



## Single Payer Health Insurance: Frequently Asked Questions

### Is national health insurance “socialized medicine”?

No. Socialized medicine is a system in which doctors and hospitals work for the government and draw salaries from the government. Doctors in the Veterans Administration and the Armed Services are paid this way. Examples also exist in Great Britain and Spain. But in most European countries, Canada, Australia and Japan they have socialized financing, or socialized health insurance, not socialized medicine. The government pays for care that is delivered in the private (mostly not-for-profit) sector. This is similar to how Medicare works in this country. Doctors are in private practice and are paid on a fee-for-service basis from government funds. The government does not own or manage their medical practices or hospitals.

The term socialized medicine is often used to conjure images of government bureaucratic interference in medical care. That does not describe what happens in countries with national health insurance. It does describe the interference by insurance company bureaucrats in our health system.

### Won't this raise my taxes?

Currently, about 64% of our health care system is financed by public money: federal and state taxes, property taxes and tax subsidies. These funds pay for Medicare, Medicaid, the VA, coverage for public employees (including teachers), elected officials, military personnel, etc. There are also hefty tax subsidies to employers to help pay for their employees' health insurance. About 17% of health care is financed by all of us individually through out-of-pocket payments, such as co-pays, deductibles, the uninsured paying directly for care, people paying privately for premiums, etc. Private employers only pay 19% of health care costs. In all, it is a very “regressive” way to finance health care, in that the poor pay a much higher percentage of their income for health care than higher income individuals do.

A universal public system would be financed this way: The public financing already funneled to Medicare and Medicaid would be retained. The difference, or the gap between current public funding and what we would need for a universal health care system, would be financed by a payroll tax on employers (about 7%) and an income tax on individuals (about 2%). The payroll tax would replace all other employer expenses for employees' health care. The income tax would take the place of all current insurance premiums, co-pays, deductibles, and any and all other out of pocket payments. For the vast majority of people a 2% income tax is less than what they now pay for insurance premiums and in out-of-pocket payments such as co-pays and deductibles, particularly for anyone who has had a serious illness or has a family member with a serious illness. It is also a fair and sustainable contribution. Currently, over 41 million people have no insurance and thousands of people with insurance are bankrupted when they have an accident or illness. Employers who currently offer no health insurance would pay more, but they would receive health insurance for the same low rate as larger firms. Many small employers have to pay 25% or more of payroll now for health insurance – so they end up not having insurance at all. For large employers, a payroll tax in the 7% range would mean they would pay less than they currently do (about 8.5%). No employer, moreover, would hold a competitive advantage over another because his cost of business did not include health care. And health insurance would disappear from the bargaining table between employers and employees.

Another consideration is that everyone would have the same comprehensive health coverage, including all medical, hospital, eye care, dental care, long-term care, and mental health services. Currently, many people and businesses are paying huge premiums for insurance that is almost worthless if they were to have a serious illness.

### Won't this result in rationing like in Canada?

The U.S. Supreme Court recently established that rationing is fundamental to the way managed care conducts business. Rationing in U.S. health care is based on income: if you can afford care you get it, if you can't, you don't. A recent study by the prestigious Institute of Medicine found that 18,000 Americans die every year because they don't have health insurance. That's rationing. No other industrialized nation rations health care to the degree that the U.S. does.

If there is this much rationing why don't we hear about it? And if other countries do not ration the way we do, why do we hear about them? The answer is that their systems are publicly accountable and ours is not. Problems with their health care systems are aired in public, ours are not. In U.S. health care no one is ultimately accountable for how it works. No one takes full responsibility.

The rationing that takes place in U.S. health care is unnecessary. A number of studies (notably the General Accounting office report in 1991, and the Congressional Budget office report in 1993) show that there is more than enough money in our health care system to serve everyone if it were spent wisely. Administrative costs are far higher in the U.S. than in other countries' systems. These inflated costs are directly tied to our failure to have a publicly-financed, universal health care system. We spend at least twice more per person than any other country, and still find it necessary to deny health care.

## **Who will run the health care system?**

There is a myth that, with national health insurance, the government will be making the medical decisions. But in a publicly-financed, universal health care system medical decisions are left to the patient and doctor, as they should be. This is true even in the countries like the UK and Spain that have socialized medicine.

In a public system the public has a say in how it's run. Cost containment measures are publicly managed at the state level by an elected and appointed body that represents the people of that state. This body decides on the benefit package, negotiates doctor fees and hospital budgets. It also is responsible for health planning and the distribution of expensive technology.

The benefit package people will receive will not be decided upon by the legislature, but by the appointed body that represents all state residents in consultation with medical experts in all fields of medicine.

