PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Activist Newsletter
September 2005

Legislative Update: Rep. Hilda Solis Co-Sponors HR 676

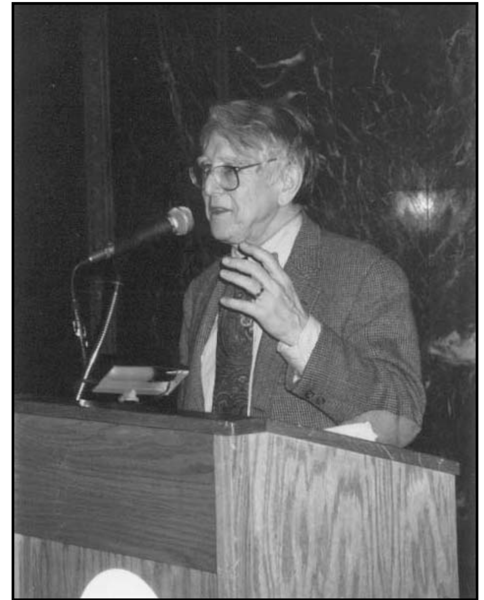
Congresswoman Hilda Solis (D-CA) became the newest U.S. Representative to back single-payer when she signed on as a co-sponsor of the U.S. National Health Insurance Act on July 12.

Solis, now in her second term in Congress, serves on the House Energy and Commerce committee and is the current chair of the Congressional Hispanic Caucus Health Policy Taskforce.

"In a country that prides itself on equality, it is evident that our health care system is broken when people suffer from a lack of access to health insurance and to quality care," Solis said is a statement. "The uninsured [are] a national problem and need a national solution. The United States National Health Insurance Act is a federal commitment to the 45 million Americans across the nation who deserve ...access to affordable, quality health care."

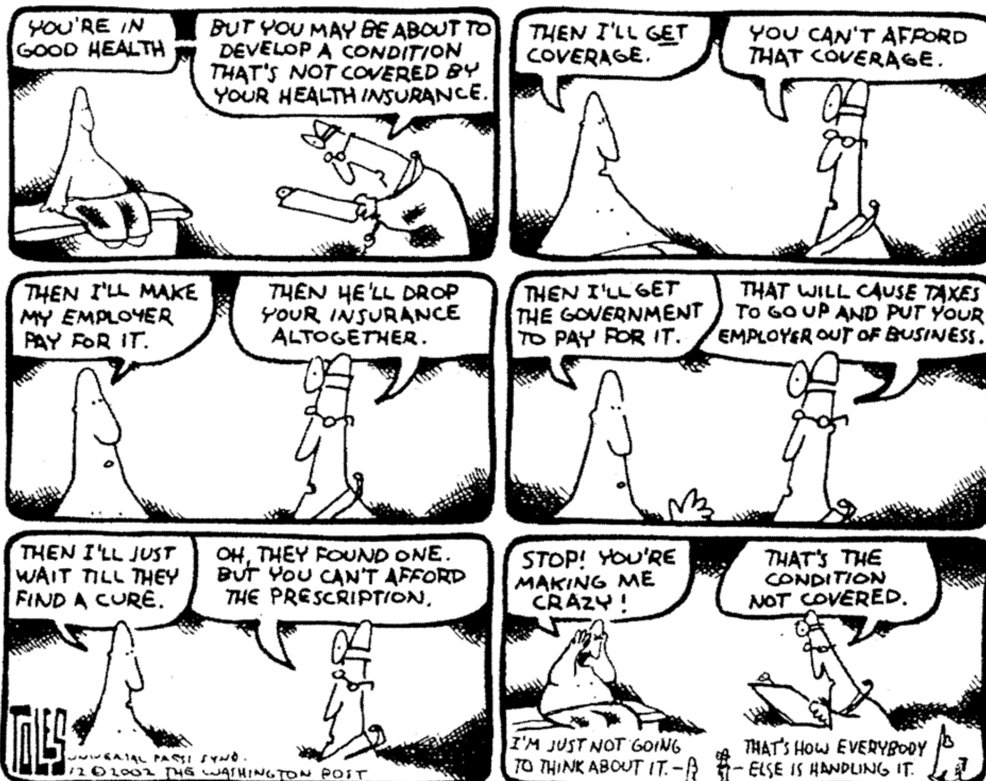
In addition to the 35 Congressional supporters of HR 676 in 2003, 16 new congressmen have signed on in support of single-payer.

