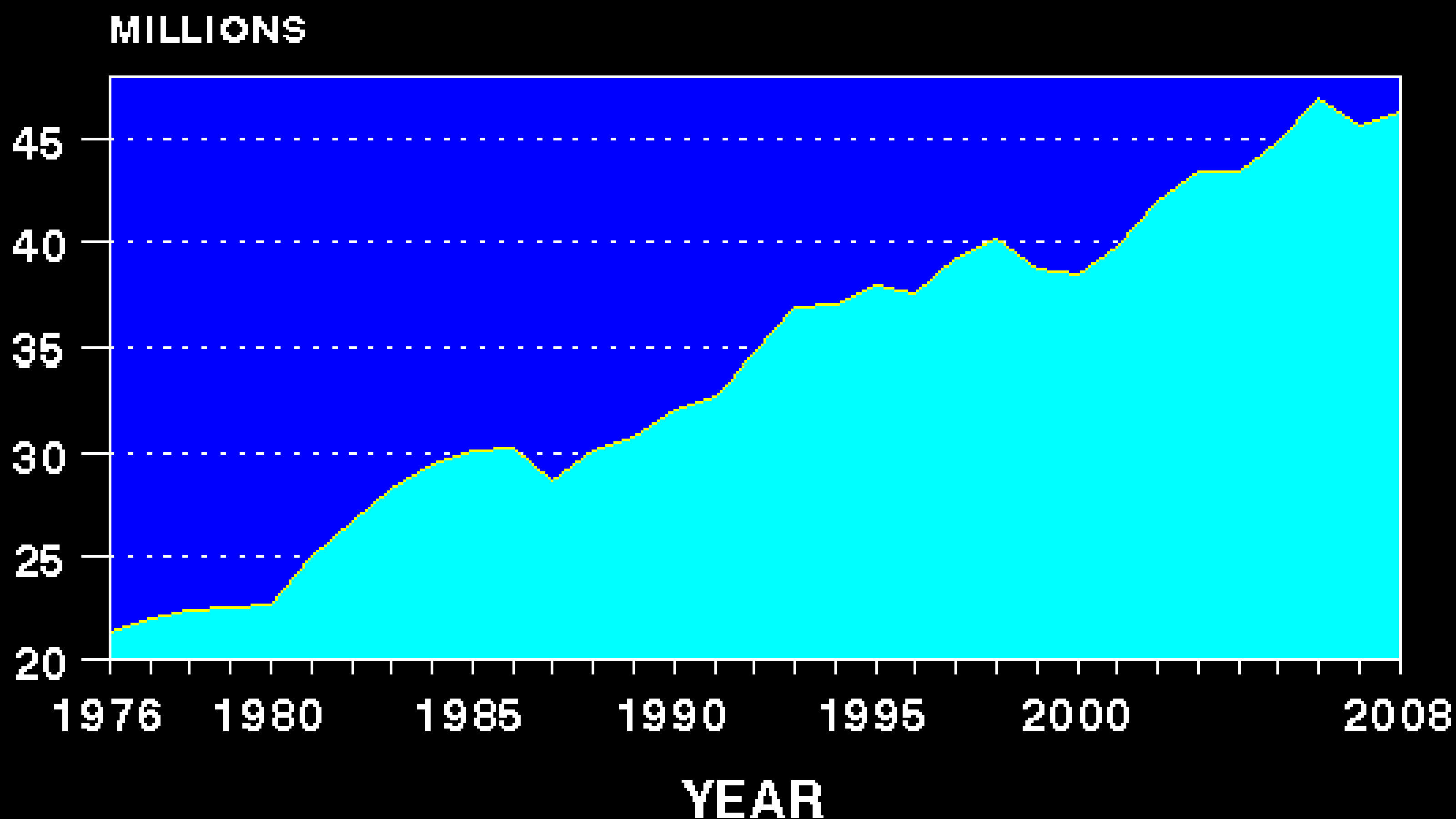
CHALLENGES FACING HEALTH REFORM

1. Declining access
2. Escalating costs
3. Defining of benefits
4. Restricted choice
5. Uneven Quality
6. Lack of primary care
7. How to pay for reform

