



FAQ Supplemental: Alternatives to Single Payer

What about incremental reform of the health system?

As a matter of policy, PNHP expressly opposes many so-called gradual steps towards single payer. Many well-meaning supporters often push these bills as “feasible steps” to move us towards single payer, but the history of these kinds of health reform efforts - Hawaii in 1974, Massachusetts in 1988, Oregon in 1989, Tennessee in 1992, Minnesota in 1992, Maine in 2003, etc. - shows that despite their claims of pragmatism, incremental reforms have consistently failed for more than three decades. Incremental reforms cannot garner administrative savings and redirect them to care. Hence they always founder on the shoals of cost. In addition, these reforms distract attention from the economically realistic, if politically challenging, option of single-payer reform.

Can the ACA exchanges serve as a stepping stone to single-payer reform?

A properly structured single-payer system is administratively very simple, requiring little complex bureaucratic infrastructure. Moreover, most of the needed infrastructure already exists within the Medicare program. While Medicare charges copayments and deductibles that should be entirely eliminated, its process to determine covered services (and current list of current services) is generally sound, and there is no reason to reinvent that wheel. The only real work needed on the benefit package is the inclusion of outpatient prescription drugs, long term care, and dental care. For outpatient prescription drugs, some of the Canadian provincial programs have in place reference pricing systems that work well and should be copied.

Most of the complexity regarding the benefit package derives from the impulse to charge (and hence determine the levels of and exemptions from) copayments and deductibles. Such charges are highly regressive (i.e. they take a far larger share of the income of the poor than of the rich); discourage needed and unneeded care to the same degree; and do not result in system-wide savings since providers increase the care provided to the wealthy to make up for lost income due to reductions in care for the poor. This was clearly demonstrated in both Quebec and Manitoba, where the abolition of out-of-pocket payments resulted in virtually no overall cost increase, just a shift of care from the healthy and wealthy to the sick and poor. Moreover, the institution of copayments in Manitoba (when a Conservative government came to power) resulted in no net savings. Limiting the supply of expensive testing equipment, inpatient beds, and specialists has been the key to cost containment in successful single-payer systems.

Adopting a Blue Cross or other private insurer’s benefits package would be a serious error. Our studies (together with Elizabeth Warren) have found that three quarters of those bankrupted by

illness or medical bills were privately insured. Since Blue Cross was the dominant insurer in several of the states we have studied, it is clear that its benefit package left a very large number of its enrollees vulnerable to medical bankruptcy.

Medicare also provides a simple model for the enrollment process. It uses the Social Security records to identify all eligible persons. Since Social Security maintains current addresses for registered individuals, gleaming a list of the vast majority of state residents eligible for a state single-payer system should be simple, leaving only the task of enrolling the relatively small number of individuals without Social Security numbers.

Paying providers should also be simple if a single-payer plan is properly structured, and here too Medicare provides much of the needed infrastructure. Medicare has collected detailed financial data for decades from every hospital, home care agency, and dialysis center. Hence, determining these institutions’ global budgets should be a fairly simple matter. Virtually every outpatient fee-for-service provider also has a UPIN number. Of course, Medicare also has an extensive infrastructure for disbursing payments to fee-for-service providers. So the only substantive administrative task needed to implement a single-payer system on the outpatient side is revising Medicare’s fee schedule. It is only the introduction of complex, untested, and highly questionable new payment strategies that demands a large new administrative effort. ACO-type payment schemes are already triggering a sharp upswing in these costs.

Some have suggested that implementation of Canada’s provincial programs would have been faster had they laid the groundwork in advance using structures like the ACA exchanges. History suggests that this is a curious claim. Saskatchewan’s medical care legislation was passed in November of 1961 and initially scheduled for implementation on April 1, 1962. Implementation was delayed until July 1, 1962, but resistance from physicians (and an eventual physician strike) caused the delay, not any lack of administrative infrastructure. How much faster than five months could this program have been implemented? The situation was similar in other provinces, where any delays in implementation were largely attributable to physician and business opposition rather than administrative difficulties. Experience with the implementation of U.S. Medicare is also apropos. That program went live about nine months after its passage, and implementation required inspections of all hospitals to assure their compliance with desegregation, and did not enjoy the advantage of a pre-existing Medicare infrastructure that we have today.

Others have suggested that Switzerland and Germany can provide useful expertise in this stage of health reform, and that their systems provide possible models of a bridge to single payer. Switzerland and Germany have among the highest administrative

costs of any health care system besides the U.S. The Swiss system has the highest out-of-pocket costs in the world as well as relatively high overall costs, and studies show a sharp income gradient in access to care, with the poor facing grave difficulties. Far from being a stepping stone to single payer, the Swiss reform was opposed by progressives in that nation who viewed it as a significant backward step from its previous system. Similarly, the German system, in place since the 1880s, is hardly a stepping stone to a single-payer system. On the contrary, it is being invaded by for-profit hospitals and is struggling with costs and administrative complexity.