Dr. Young and PNHP leaders Dr. Rudy Meuller and Dr. Olveen Carrasquillo will also be presenting at the Congressional Black Caucus' annual Leadership Meeting on September 22.



PNHP National Coordinator
Dr. Quentin D. Young

For a complete list of HR 676 consponsors, visit: http://thomas.loc.gov/cgi-bin/bdquery/z?d109:HR00676: and click "Cosponsors"



Tom Toles / Washington Post

Dr. Quentin Young Addresses Retired Auto Workers

PNHP National Coordinator Dr. Quentin Young joined Rep. John Conyers on August 11 for a teach-in and strategy session on single-payer for retired UAW members in Detroit.

More than 40 labor activists from the United Auto Workers gathered to discuss strategies for lobbying and winning support for the U.S. National Health Insurance Act (HR 676), introduced by Rep. Conyers (D-MI).

The retirees plan to encourage UAW union president Ron Gettlefinger to focus more attention on HR 676, to devote more of the state organization to lobbying on behalf of the bill, and to develop a PowerPoint presentation that UAW leaders can take to their locals to teach membership about national health insurance.

"Working hand-in-hand with labor in the struggle for single-payer is critical," Dr. Young said. "No nation in the world has won a national health insurance system without the support of labor."

See below for a selected list of unions that have passed resolutions endorsing single-payer national health insurance.

Selected Unions Supporting Single-Payer

National

United Auto Workers
United Electrical, Radio and Machine Workers
United Mine Workers
Petroleum, Atomic and Chemical Workers
United Steelworkers
Transport Workers' Union

Locals

Duluth (MN) AFL-CIO Central Labor Body
Federation of Government Employees 2028 (PA)
Plumbers and Steamfitters Local 188 (GA)
UAW Local 2322 (Holyoke, MA)
Washington Alliance of Tech. Workers 37083 (WA)
California Nurses' Assocaition
Plumbers and Pipefitters Local 630 (FL)
Coalition of Labor Union Women
Coalition of Black Trade Unionists
Jefferson County Teachers' Association
Northwest Indiana AFL-CIO
Pumbers and Steamfitters Local 393 (CA)
Nurses' Professional Organization (KY)

For a complete list:
http://www.house.gov/conyers/news_hr676_7.htm

For more information on working with unions:
Kay Tillow, Nurses' Prof. Org. nursenpo@aol.com

Kentucky Activists Pass Single-Payer City Council Resolution

PNHP Kentucky chapter activist Dr. Ewell Scott led a successful campaign to pass a city council resolution in support of single-payer national health insurance in his hometown of Morehead (reprinted on next page). The resolution passed at the council's August 15 meeting.

In its unanimous vote in favor of single-payer, which included one Republican, the Council agreed that progressive public financing is the most reasonable and economical solution to the U.S. health care crisis.

Dr. Scott, an internist who practices at the Morehead Clinic and has given many talks about single-payer in the community, first sent the resolution to a friendly member of the council, then asked that it be put on the agenda during the "public comment" portion of the council meeting.

After handing out brochures from Kentuckians for Single-Payer Health Care, Dr. Scott made brief remarks before the council.

"We are the only nation in the industrialized world that does not have universal health care," Dr. Scott told council members. "It is a national shame."

The next edition of the city's newspaper ran a front-page story about Dr. Scott, the resolution, and PNHP.

The council sent copies of the resolution to state officals and the state's entire congressional delegation in Washington.

PNHP Conference A Winner At American Psychiatric Association

PNHP Hawaii chapter leader and community psychiatrist Dr. Leslie H. Gise chaired a symposium of single-payer supporters on May 23 at the national meeting of the American Psychiatric Association in Atlanta.

The event was a resounding success, with more than 110 physicians staying for the entire three-hour meeting, entitled "Health Care Meltdown: What Can We Do?" despite being held during the APA conference's 'prime-time.' In addition to a panel of PNHP members representing the specialty, the event featured a Canadian psychiatrist and a closing address by past U.S. Surgeon General Dr. David Satcher.