CHALLENGE #1

DECLINING ACCESS

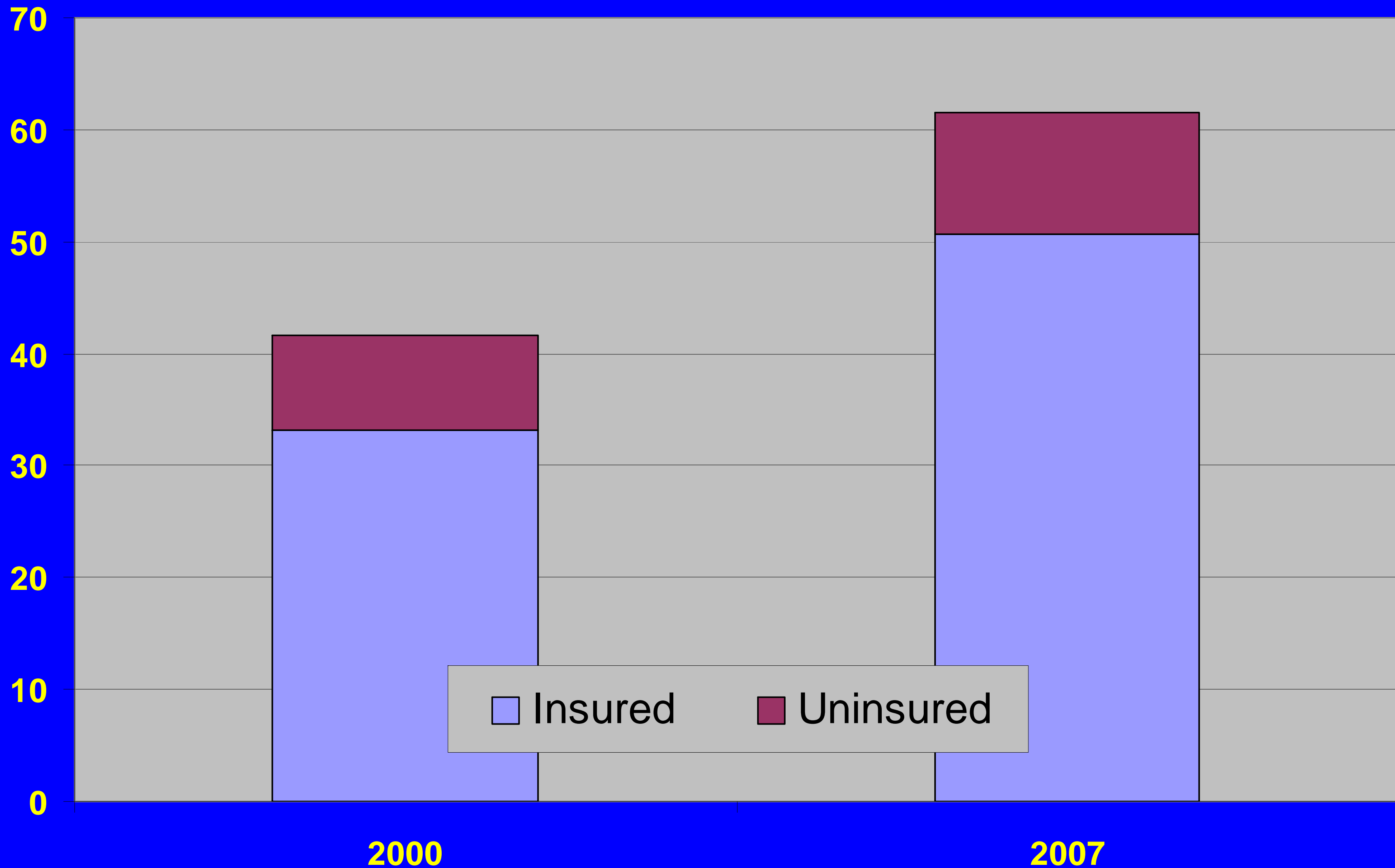
Number of Uninsured Americans 1976-2008



Source: Himmelstein, Woolhandler & Carrasquillo - Tabulation from CPS & NHIS Data

The Epidemic of Underinsurance

Number of people spending more than 10% of income on health care (Millions)



Source: ***Too Great a Burden***, Families USA, December 2007

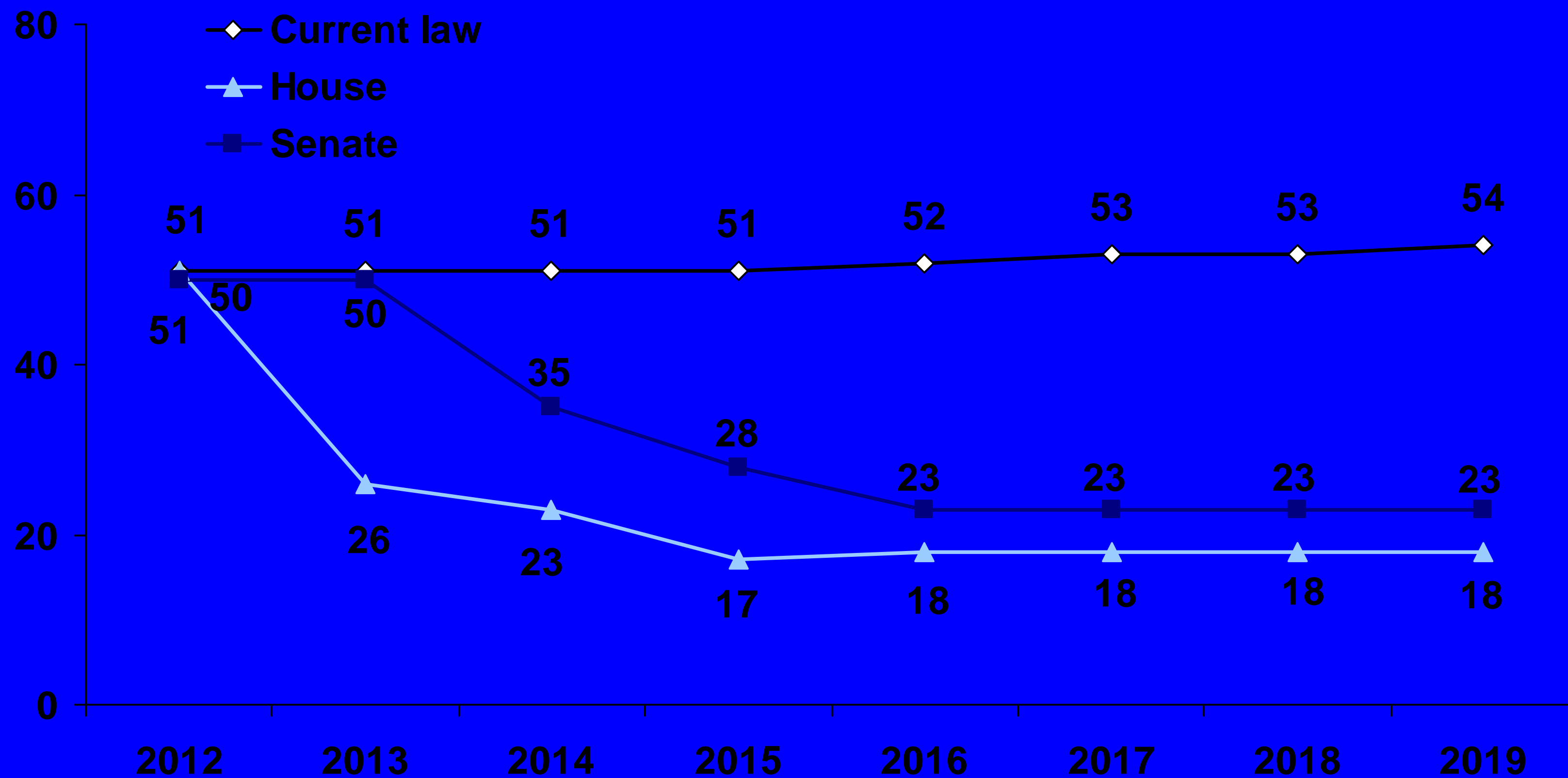
Improved
MEDICARE FOR ALL

- Automatic enrollment
- Federal guarantee
- All residents of the United States
- “Everybody in, nobody out”

Congressional
HEALTH CARE REFORM

- Mandates purchase of private HI
- Expands Medicaid eligibility
- Subsidizes premiums up to < 400% FPL
- Insurance market reforms: Guaranteed issue; no rescissions; no annual/life limits

Trend in the Number of Uninsured Nonelderly, 2012–2019 Under Current Law and House and Senate Bills



