Improved/Single Payer
MEDICARE FOR ALL
and
HEALTH CARE REFORM

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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

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

High Cost of Health Insurance

Premiums: It’s Even Too Expensive for the Middle Class Today

National Average for Employer-provided Insurance

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Cost per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Coverage</td>
<td>$5,791</td>
</tr>
<tr>
<td>Family Coverage</td>
<td>$13,375</td>
</tr>
</tbody>
</table>

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

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

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

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

Percent Overhead

- Medicare: 3.1%
- Non-Profit Blues: 16.3%
- Commercial Carriers: 19.9%
- Investor-Owned Blues: 26.5%

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
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.
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

Creation of HI Exchanges Expands Choice

• 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
Restricts Choice when it comes to abortion

- **House: Stupak Amendment**
  - Codifies Hyde Amendment
  - Bans abortion coverage in “public option”
  - Bans abortion coverage in any private plan that accepts public subsidy 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


• Fein O, Birn AE. (editors), *Comparative Health Systems*. Am Jour Public Health 2003; 93: 1-176


• 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

Administrative costs, 2009 - $ billions

- **Current System**
  - Insurance Overhead: $673
  - Employers' Ben. Mgt.: $250
  - Long Term Care Admin.: $200
  - MD Office Admin.: $100
  - Hospital Admin.: $100
  - Total: $1,343

- **Public Plan Option**
  - Insurance Overhead: $626
  - Employers' Ben. Mgt.: $250
  - Long Term Care Admin.: $200
  - MD Office Admin.: $100
  - Hospital Admin.: $100
  - Total: $1,376

- **Single Payer**
  - Insurance Overhead: $310
  - Employers' Ben. Mgt.: $0
  - Long Term Care Admin.: $0
  - MD Office Admin.: $0
  - Hospital Admin.: $0
  - Total: $310

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%