## **What about medical research?**

Much current medical research is publicly-financed through the National Institutes of Health. Under a universal health care system this would continue. A great deal of drug research, for example, is funded by the government. Drug companies are invited in when it comes to marketing successful new drugs. AZT for HIV patients is one example. All the expensive clinical trials were conducted with government money. When it was found to be effective, marketing rights went to the drug company. (This is a controversial practice because it means pharmaceutical companies enjoy significant profits on the back of taxpayer-financed research.)

Medical research does not disappear under universal health care system. Many famous discoveries have been made in countries that have national health care systems. Laparoscopic gallbladder removal was pioneered in Canada. The CT scan was invented in England. The new treatment to cure juvenile diabetics by transplanting pancreatic cells was developed in Canada.

It is also important to note that studies show that the number of clinical research grants declines in areas of high HMO penetration. This suggests that managed care increasingly threatens clinical research. Another study surveyed medical school faculty and found that it was more difficult to do research in areas with high HMO penetration.

## **Won't this just be another bureaucracy?**

The United States has the most bureaucratic health care system in the world. Over 24% of every health care dollar goes to paperwork, overhead, CEO salaries, profits, and other non-clinical costs. Because the U.S. does not have a system that serves everyone and instead has over 1,500 different insurance plans, each with their own marketing, paperwork, enrollment, premiums, rules, and regulations, our insurance system is both extremely complex and fragmented. The Medicare program operates with just 3% overhead, compared to 15% to 25% overhead at a typical HMO.

It is not necessary to have a huge bureaucracy to decide who gets care and what care they get, if and when everyone is covered and has the same comprehensive benefits. With a universal health care system we would be able to cut our bureaucratic burden in half and save nearly \$150 billion per year.

## **How will we keep costs down if everyone has access to comprehensive health care?**

People will seek care earlier when diseases are more treatable (and affordable). We know that the uninsured delay or avoid seeking care because they are afraid of health care bills. This will be eliminated under such a system. Undoubtedly costs of taking care of the medical needs of people who are currently doing without will cost more money in the short run. But we will be spending proportionately less on administration to compensate.

In the long run, the best way to control costs is to negotiate fees and budgets with doctors, hospitals, and drug companies and to set and enforce an overall budget.

### **How will we keep doctors from doing too many procedures?**

This is a problem in systems that reimburse physicians on a fee-for-service basis. In today's health system, another problem is physicians doing too little for patients. So the real question is, "how do we discourage both overcare and undercare"? One approach is to compare physicians' use of tests and procedures to their peers with similar patients. A physician who is "off the curve" will stand out. Another way is to set spending targets for each specialty. This encourages doctors to be prudent stewards and to make sure their colleagues are as well, because any doctor doing unnecessary procedures will be taking money away from other physicians in the same specialty. Another way is to continue to develop expert guidelines by groups like the American College of Physicians, etc. to shape professional standards – which will certainly change over time as treatments change. This really gets to the heart of "how do you improve the quality of health care" which is a longer topic. Suffice it to say that universal coverage is a pre-requisite for quality improvement.

### **What will happen to physician incomes?**

On the basis of the Canadian experience, average physician incomes should change little. However, the income disparity between specialties is likely to shrink.

The drop in income that a physician might experience under a single-payer system could be mitigated by a drastic reduction in office overhead and malpractice costs. Billing would involve imprinting the patient's national health program card on a charge slip, checking a box to indicate the complexity of the procedure or service, and sending the slip (or a computer record) to the physician-payment board. This simplification of billing would save thousands of dollars per practitioner in annual office expenses.

### **How will we keep drug prices under control?**

When all patients are under one system, they wield a lot of clout. The VA can purchase drugs for 40% discounts because they are a bulk purchaser. This is called monopsony buying power and it is the main reason why other countries' drug prices are lower than ours. The same could happen with medical supplies and durable medical equipment.

### **Why shouldn't we let people buy better health care if they can afford it?**

Whenever we allow the wealthy to buy better care or jump the queue, health care for the rest of us suffers. One need only look at the example of the nation's health insurance program for the poor, versus the National Naval Medical Center in Bethesda, MD, that serves members of Congress. Access to care for the poor is deteriorating because Medicaid is a grossly underfunded health care program. Because it doesn't serve the wealthy, the payment rates are low and many physicians refuse to see Medicaid patients. Calls to improve Medicaid fall on deaf ears because the beneficiaries are not considered to be politically important. On the other hand, members of Congress have completely free access to care at National Naval, where the quality of care couldn't be better.