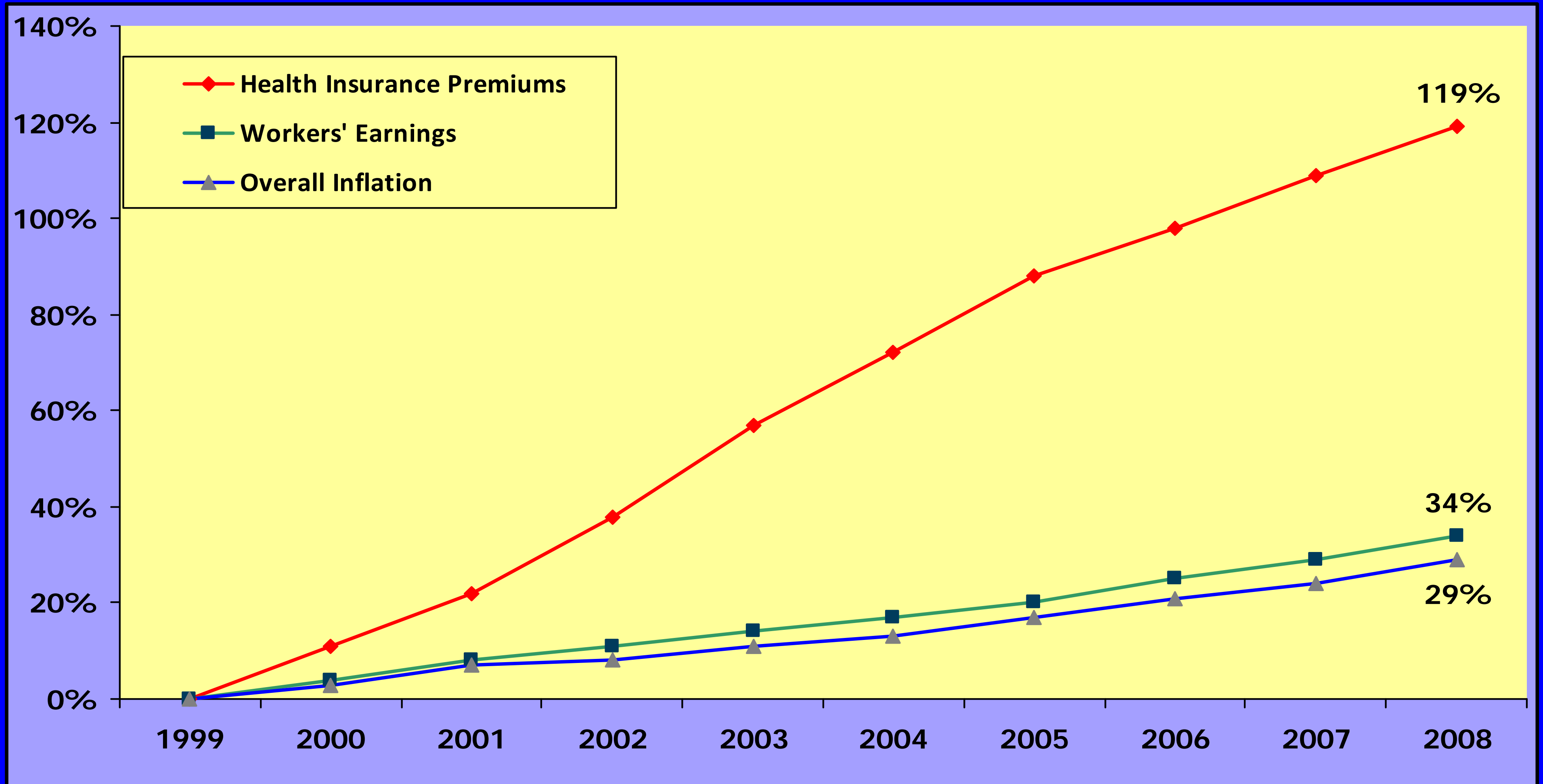
Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 94% and 96% of legal nonelderly residents are projected to have insurance under the Senate and House proposals, respectively.

Data: Estimates by The Congressional Budget Office.

CHALLENGE #2

ESCALATING COSTS

Insurance Premiums • Workers' Earnings • Inflation 1999-2008



Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index

High Cost of Health Insurance Premiums: It's Even Too Expensive for the Middle Class Today

National Average for Employer-provided Insurance

Single Coverage	$5,791 per year
Family Coverage	$13,375 per year

Note: Annual income at minimum wage = $13,624
Annual income of average Wal-Mart worker = $17,114

Source: Kaiser Family Foundation/HRET Survey of Employee Benefits, 2009

RISE IN PERSONAL BANKRUPTCIES

62% of personal bankrupcties are due to medical expenses and over 75% had health insurance at the outset of their bankrupting illness.*

* Himmelstein, et.al. Am J Med, August, 2009

Improved
MEDICARE FOR ALL

Low Administrative Costs = Single Payer

- **Administrative cost and profit**

  - Medicare: 2-3 %
  - Private insurance: 16-30%

- **$400 billion* redirected to cover the uninsured and to expand coverage for the underinsured**

  * NEJM 2003:349;768-775

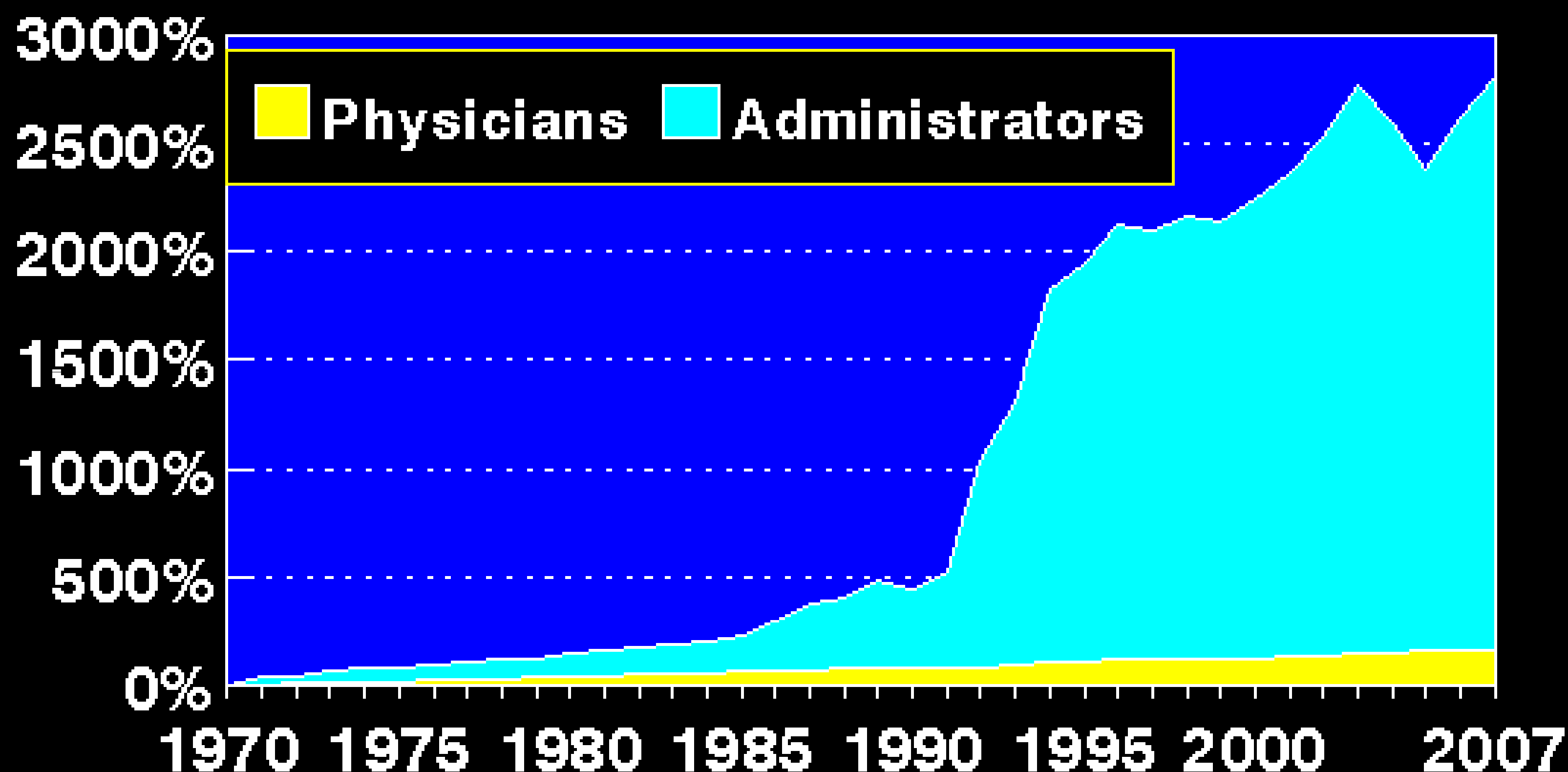
Covering Everyone and Saving Money through Medicare for All