Dr. Jon Davine, Associate Professor of Psychiatry at McMaster University in Ontario, made a presentation entitled "Working Under a Universal Health Care Plan." Dr. Davine described his community-based practice in Hamilton, Ontario, commenting on the highly efficient administrative aspects of the system. He also presented the 2005 Ontario psychiatrist reimbursement fee schedule under Canada's national health insurance system, which reimburses psychiatrists on par with other specialties.

PNHP panelists Dr. Karen Hochman and Dr. Ray Kotwicki of Emory University Medical School's Department of Psychiatry and Behavioral Sciences talked about theoretical and practical reasons why mental health care for patients with severe and persistent mental illness should be federally funded. Dr. Hochman, a Canadian citizen who is a permanent resident of the U.S., spoke about how a single-payer system positively impacts the practice of community psychiatrists in Canada.

PNHP Georgia chapter chairman, Dr. Henry Kahn of Emory University's School of Medicine and Rollins School of Public Health, spoke about the work of Georgians for a Common Sense Health Plan and their state single-payer proposal, Georgia SecureCare. Dr. Kahn also presented data on the economic benefit of the single-payer model from the nationally-respected Lewin Group research firm.

The symposiums closed with speeches by former Surgeon General Dr. David Satcher and APA president Dr. Steve Sharfstein. Both gave rousing talks about the need for single-payer and their longstanding support for PNHP.

"This program was such a huge success, I think PNHP activists in every medical specialty organization should do this," Dr. Gise said. "I am new to this, having just educated myself about single-payer a few years ago, so I'm convinced that anyone can organize a program this. You don't have to be an expert or a speaker, just committed to putting something together."

PNHP'er Dr. Peter Cohen is working on arranging a similar program at APA's upcoming national meeting in Toronto (2006). If you are interested in helping Dr. Cohen at the Toronto meeting or helping organize for San Diego (2007), please contact Dr. Cohen by email at petercohen@pol.net or Nick Skala at the PNHP office (nick@pnhp.org) respectively.

Morehead, Kentucky City Council Resolution on HR 676

Passed Unanimously August 15, 2005

Whereas the cost of health insurance is excessive and places a burden on the budget of City Government, and whereas other essential services and fair wages may be compromised, and whereas police and fire protection services are placed in jeopardy and whereas there is no national policy or strategy to reduce this burden, therefore the City does request responsible lawmakers to urgently address these issues

Furthermore, since a single-payer plan with progressive public financing is the most reasonable and economical solution, the City urgently urges our Federal Representatives to give consideration to such solution and to support THE U.S. National Health Insurance Act, HR 676, introduced by Rep. John Conyers, Jr.

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PNHP Fact Sheet: Health Savings Accounts – No Savings

What is a Health Savings Account?

Health savings accounts (HSAs) are promoted by insurers as the "consumer-directed" solution to the health care crisis, and by some conservatives as a way to make individuals more "responsible for their health care choices." HSAs, which were created by the 2003 Medicare drug law, are tax-free savings accounts. Individuals and families with high-deductible health insurance plans (HDHP) (a minimum of $1,000 for an individual or $2,000 for a family) are eligible to open/purchase an HSA.

Individuals and employers can contribute funds tax-free to the HSA (maximum deposit depends on insurance plan deductible), which can only be spent on *approved* medical expenses. Unused funds (less the significant set-up, transaction, and management fees) roll over from year to year. At retirement, an individual can cash out an HSA by paying taxes on it. A wide variety of corporations – from insurers to banks – have started selling HSAs to profit off the hefty management fees and, like pharmacies, the detailed data sets on health care utilization that will result.

The Theory Behind Consumer-Directed Health Care (CDHC)

Advocates of HSAs contend that health insurance "disguises" the true cost of health care. Patients with health insurance, advocates say, see the health services they receive as being "free," and therefore overuse them, causing health care costs to rise. This is known as the theory of "moral hazard."

Health savings accounts purportedly solve this problem by forcing consumers to purchase health services "with their own money." When patients pay for care out of private accounts, the theory goes, they will cut back on "frivolous" health services and demand price competition from doctors, hospitals, and other providers, thereby lowering costs. Both parts of the theory behind HSAs have proven false (1, 2).

What Does An HSA Plan Look Like?