### **What will be covered?**

All medically necessary care, including doctor visits, hospital care, prescriptions, mental health services, nursing home care, rehab, home care, eye care and dental care.

### **What about alternative care, will it be covered?**

Alternative care that is proven in clinical trials to be effective will be covered. For example, spinal manipulation for some back conditions. Other treatments will be decided by the health care planning board or other public body. New kinds of treatments will be added to the benefits package over time as they are shown to be effective, including "alternative" treatments. Similarly, ineffective, harmful, or wasteful care can be removed from the benefits package, such as funding for a costly medication that is no better than aspirin for arthritis.

### **Isn't a payroll tax unfair to small businesses?**

The payroll tax is more costly to businesses who are not currently insuring their workers. However, it is much less THAN what they would pay for good private insurance for themselves and their workers. For most of the small businesses already providing coverage, the payroll tax will be much less expensive than what they are paying now.

Ideally, the payroll tax will be replaced in the future by a tax that doesn't charge an administrative assistant making \$17,000 a year the same percentage of salary as a CEO earning \$175,000 a year.

## Can a business keep private insurance if they choose?

Yes and no. Everyone has to be included in the new system for it to be able to control costs, reduce bureaucracy, and cover everyone. However, business and anyone who wants to can purchase additional private insurance that covers things not covered by the national plan (e.g. cosmetic surgery, orthodontia, etc.).

Insurance companies will no longer be needed to decide who gets medical care and what kind of medical care, and would not be allowed to offer the same benefits as the universal health care system. Any allowance for this would weaken and eventually destabilize the health care system. It would undermine the principle of pooling the risk. Health care systems act as universal insurers. At any one time the healthy help pay for those who are ill. If private insurers are allowed to cherry pick the healthy, leaving the public health care system with the very sick, the system cannot help but fail. This is part of what is happening in U.S. health care now.

Another reason is that, if allowed, patients would enroll in the private system while they were healthy (and their premiums were low), and enroll in the public system when their care (and private premiums) became expensive. This, in fact, is what we saw happen to Medicare and HMOs. There, patients needing expensive care, e.g., a hip replacement, were encouraged to drop out of their HMO so traditional Medicare would pick up the tab. However, while they are healthy they enroll in the HMO for the modest additional dental and drug benefits.

## What will happen to all of the people who work for insurance companies?

The new system will still need people to administer claims. Administration will shrink, however, eliminating the need for a large bureaucracy. The focus will shift to those who deliver health care. More health care providers, especially in the field of long-term care and home health care, will be needed, and many insurance clerks can be retrained to enter these fields. Many people now working in the insurance industry are, in fact, already health professionals (e.g. nurses) who will be able to find work in the health care field again.

## How will we contain costs with the population aging and the advent of expensive technology?

Japan and Europe are already facing this problem head-on and doing fine. They have a much higher percentage of elderly than we do, and still spend less on health care by far.

The best way to approach this is to regard it as a societal problem, one that needs a solution with everyone in mind. Germany and Japan recently adopted single-payer long-term care systems to cover the long-term care needs of the elderly at home and in specialized housing. Germany is pioneering a program that pays family members to care for the elderly at home. That's family values!

## What about ERISA? Doesn't it stand in the way of implementing a universal health care plan?

No. ERISA (the Employees Retirement Income Security Act) prevents a state from requiring that a self-insured employer provide certain benefits to their employees. However, a single payer plan would not mandate the composition of employer benefit plans – it would replace them with a new system that would essentially be “Medicare for All”. The state would require employers to pay a payroll tax into the health care trust fund. This is legal and is done now with taxes levied to pay for Medicare.

## How will the Health Planning Board operate?

In Vermont, it would work something like this: The health planning board (the Health Care Administration) would be a public body with representatives from every legislative district. The representatives would be appointed by each member of the state house of representatives. The state would be divided into 7 regions. The appointed members from each region would elect one person among them to serve on the health planning board. The board would consult regularly with a medical expert advisory committee. The latter would advise the regional board members on what treatments, medications and services should be covered, decisions supported by medical science.

Since we could finance a fairly good system, like the Norwegian, Danish or Swedish system with the public money we are already spending (60% of health costs), why do we need to raise the additional 40% (from employers and individuals)?

There are three reasons why the U.S. health care system costs more than other systems throughout the world. One, we spend 2-3 times as much as they do on administration. Two, we have much more excess capacity of expensive technology than they do (more CT scanners, MRI scanners, mammogram machines than we need). Three, we pay higher prices for services than they do. There is no doubt that we do not need to spend more than we currently spend to cover comprehensive care for everyone. But it would make the transition to a universal system very difficult at first if we spent less. That is because we have a tremendous medical infrastructure, some of which would likely retain its slightly larger than necessary capacity during the transition phase. Secondly, we would likely retain salaries for health professionals at

their current levels. Thirdly, we would cover much more than most other countries do by including dental care, eye care, and prescriptions. And for these reasons we would need the extra 40% that we are already spending – but NOT more. We could cover all the uninsured for the same amount we are currently spending!