Additional costs		$ B
Covering the uninsured and poorly-insured	+6.4%	134
Elimination of cost-sharing and co-pays	+5.1%	107
Total Costs	**+11.5%**	**241**
Savings		
Reduced insurance administrative costs	-5.3%	-111
Reduced hospital administrative costs	-1.9%	-21
Reduced physician office costs	-3.6%	-76
Bulk purchasing of drugs & equipment	-2.8%	-59
Primary care emphasis & reduce fraud	-2.2%	-46
Total Savings	**-15.8%**	**-313**
Net Savings	**- 4.3%**	**- 73**

Source: Health Care for All Californians Plan, Lewin Group, January 2005

GROWTH OF PHYSICIANS & ADMINISTRATORS 1970-2007

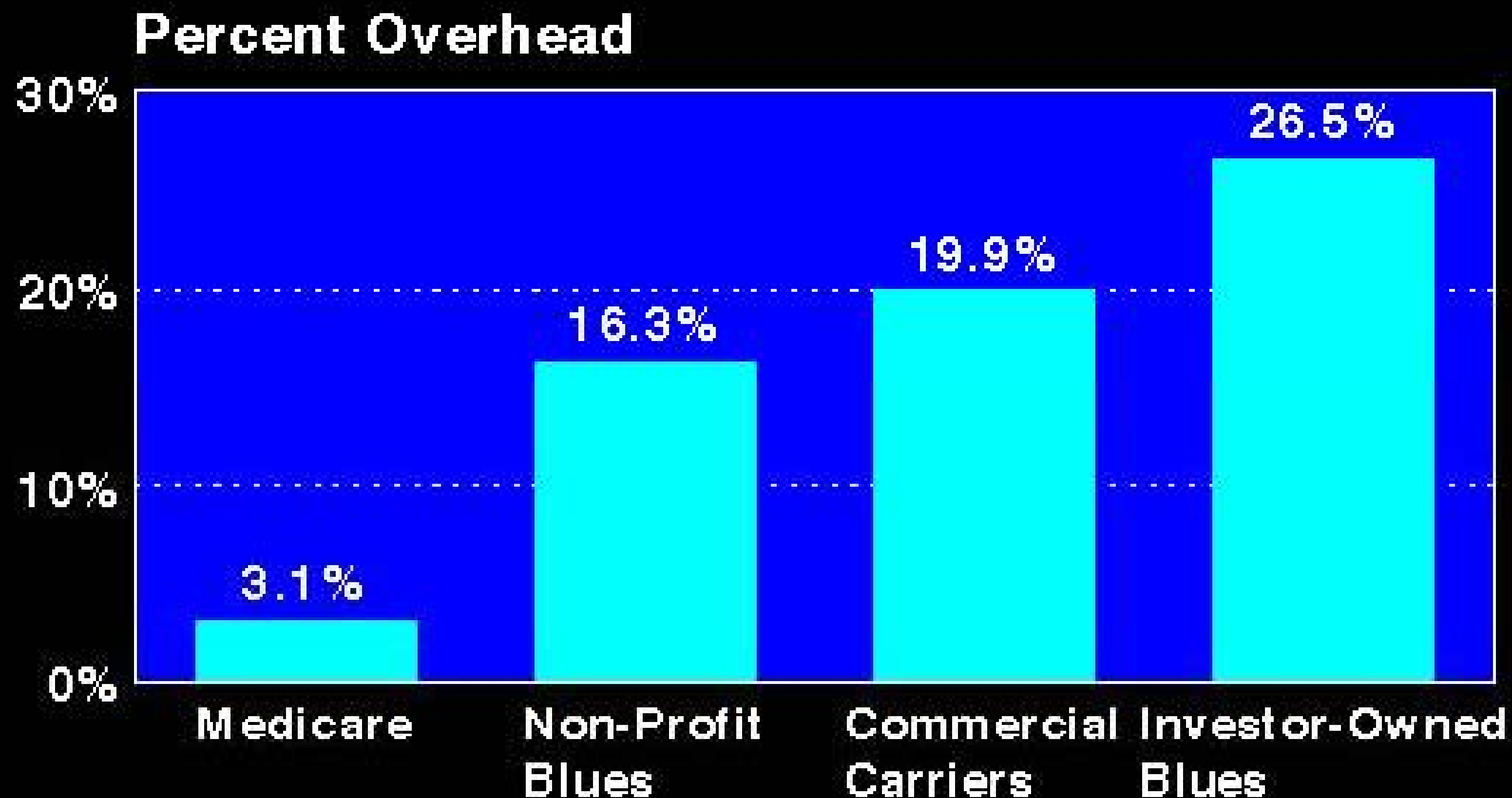
GROWTH SINCE 1970



Source: Bureau of Labor Statistics; NCHS; and analysis of CPS

Private Insurers' High Overhead

Investor-Owned Plans are Worst



Source: Schramm. Blue Cross Conversion. Abell Foundation. and CMS

SINGLE PAYER OFFERS REAL TOOLS TO CONTAIN COSTS

- Global budgeting of hospitals
- Capital investment planning
- Emphasis on primary care; coordination of care; alternative ways of paying for care
- Bulk purchasing of pharmaceuticals

Congressional
HEALTH CARE REFORM

Enlarges the risk pool by mandating Penalties for Un-insurance

1. **Individual mandate**
   - **House:** penalty=2.5% adjusted gross income
   - **Senate:** penalty=$1500/family

2. **Employer mandate (if payroll > $750,000)**
   - **House:** penalty=8% of payroll
   - **Senate:** penalty=$750/employee