The notion that the ACA infrastructure provides a useful taking off point for single payer is false. Quite the contrary, as Massachusetts' experience has shown, the exchange introduces additional administrative complexity and cost (a 3% add on to premiums in Massachusetts).

Answer contributed by PNHP co-founders Drs. David Himmelstein and Steffie Woolhandler

Would a “public plan option” at least be a step in the right direction?

Below are two responses to this question written by PNHP leaders while the Affordable Care Act was being debated in 2009 (and the public option was still considered a possibility). For more information on how this policy falls short, visit pnhp.org/PublicOption.

I am not convinced that it is fair to call the “public plan option” (aka Jacob Hacker’s proposal) “a move in the right direction.”

In the best case scenario this proposal would, I believe, accelerate the trend towards two-tiered care in our country. But we should recognize first that MoveOn and its friends are suggesting scenarios, not backing a specific proposal. The “public plan option,” as yet, amounts to no more than talking points, with some therefore ungrounded assertions along the lines of the quotes by Dr. Howard Dean. (Single payer advocates in contrast have been winning support for legislation — H.R. 676 in the house and now a bill in the Senate, introduced by Senator Sanders.)

If these “public plan option” talking points are intended as a wedge for single payer against private insurance, we should see that they are also a wedge for private health insurance against single payer, the program of national health insurance that the large majority have been shown to want in poll after poll. Single payer has been dismissed by Dr. Dean and many other leading Democrats as “not politically feasible.” Indeed, the “public option” notion grew out of this very idea — the assumption that the insurance industry is too powerful, that we will always have private health insurance.

When Dean and others insist on the “choice” of insurer, they insist upon the “choice” of “keeping the insurance you have” — let’s keep the insurance business and its market, they assert. But the purpose of private health insurance and its market are the opposite of social responsibility — and individual responsibility too.

Choice of insurance companies only matters because it restricts choice in care. What matters for our health is choice among caregivers, choice in location of care. The very purpose of the insur-

ance market is to restrict these choices and by doing so extract money from the health care system. “Adverse selection,” the name of the game of health insurance business success, is a reason why we should abolish health insurance as a business. Keeping that market offers the industry plenty of what has been called “protection.”

The insurance companies know all about how to keep the healthy and wealthy while showing the sick and the poor the “choice” of another plan. That is why the insurance industry lately has offered to move to community rating — if only the government will criminalize the uninsured and mandate the purchase of health insurance.

Getting back to one of the scenarios — the “choice” of buying Medicare, the “option” of paying health insurance premiums to a government entity (1) will not guarantee health care to all (as Dr. Dean asserts) and (2) will not be sustainable due to cost. Hundreds of billions of additional dollars annually will not be sustainable — on top of 2.5 trillion dollars, on top of spending that is twice what any nation spends per person. That is why Mr. Obama called \$600 billion over 10 years a “down payment.”

In another scenario, Senator Baucus, leader of the bipartisan “board of directors” who are working this out behind closed doors has suggested that the “public option” will be the chance to buy insurance through Federal Employee Health Benefit Program, something candidates Clinton and Obama discussed. These are (1) administered by the insurance industry and (2) way out of reach for the uninsured and underinsured, thus would at least require colossal government subsidy, way beyond the \$600 billion “down payment.” Baucus also supports a “mandate” that criminalizes the uninsured.

The “public plan option” will not expand our choice of caregivers, will not be universal, cannot offer comprehensive care (and thus cannot lessen disparities in care or improve quality) — and above all there will be no way to pay for it, especially as the economy continues to tank. We should conclude that it is not reform!

We should also recognize, with confidence in people to decide and act for themselves, that the single-payer cause is growing into a mass movement for civil rights. We may not be likely to win single payer this spring, but as the only proposal for health reform that will save hundreds of billions of dollars annually, and that is comprehensive and just and practical, our prospects will continue to brighten, no matter what inside-the-beltway compromise people like Dr. Dean ultimately recommend we make with the insurance industry.

Answer contributed by PNHP past president Dr. Andy Coates

The option to purchase a public plan within a market of private health insurance plans would merely provide one more player in our inefficient, dysfunctional, fragmented, multi-payer system of financing health care; that is if the public option even survives the political process. It would leave in place the deficiencies that have resulted in very high costs with the poorest health care value of all nations (i.e., overpriced mediocrity in health care).