## **How much of the health care dollar is publicly financed?**

Previous calculations of the percentage of the health care dollar that is publicly financed were estimated to be around 50%. That was from federal and state taxes to fund Medicare, Medicaid and the VA. 30% was out-of-pocket and 20% from employers.

Estimates differ depending on how they factor in certain costs. For example, recent studies put the tax subsidy offered to employers into the public spending column. A tax subsidy to help employers buy health insurance for employees means the public helps pay the bill. Another factor is that many employees pay the full cost of the premiums for their health insurance at work – not the employer. Newer analyses of these factors put the public financing estimate at 60%, out-of-pocket at 17% (for uncovered services, premiums not paid for by an employer) and employers' contributions at 19%.

(Woolhandler and Himmelstein, Health Affairs, 2002, 21(4), 88, "Paying for National Health Insurance—And Not Getting It,")

## **Why not MSAs?**

Medical savings accounts (MSAs) and similar options such as health reimbursement arrangements are individual accounts from which medical expenses are paid. Once the account is depleted and a deductible is met, then medical expenses are covered by a catastrophic managed care plan, usually a restricted PPO plan. Individuals with significant health care needs may rapidly deplete their accounts and then be exposed to large out-of-pocket expenses. They would tend to select plans with more comprehensive coverage. Since only healthy individuals would be attracted to the MSAs, 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. Also, since healthy individuals cannot possibly predict whether or when they would develop significant health care needs, they would eliminate that potential financial risk by being included in the comprehensive pool with everyone else.

## **Why not use tax subsidies to help the uninsured buy health insurance?**

The major flaw of tax subsidies is that they would be used to help purchase plans in our current fragmented system. The administrative inefficiencies and inequities that characterize our system would be left in place, and we would continue to waste valuable resources that should be going to patient care instead. In spite of tax subsidies, moderate and lower income individuals would be able to afford only those plans with very modest benefits, and with higher cost sharing that might make health care unaffordable. Instead of perpetuating our current inequities, tax policies should be used to create equity in contributions to a system in which everyone is assured access to comprehensive beneficial services.

If the tax subsidies are granted to individuals, employers would be motivated to drop their coverage, and most individuals covered would have merely rotated from employer coverage to individual coverage. The net reduction in the numbers of uninsured would be close to negligible. If the tax subsidies are granted to employers, a major shift in funding passes from employers to taxpayers without significant improvements in the inefficiencies and inequities of our current system. We can use the tax system to create equity in the way we fund health care, but we should also expect equity and efficiency in allocation of our health care resources. That is possible only if we eliminate the private health plans and establish our own publicly administered system.

## **Won't competition be impeded by a universal health care system?**

Advocates of the free market approach to health care claim that competition will streamline the costs of health care and make it more efficient. What is overlooked is that competitive activities in health care under a "free market" system have been wasteful and expensive and can be blamed for raising costs. Not only have they NOT contained costs, they have raised costs. In fact it has been shown that in some states where competition among insurers and HMOs is fiercest, such as California, costs are higher than the national average.

There are two main areas where competition exists in health care. Among the providers, and among the payers. When, for example, hospitals compete they often duplicate expensive equipment in order to corner more of the market. This drives up overall medical costs to pay for the equipment. They also waste money on advertising and marketing. The preferred scenario has hospitals coordinating services and cooperating to meet the needs of the public.

Competition among medical care providers can be beneficial in terms of improving the quality of medical care. Take for example, three primary care doctors in a certain area “competing” for patients for which they will receive equal reimbursement from every patient. The doctor who is most competent in different areas will attract the most patients in that area. One doctor may make house calls to see the elderly. Another may be very good at mental health care. This is competition based on quality not on price. Competition among insurers (the payers) is not effective in containing costs either. Rather, it results in competitive practices resorted to by private payers such as avoiding the sick, cherry picking, denial of payment of expensive procedures, marketing, etc.