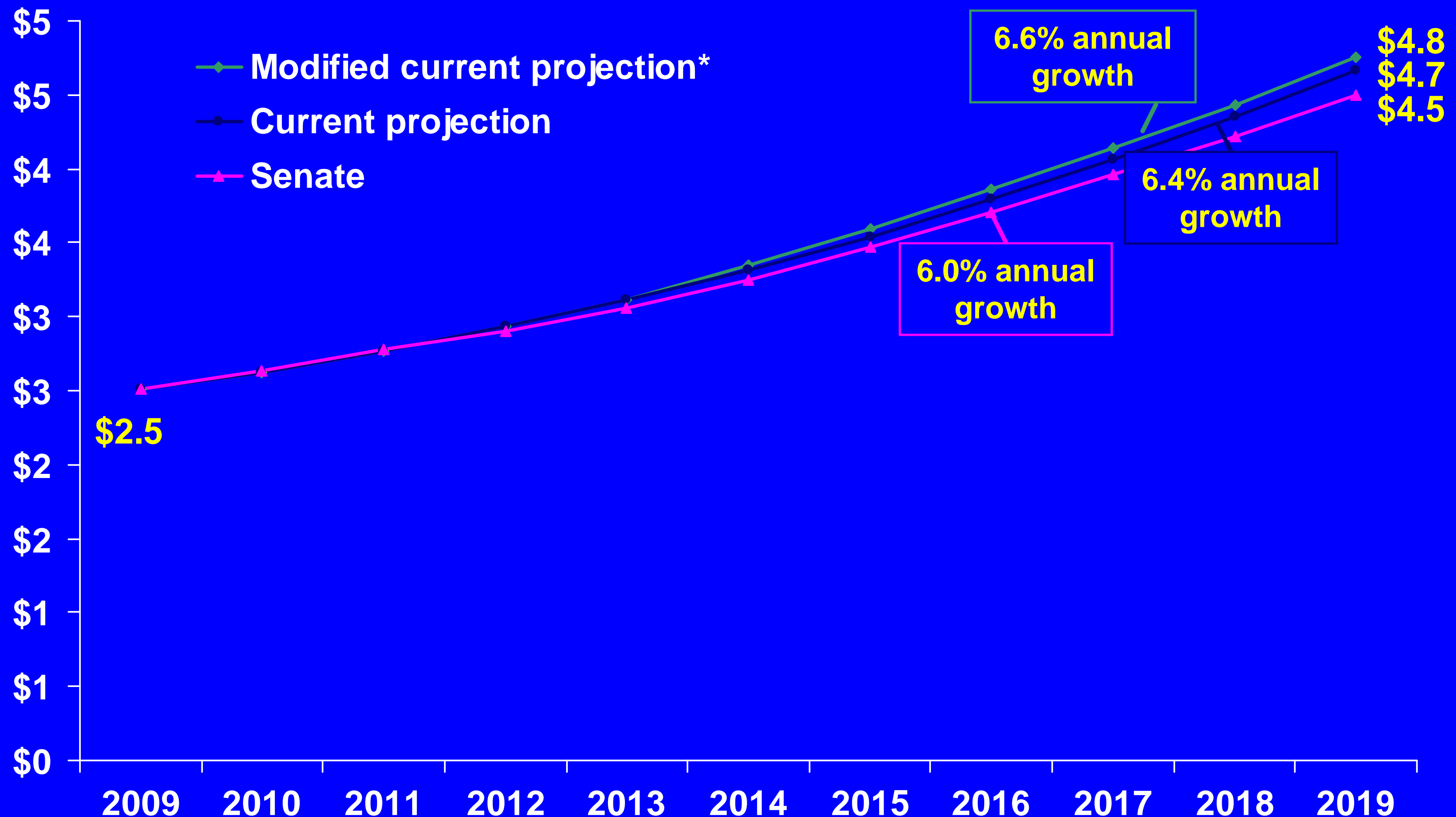
3. **Employment-based insurance unchanged**
   - **Employers can change plans and coverage**
   - **Insurers can change provider networks**
   - **Employees must accept employer plan**

Congressional
HEALTH CARE REFORM

Offers pseudo-tools to contain costs

- **Health Information Technology (HIT)**
- **Chronic Disease Management**
- **Payment reforms** (e.g., medical homes)

Total National Health Expenditures (NHE), 2009–2019
Current Projection and Alternative Scenarios



Notes: * Modified current projection estimates national health spending when corrected to reflect underutilization of services by previously uninsured.
Source: D. M. Cutler, K. Davis, and K. Stremikis, Why Health Reform Will Bend the Cost Curve, Center for American Progress and The Commonwealth Fund, December 2009.

CHALLENGE #3
DEFINING BENEFITS

- **Basic/Preventive vs. Comprehensive benefits**
- **Primary care vs. specialty care**
- **Alternative and Experimental therapies**

Improved
MEDICARE FOR ALL

Comprehensive coverage

- Preventive services
- Hospital care
- Physician services
- Dental services
- Mental health services
- Medication expenses
- Reproductive health services

-Home nursing home care

"All medically necessary services"

Any exclusions? How decided?

Improved
MEDICARE FOR ALL

No Co-Pays or Deductibles

- **Reduce use of needed and unneeded services equally**
- **Under use of primary care services**
- **Not effective in reducing over use of technology intensive services**

- Eliminate self-referral to MD owned

- Reduce defensive medicine

Congressional
HEALTH CARE REFORM

- **No Standard Benefit Package mandated**
- **Reduces or eliminates co-pays and deductibles on preventive services only**

CHALLENGE #4
RESTRICTED CHOICE

- 42% of employees have no choice
- Private health insurance limits choice to the network of doctors and hospitals with whom they have negotiated contracts
- You pay more to go out of network

Improved
MEDICARE FOR ALL

Expands Choice

- No limit to a network of providers
- Free choice of doctor and hospital
- Delinks health insurance from employment

Congressional
HEALTH CARE REFORM

<u>Creation of HI Exchanges Expands Choice</u>

- **House: National Exchange with State option**
  - Combines individual and small group markets into one insurance pool and one Exchange
  - National public option

- **Senate: State exchanges with federal back-up**
  - Separate pools for individual and small groups
  - No public option

- **You remain limited to the insurer's network**

Congressional
HEALTH CARE REFORM

Restricts Choice when it comes to abortion

- **House: Stupak Amendment**

  - Codifies Hyde Amendment
  - Bans abortion coverage in "public option"
  - Bans abortion coverage in sany private plan that accepts public subside funds
  - Allows separate abortion "riders"

- **Senate: Nelson Amendment**

  - Allows states to prohibit abortion coverage in state-run exchanges
  - If states allow abortion coverage, requires enrollees or employers to send two checks
  - Insurers must keep abortion coverage money separate from federal subsidies

CHALLENGE #5: UNEVEN QUALITY

- **In 2008, U.S. was last among 19 industrialized nations in mortality amenable to health care.**

- **In 2006, we were 15th.**

Improved
MEDICARE FOR ALL

- National data on health care quality vs. proprietary data held by private HI
- National standards and public reporting
- HIT for the nation with patient protections

Congressional
HEALTH CARE REFORM

- Comparative Effectiveness Research
- Center for Quality Improvement (House)
- Patient-Centered Outcomes Research (Senate)
- National quality strategy with public reporting

CHALLENGE #6:
LACK OF PRIMARY CARE

- **Average medical school debt = $160,000**
- **Primary care is under-reimbursed**
- **Medical school graduates going into specialties**

Improved
MEDICARE FOR ALL

- **Debt forgiveness for primary care**
- **Malpractice payment for primary care providers** (MDs, NPs and PAs)
- **Patient-Centered Medical Homes** (team based care, open access, coordination of care; phone/internet medicine)

Congressional HEALTH CARE REFORM

- **House**
  - Pilot medical homes and ACO programs
  - Center for Payment Innovation
  - Increase Medicare payments for PCPs by 5%
  - Brings Medicaid PCPs up to Medicare level
  - National prevention and wellness strategy
  - Prevention and Wellness Trust Fund
  - Reduced cost sharing for prevention

