PNHP's Suggestions for Participants in Obama/Biden Transition Team Health Care Community Discussions

We hope to achieve two goals:

1. Educate discussion participants in the advantages of the single payer approach and the impracticality of lesser reforms.

A. Only single payer can realize the large administrative savings needed to make universal coverage economically feasible. According to studies in the New England Journal of Medicine, and by the Congressional Budget Office (CBO) and General Accountability Office (GAO), single payer could save more than 10% of total health spending by simplifying administration – more than $250 billion annually – enough to cover all of the uninsured and to upgrade coverage for everyone by eliminating co-payments, deductibles, etc. Lesser reforms that retain private insurers cannot achieve substantial administrative savings (the CBO says savings from computerization are completely unproven), and can only expand coverage by further increasing costs.

B. Reforms similar to those outlined by Senator Daschle have failed repeatedly in the past, including measures passed in Massachusetts (1988), Oregon (1989), Tennessee (1992), Minnesota (1992), Vermont (1992) Washington state (1993), and Maine (2003). Because they all perpetuated the role of private insurers, all ultimately proved unaffordable and eventually collapsed. The latest such effort in Massachusetts (2006) is already facing steep cost overruns and burdens patients with unaffordable premiums and co-payments; hundreds of thousands of Massachusetts residents remain uninsured.

C. Adding an option to purchase a private plan through an insurance-exchange doesn't make coverage affordable. Under Massachusetts' 2006 reform, the health exchange adds a 4% administrative surcharge to every policy it brokers (on top of private insurers' already high overhead). For a 58-year-old, the cheapest coverage available costs more than $4,872 annually, with a $2,000 deductible, and steep co-payments after that. Under the widely touted federal employees health benefit exchange (FEHBP), government picks up 75% of the cost of coverage, yet 230,000 federal workers remain uninsured because costs are so high.

D. Adding the option to purchase a public plan like Medicare will merely replay the disastrous Medicare HMO experience. For the past 20 years Medicare patients have been allowed to opt for the traditional Medicare program or enrollment in a private plan paid for by Medicare. This option was supposed to stimulate competition and lead to improved efficiency. Instead, the

private plans have used every trick in the book to undermine real competition and drive up costs – e.g. selectively recruiting healthy, profitable patients while leaving the sick and expensive ones to Medicare; and successfully lobbying Congress to add extra payments to prop up the private plans. The GAO estimates that private plans cost Medicare an extra $8.5 billion in 2008, raising premiums for all Medicare recipients (not just those enrolled in private plans) and depleting the Medicare Trust Fund.

2. Send the Transition Team a clear pro-single-payer message. The questions circulated to Community Discussion Participants are too narrowly framed, excluding single payer – the only really viable option for reform.

A. Ask for discussion of: "How important is it to you that private health insurance companies continue to play a central role in health care?"

B. Ask others to join in telling the Transition Team that we want to replace private insurers with a single, comprehensive public plan covering all Americans.