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Physicians for a National Health Program analyzed a recent health care proposal from the Center for American Progress (CAP), called "Medicare Extra for All." Click here for a side-by-side comparison of CAP and single payer. Below we identify three major flaws in the CAP plan that would undermine its stated goal of providing universal coverage to all Americans.

1) The CAP plan would perpetuate a role for private insurers, adding complexity and cost.

In addition to public Medicare, the CAP plan preserves employment-based health plans and adds private Medicare "Choice" plans, modeled on today's privatized Medicare Advantage plans. The persistence of multiple payers would require hospitals and physicians to maintain today's complex billing and cost-tracking bureaucracies. Only a single-payer system would allow Medicare to pay hospitals global operating budgets rather than on a per-patient basis, which could save more than $150 billion annually on hospital administration. CAP's multi-payer system would also hobble efforts to streamline physicians' billing, documentation and coding, foregoing another $75 billion or more in annual savings. Additional health care dollars would be wasted on private insurers' overhead, which runs about 15-20 percent, compared to about 3 percent for traditional Medicare and 2 percent in Canada. Strikingly, despite having far higher overhead and limiting patients' choice of providers, Medicare Advantage plans have been able to outcompete traditional Medicare by cherry picking profitable patients, avoiding unprofitable ones, upcoding, and cheating on quality measures. Under the CAP plan, traditional Medicare would become a defacto high-risk pool that assumed the insurance losses, while private insurers took the profits.

2) The CAP plan would do nothing to enhance health planning.

A fractured, multi-payer system like CAP's precludes the implementation of effective of health planning that can target investments in new or upgraded facilities according to community needs, and can prevent the wasteful duplication of expensive high-tech facilities. Under a single-payer plan like H.R. 676, hospitals would be paid global operating budgets, and would be forbidden from retaining surplus operating funds for new investments. New capital investments would be funded by explicit grants based on need. That's how we allocate investments in most other public services such as the military, schools and fire departments, and how nations such as Canada and Scotland (as well as our VA system) fund hospital investments. In contrast, the CAP plan would allow profitable hospitals to continue to expand and modernize, investing in profitable but unneeded services that encourage the delivery of low-value care. Unprofitable hospitals would shrivel, even those in areas with a shortage of medical facilities.

3) The CAP plan would leave millions of people saddled with high copayments and deductibles.

Although the CAP has not specified the the amount of copays and deductibles required in its plan, for most people the plan would cover only 80 percent of their medical costs. That's worse coverage than current large employer plans, which cover an average of 85.4 percent of an employee's health care costs. Many employers with high-cost (e.g. older and sicker) employees would surely choose to dump their current expensive coverage, forcing workers into the Medicare "Extra" plan with higher out-of-pocket costs. Meanwhile, insurers would offer attractive premium rates to employers with young, healthy workers. As a result, many older and sicker workers would see their coverage deteriorate, while only the young and healthy would continue to enjoy "Cadillac" coverage. In contrast, a single-payer plan would use the massive administrative savings to offer universal, first dollar ("Tesla level") coverage.

Abolishing copays and deductibles is both good politics and good policy. Cost sharing is often framed as a way to control costs by forcing patients to have "skin in the game," but even relatively modest copays deter patients from seeking needed medical care. In the Rand Health Insurance Experiment, copays reduced the use of highly effective care for acute conditions such as chest pain, urinary tract infections and fractures by 29 percent, and reduced prescriptions for several potentially life-saving medications such as insulin, asthma inhalers, and beta blockers by about 50 percent. When Medicare added new copays, outpatient visits dropped, but hospitalizations rose. Recent studies have also found that copays deter patients from taking essential medications after suffering a myocardial infarction (MI), raising their risk of recurrent cardiovascular events; cause patients suffering an MI to delay seeking emergency care; and decrease kids' use of outpatient asthma medications and ultimately increase their hospitalization rates.

International evidence indicates that cost sharing is neither necessary nor effective for cost control: When Canada outlawed copays and deductibles in 1981, it experienced no surge in care, and has seen both faster health improvement and slower cost growth than in the U.S. Patient cost sharing would also diminish the administrative savings achievable through single payer system. The CAP plan would require a massive Medicare bureaucracy to track individuals' changing incomes and family status and collect premiums.