HSA-compatible high-deductible insurance plans trade a small reduction in premiums for a significant increase in the plan's deductible and other cost-sharing (e.g. co-pays and co-insurance). Funds deposited tax-free in the HSA can be used to pay out-of-pocket costs. Once HSA funds are depleted, the individual is responsible for paying all costs until the deductible is reached. After that, the insurance coverage kicks in, but often still requires significant patient outlays for cost-sharing and uncovered services. The rules about what HSAs can cover and what expenses apply to the deductible are so complicated that Bruce Bodaken, CEO of Blue Cross of California, stated that he can't understand his own plan.

For patients who have low or no health spending in a given year, HSAs allow the benefit of a slightly lower premium. Additionally, the funds in the HSA are sheltered from taxes (benefiting those in higher brackets most) and unspent funds (less management fees) roll over each year, becoming a small additional retirement account.

Patients with a serious injury, illness or chronic disease, however, will rapidly deplete their HSA savings. They will face the full brunt of the skimpy benefits of their HDHP (both in deductible and co-insurance, which at a typical level of 20% of hospital and physician costs, could quickly bankrupt a middle-class family). Thus, "consumer-directed" health care intentionally shifts costs (and risk) from insurers to

patients. Already, 40 percent of Americans aged 18-65 (77 million) report problems with medical debt and reduced access to health care due to debt and costs. Half of all personal bankruptcies are related to medical bills and injury.

Why HSAs won't work:

* **Health care doesn't work as a "market."** Economists have concluded that medical care does not and cannot work like a market; it works like a public good. Patients don't decide what to "buy," they rely on doctors and nurses to guide treatment decisions, and hospitals to have all necessary personnel, equipment, and supplies at the ready. The information to compare prices and quality (such as when car shopping) does not exist and would be extremely unreliable anyway, since the easiest way for a provider to improve quality and lower price would be to shun the sickest patients. Finally, patients are poorly equipped to "shop around" for health care at the time in their life they are most vulnerable and in need of guidance and compassionate care (3).

* **Health savings accounts will not control costs.** Each year, ten percent of the population accounts for 69 percent of health spending. HSAs do nothing to control costs for these patients, they merely shift costs from the insurers to the patient (4,5).

* **Financial disincentives lead to rationing, discourage prevention, and result in worsened health outcomes.** Exposing patients to high out-of-pocket costs leads to rationing based on ability to pay. Studies have shown that increasing out-of-pocket expenses causes patients to forego needed primary and preventive care. It worsens health outcomes, particularly for low income patients and those with chronic illnesses such as high blood pressure (6,7,8).

* **HSAs will do nothing to reduce the number of uninsured.** Since the primary difference between an HSA and a regular savings account is that the HSA income isn't taxed, the only attraction of an HSA is its tax-deductibility. More than half of the uninsured have no income tax liability. In addition, skimpy HSA-compatible plans still have high premiums. A recent study estimates that widespread implementation of HSAs will reduce the number of uninsured Americans by less than 100,000 (9).

* **HSA plans increase administrative costs.** Administrative bloat and bureaucracy already consumes 31 percent of our health spending, hundreds of billions of dollars in waste each year. HSA plans, which require the tracking of all out-of-pocket spending by each patient, their HSA corporate manager, and their insurer will only increase these costs (10).

* **Patients are left exposed to massive debt.** Those experiencing an illness or injury find will themselves exposed to high out-of-pocket costs through the required deductible, co-payments co-insurance and uncovered costs. Many patients have been bankrupted well below the "catastrophic" thresholds outlined in some plans (11).

* **HSAs deplete funds from the insurance risk pool.** While the poor and sick quickly deplete their HSA funds each year, the rich and healthy retain their unspent money which would have previously gone to subsidize care for the sick. These health dollars are effectively removed from the system and will need to be replaced by cutting costs or raising premiums. Furthermore, as the subsidy of healthier patients disappears, the stability of insurance plans as a whole are threatened (the "death spiral")(12).

* **Patients with experience with HSA plans are dissatisfied with them.** A June, 2005 study by the pro-HSA consulting firm McKinsey & Company found that most (56 percent) of patients with HSAs are less satisfied with them than with their previous health plans. In some companies, as many as 75 percent said they were dissatisfied with their HSA-compatible plan (13).

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