- **Senate**
  - Medicaid enrollees may designate medical home
  - ACOs may share savings with Medicare
  - Creates a CMS Innovations Center
  - Free annual wellness visit for Medicare
  - Encourage state and employer wellness programs
  - Reduced cost sharing for prevention

CHALLENGE #7

HOW TO PAY FOR REFORM

Improved
MEDICARE FOR ALL

- **Public funding**

  - Payroll tax
  - Corporate taxes
  - Incomes taxes

- **No premiums: regressive**

- **No increase in overall health care spending, because of administrative savings**

Improved
MEDICARE FOR ALL

Non-profit/private delivery system under local control

- **Doctors not salaried by government**
- **Hospitals not owned by government**
- **This is not “socialized medicine”**

A publicly funded-privately delivered partnership

Congressional
HEALTH CARE REFORM

1. **Increased taxes**
   - House: Surtax on wealthy ($461 mill)
   - Senate: Excise tax on "Cadillac" health insurance plans

2. **Savings from Medicare**
   - Advantage: ($136 – 170 mill)
   - Provider payment: ($151 – 177 mill)

3. **Revenue from reduced fraud and abuse**

OBAMA PLAN

1. Expanded coverage, but not universal

2. Cost control by market means

3. No definition of coverage

4. Choice thru State-based exchanges, but no public option

5. Limits on abortion

6. Primary care/quality pilots

7. Funding: Excise tax on "Cadillac" plans and Medicare cutbacks

Single Payer
MEDICARE FOR ALL
THE PHYSICIANS' PROPOSAL
(JAMA, August 13, 2003 P. 798-805)

1. **Universal coverage/automatic enrollment**
2. **Low administrative costs=single payer**
3. **Comprehensive coverage without co-pays and deductibles**
4. **Maximum choice of Doctor, NP, Hospital**
5. **Improved quality**
6. **Expanded primary care**
7. **Publicly-funded/privately delivered**

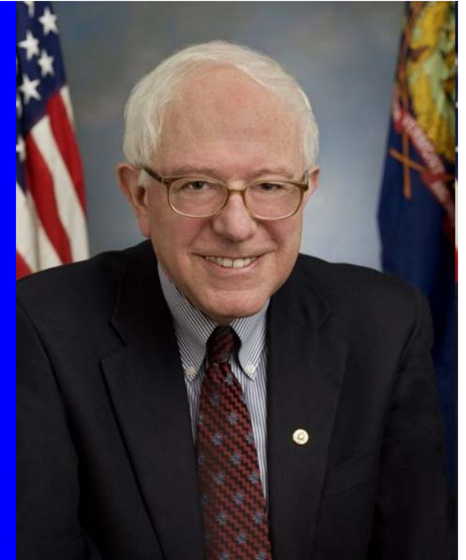
MEDICARE 2.0

Conyers HR 676
Expanded and improved
MEDICARE-FOR-ALL
"Single Payer NH Care"

(86 Co-sponsors in House of Rep)

- Automatic enrollment
- Comprehensive benefits
- Free choice of doctor and hospital
- Doctors and hospitals remain independent
- Financed through progressive taxes
- Costs contained through capital planning, budgeting, quality reviews, primary care emphasis

Sanders (& McDermott): American Health Security Act S 703 (HR 1200)



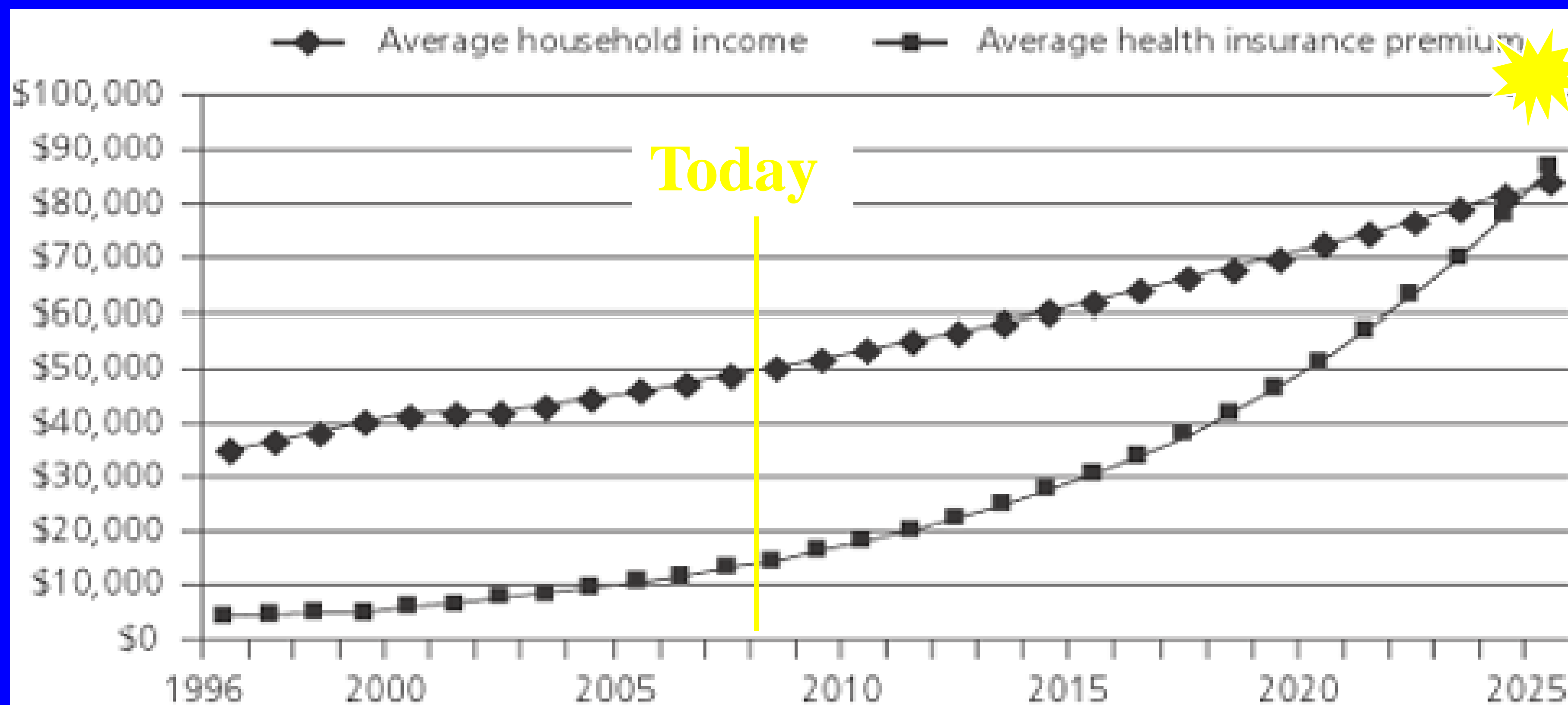
1. Automatic enrollment
2. Comprehensive benefits
3. Operated by States using Federal standards
4. Free choice of doctor and hospital
5. Doctors and hospitals remain independent
6. Public agency processes and pays bills
7. Financed through payroll taxes

IN CONCLUSION

- **A system based on private insurance plans**
  - will not lead to universal coverage
  - will not create affordable insurance

- **A Medicare for All System**
  - can provide comprehensive services while costing no more than present
  - can provide tools to control costs in the future

We Can't Wait Another 16 Years! We Need Real Health Care Reform Before the Premium Takes All our Income!