## **Why not make people who are Higher Risk pay Higher Premiums?**

Experience rated insurance requires higher risk people to pay higher premiums. This approach says that people who have had cancer or other problems in the past, or who have chronic conditions like diabetes and hypertension, must pay more because they are at higher risk of getting cancer again or having a stroke or other health problem. Experience rating allows insurance companies to “cherry pick” the healthiest people and either refuse to insure the sickest or, what amounts to the same thing, charge prohibitively high rates. This approach makes no sense. The whole point of insurance is to spread the risk so that everyone is covered. If you raise premiums – and thereby exclude from coverage – those people unfortunate enough to have been sick in the past, you defeat the point of both insurance and the health care system. Genetic conditions, childhood diseases, accidents, injuries and income distribution (or how much equality there is in a society) play a much bigger role in people’s health than so-called “lifestyle” factors. It costs much less to care for a smoker than a driver who has a paralyzing accident. (Of course, we need public health and education programs to try to prevent both!).

Community rated health insurance is the socially fair approach. It spreads the risks evenly among all the insured. It removes the punitive element. It does not discriminate against the very sick, nor against those of us who are at higher risk because of our age (say, over 50) or our gender (females have higher health expenses in their 20’s and 30’s than men do).

It appears that for what should be a broad social service an insurance-based approach does not work. For it to work at all society is asked to surrender all control of the system and what is left is both discriminatory and unaccountable to anyone. At some point in our lives all of us without exception have needed or will need some level of health care. Health insurance is unlike any other form of insurance. We all are involved in it. It is profoundly intertwined with social principles of decency and fairness. A system that punishes the sick is neither. Any reform of the health care system must begin from a principled approach.

## **Walter Reed Army Medical Center has been in the news lately for poor care and treatment of returning soldiers from Iraq. Won’t national health insurance have similar problems?**

As we consider what we can learn from the Walter Reed Army Medical Center debacle with regard to government-run efforts, some clarifications should be made:

- Walter Reed Army Medical Center is an Army hospital and is run by the Department of Defense. The VA hospitals are run by the Veterans Administration (Veterans Health Administration) and are a separate structure. The reporting in the news media has clouded this fact and has led the public to presume that all government-run health efforts should be tarred and feathered and run out of town. Nevertheless, the VA health system continues to hold the position of the US health system with the most satisfied patients and one of the highest quality ratings for its use of information systems, access of patients to their medical records, transparency and accountability programs for dealing with medical errors, application of AHRQ quality guidelines to patient care for both inpatients and outpatients, and it won the Baldrige Prize (2004) for quality and patient-safety improvements.
- There is a lot we can learn from the Walter Reed disgrace. Its operation was outsourced to a Halliburton-connected company in 2002, over the objections of some Army medical personnel and leadership, with a subsequent loss of government employees with institutional experience and a drastic reduction in staff. There was also some hanky-panky with the contracting process when the government employees’ bid for the operations contract came in lower than the Halliburton company’s bid, and the bids were subsequently “recalculated” to make the private company the lowest bidder. Here is a link to an eye-opening article:

“Bush Administration push for privatization may have helped create Walter Reed ‘disaster’”

This article has links to Rep. Waxman’s letter to the Army generals and to the Army Times article that “connects the dots”. (contributed by Dr. Anne Carroll)

## **What about incremental reform of the health system?**

As a matter of policy, HCFAT expressly opposes what are sold as “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 all their claims of pragmatism, incremental reforms have failed to shepherd in meaningful reform in more than three decades of trying. In addition, these reforms distract attention away from the real problems, and since they are bound for failure, compromise the ability to enact real reform.

Furthermore, many incremental reforms would expand the private insurance industry, precluding any of the positive aspects of single-payer (administrative savings, global budgeting, cost control, single-tier universal coverage, etc). It is our fear that these bills distract attention away from the real problems and solutions, and would hurt the chances of real reform down the road (as the Clinton plan did to health reform for 15 years.)

## **What happens to investor-owned hospitals under national health insurance?**

“The NHI program would compensate owners of investor-owned hospitals, HMO.s, nursing homes and clinics for the loss of their clinical facilities, as well as any computers and administrative facilities needed to manage NHI. They would not be reimbursed for loss of business opportunities or for administrative capacity not used by NHI”..... “Investor-owned providers would be converted to non-profit status. The NHI would issue long-term bonds to amortize the one-time costs of compensating investors for the appraised value of their facilities. These conversion costs would be offset by reductions in payments for capital that are currently folded into Medicare and other reimbursements.” (Physicians’ Proposal, JAMA, August 13, 2007).

## **What happens to employees of insurance companies under single payer?**

National health insurance would eliminate many administrative and insurance worker positions, necessitating a major effort at job placement and retraining. Many of these displaced workers might be deployed as support personnel to free up nurses for clinical tasks; other might be retrained to staff expanded programs in public health, home care, and the like. (Physicians’ Proposal, JAMA, August 13, 2007).

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