Those who believe that the people of this nation would have the wisdom to drop their private plans and join the government

program are ignoring history. When Congress authorized private plans to compete with our existing public program, Medicare, many enrollees did just the opposite. One-fifth have left the traditional Medicare program and joined the private plans.

So why should we care? Why shouldn't they have the right to choose private plans if they want them? We know that those private plans are wasting money, both in their own costs and the administrative burden they place on the delivery system, but what all too many don't realize is that we are all paying for that waste because of the inherent structural deficiencies in our financing system. Plus, we are being deprived of the reforms needed in our health care delivery system that our own single-payer monopsony would bring us.

Single payer activists, don't give up. As President Obama said in his press conference this week, "persistence!"

Answer contributed by PNHP senior policy fellow Dr. Don McCann

Why not MSAs/HSAs?

Medical savings accounts (MSAs) and similar options such as health savings accounts (HSAs) are individual accounts from which medical expenses are paid. Once the account is depleted and a deductible is met, medical expenses are covered by a catastrophic plan, usually a managed care plan.

Individuals with significant health care needs would rapidly deplete their accounts and then be exposed to large out-of-pocket expenses; hence they would tend to select plans with more comprehensive coverage. Since only healthy individuals would be attracted to the MSAs/HSAs, higher-cost individuals would be concentrated in the more comprehensive plans, driving up premiums and threatening affordability. By placing everyone in the same pool, the cost of high-risk individuals is diluted by the larger sector of relatively healthy individuals, keeping health insurance costs affordable for everyone.

Currently, HSAs offer substantial tax savings to people in high-income brackets, but little to families with average incomes, and thus serve as a covert tax cut for the wealthy.

Moreover, MSA/HSA plans discourage preventive care, which generally would be paid out-of-pocket, and do nothing to restrain spending for catastrophic care, which accounts for most health costs. Finally, HSAs/MSAs discriminate against women, whose care costs, on average, \$1,000 more than men's annually. Hence, on the MSA/HAS plan, the average woman pays \$1,000 more out-of-pocket than her male counterpart.

What is a voucher plan? What's wrong with it?

A voucher plan is a version of health reform that seeks to provide a simplified means for individuals to purchase health insurance, while retaining the private insurance system intact. The principal advocates of this plan are Ezekiel Emanuel, a bioethicist now serving as one of President Obama's principal advisors on health care reform, and Victor Fuchs, a retired economist from Stanford University. Under this plan, individuals would be given

a health care certificate (an insurance "voucher") which would entitle them to enroll in a private health plan of their choice. Employer-based insurance would be eliminated. The vouchers would, under the Emanuel-Fuchs plan, be paid for through a value-added tax (VAT), essentially a sales tax on all manufactured goods and services. This is a highly regressive way of financing such a plan, since low-income people spend a much larger percentage of their income on purchases of goods and services than do higher-income people. However, the main problem with such a plan is that it leaves the wasteful, inefficient, and inequitable private insurance system in place, with no change at all in its operation. It simply makes it easier for us to purchase their defective product.

Answer contributed by Len Rodberg, Ph.D.

What is PNHP's response to libertarian proposals for health savings accounts and deregulated insurance plans?

In response to the libertarian view: 1) We are already spending more than enough to provide all necessary health care services to everyone, and 2) The majority of Americans believe that everyone should be able to obtain necessary health care without having to face financial hardship.

The goal then is not only to have everyone covered with insurance, but also to make sure that insurance is effective in preventing the consequences of medical debt. We have a rapidly expanding epidemic of underinsurance, and the proposals of libertarians would expose the majority of us to the potential of excessive medical debt were we to develop significant medical problems. Policies with affordable premiums work for those who remain healthy, but most of health care spending is for those with major acute and chronic problems. The deregulated insurance plans and HSAs proposed by libertarians cannot ever effectively address the problem of how we are going to pay for most of the health care in this nation.

The most efficient and effective system would be to establish a single risk pool covering everyone, and fund it equitably. The libertarians do have a problem with "equitable." That would require a transfer from the healthy to those with greater health care needs. But the United States has an additional unique problem. Since we spend twice as much per capita as the average industrialized nation, each person's share (national health expenditures divided by the U.S. population) is no longer affordable. For a family of four, that would be over \$30,000 when median household income is about \$50,000. So an equitably financed system in the United States would also require a transfer from wealthier individuals to the majority of us. Libertarians and egalitarians will never agree on the appropriate course. All other nations tend towards an egalitarian approach.

The World Health Report 2008, published by the World Health Organization, singles out the United States for its exceptionalism - a system with "singularly high additional private expenditure" that persistently underperforms "across domains of health outcomes, quality, access, efficiency, and equity."