Source: ***American Family Physician,*** **November 14, 2005**

WHY WE CONTINUE TO ADVOCATE MEDICARE FOR ALL

- Present reform proposals **won't solve** the problem
- The **economic crisis** calls for government stimulus of the economy
- **Everyone benefits**: the uninsured, the underinsured, and everyone else who is insecurely insured
- **Employers** will be relieved of the burden of rising health care costs/retiree benefits and unfair competition from employers who don't offer HI
- **Every other industrialized country** has done it
- It is morally **the right thing** to do!

CONTACTS AND REFERENCES

- **PNHP-NY Metro: www.pnhpnymetro.org**
- **PNHP National: www.pnhp.org**

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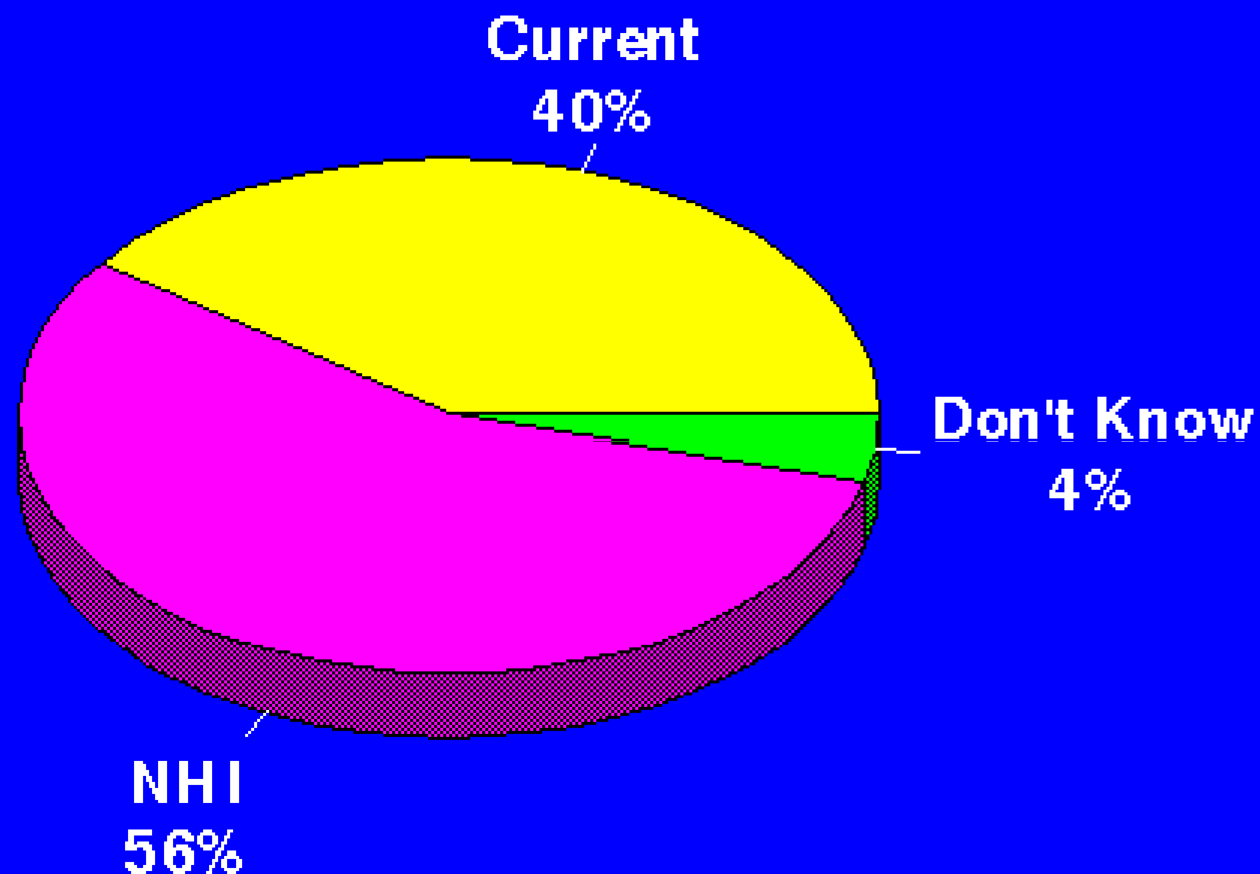
- Fein O, Birn AE. (editors), *Comparative Health Systems.* Am Jour Public Health 2003; 93: 1-176
- O'Brien ME, Livingston M (editors), *10 Excellent Reasons for National Health Care.* New Press, 2008
- Geyman J, *Do Not Resuscitate: Why the Health Insurance Industry is Dying and How We Must Replace It.* Common Courage Press, 2008

"Would you prefer the current health insurance system . . . or a universal coverage program like Medicare that is government-run and financed by taxpayers?"



Source: ABC News Poll/USA Today/Kaiser Survey 9/06

CFO Magazine Poll

February 16, 2006

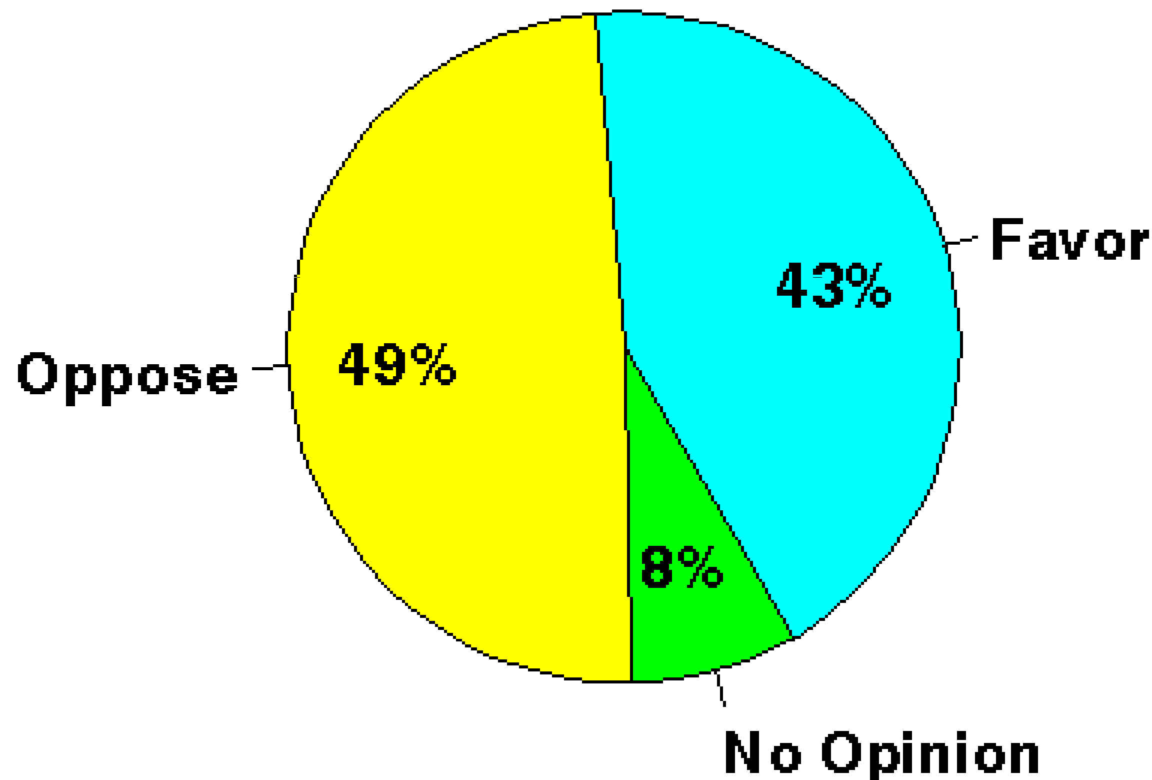
Survey of 249 Senior Financial Executives

"Do you think that Congress should consider a National Health Program (i.e., single payer health insurance ?)"

- 32% Yes
- 45% No
- 23% Not sure

Nearly Half of Small Business Owners Favor Single Payer

"[Replace] the current healthcare system with a new government-run NHI plan funded by taxpayers...?"



Source: Gallup Organization, 10/9/07

LABOR SUPPORT FOR HR676

- 560 Union organizations in 49 states
- 130 Central Labor Councils
- 39 State AFL-CIOs (AL, AR, AZ, CA, CO, CT, DE, FL, GA, KS, KY, IA, IN, MD-DC, ME, MN, MO, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, VT, WA, WI, WV, WY)
- 20 International Unions

FAITH-BASED SUPPORT FOR SINGLE-PAYER

- General Assembly of the Presbyterian Church USA proclaimed single payer, universal national health insurance, "*the program that best responds to the moral imperative of the gospel.*"

- General Assembly of the Unitarian Universalists endorsed HR 676.

LOCAL GOVERNMENT SUPPORT FOR SINGLE-PAYER

- State House Reps: Kentucky and New Hampshire, NY State Assembly passed resolutions supporting HR 676
- Cities: Baltimore to San Francisco
- U.S. Conference of Mayors (representing over 1,000 Cities with pop >30,000) adopted a resolution in support of HR 676 in June 2008

NURSE SUPPORT FOR HR 676 and SINGLE PAYER

- California Nurses Association
- National Nurses Organizing Committee
- NYS Nurses Association

PHYSICIAN SUPPORT FOR SINGLE PAYER

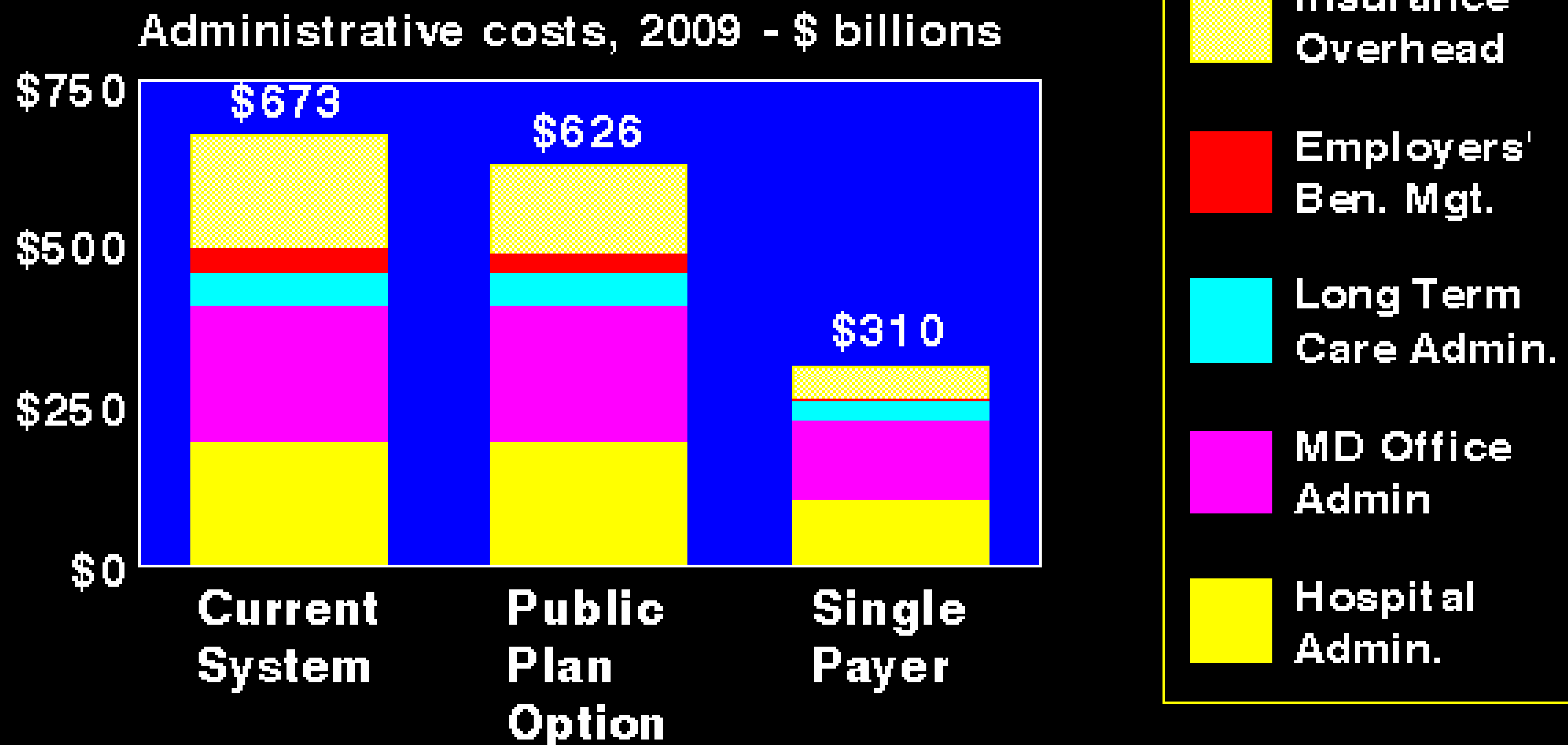
x% of physicians "support government legislation to establish national health insurance"*

- **59% of all physicians**
- 83% of psychiatrists
- 71% of pediatric sub-specialists
- 69% emergency medicine physicians
- 65% general pediatricians
- 64% general internists
- 60% family physicians
- 55% general surgeons

*Carroll AE, Ackermann RT, Annals of Internal Medicine, April 2008

Administrative Costs: Single Payer Vs. Public Plan Option

Public Plan Option Saves Little Even if Half of Privately Insured Switch



Source: Himmelstein & Woolhandler, Calculations based on NEJM 349:768 updated to 2009

Assumes: (1) Insurance overhead on public plan = traditional Medicare's;

(2) Employers' health benefit administration costs drop 25%