Ideas for the Roadmap to U.S. Single Insurer Health Care

Impossible goals become possible when Americans take back control of vital aspects of their lives from our compromised politicians. And of course, after our loved ones, the most vital aspect of our lives is our health. Right now, our health care system is held hostage to high costs by both a concerted lobbying effort compromising our Congress and disorganized plans for change. So here is the logical extension of a plan to resurrect the U.S. health care ("HC") system from an overly-expensive countrywide plague into an affordable, efficient servant of the people. Private HC insurers are largely responsible for driving up the administrative costs in US HC to 31% of total spending versus half that in other developed countries. So the key element of reform is replacing the inefficient, self-serving private HC insurance companies with an insurance entity that puts patients' medical and financial interests FIRST, as the insurers in other developed countries do.

Buying Out Private HC Insurers

In an article titled "U.S. HC Financing Reform: The Consolidation of the Health Insurance Industry," Dr. Tom Gottlieb and Eldon Van der Wege made us aware of the massive savings to the economy offered by a single insurer HC system and that the logical first step toward creating an efficient single-insurer system would be to buy out and dissolve the existing private HC insurers. They note a conversion to a single insurer system without buying out these insurers would not only subject shareholders and bondholders (representing the savings and retirement plans of ordinary Americans) to unfair financial damage with possible collateral financial market destabilization but would also represent a constitutionally-prohibited Fifth Amendment "takings" of private property. The referenced authors point out that this series of acquisitions of private HC insurers could be done at enterprise value for around $700 billion to generate over $400 billion of annual administrative savings for the country.

Acquisitions are most effective when driven by synergies and efficiencies. A major synergy of the consolidation to single insurer is the creation of one large risk pool to effectively spread costs and thus lower rates; the efficiencies are the use of Medicare's rock bottom 3% overhead and lower negotiated rates with most providers to generate massive annual health care cost reductions in addition to administrative savings. By eliminating private HC insurers, we can create a more efficient insurance entity, a twin of Medicare, for the under 65 age-group, piggybacking on Medicare's country-wide provider agreements and economies of scale. This consolidation of insurers creates a "social insurance" entity, NOT socialized medicine—providers all remain private enterprises.

The second step to reform is to require that everyone participate in at least the minimum level of Medicare-modelled coverage--80% of in-patient and out-patient costs, with supplemental plans and a Medicare-run drug plan available at reasonable cost to provide complete coverage. All must participate because no one is free from medical risks and all benefit from the safety net of the medical infrastructure. With universal coverage, everyone saves from the reduction or elimination of medical coverage in auto insurance, workman's comp and doctor liability insurance.

Financing the Buy-Out and Establishing Medicare E

Funding the private HC insurer buyout could be done with 10-year Treasury bonds which are currently requiring a rate so unusually low as to allow them to be paid off with a modest sum of around $80 billion per year over their term. Furthermore, with medical expenses drastically and uniformly reduced for everyone, the tax deduction for medical expenses could be eliminated. This would raise taxable incomes and thereby tax revenue which would provide much of the funds needed to amortize the bonds and, coincidentally, further motivate universal participation. According to the Congressional Budget

Office, the Federal Government subsidizes private health insurance coverage with tax exclusions, deductions, and credits estimated to cost $300 billion in fiscal year 2016.

Careful consideration needs to be given to the ongoing funding of this nationwide insurance program. Initially, we need to understand that expanded Medicare, call it Medicare E, needs to be funded separately from standard Medicare so as not to disrupt the old system's financing. Some want to soak the rich to pay for Medicare E and others want to soak future generations using debt to pay for it. A responsible and fair alternative financing should incorporate the following concepts: 1) the system should be fully and sustainably funded from a combination of sources, and 2) all beneficiaries of the system should help pay for it if financially able. That means actuarially-sound, income-slanted premiums should form the foundation for funding. Premiums and other fundings will need to be large enough to support subsidies for children and lower income individuals.

Realizing that employers will benefit from both an end to regulations and health benefit costs and gain a healthier and thereby more productive and expanded workforce pool, they should definitely contribute to the funding through something like a payroll tax. Since state governments will shed the medical costs of Medicaid potentially totaling as much as $200 billion/year, these entities should support the system with a sales tax or perhaps by using some of their windfall savings to shoulder the federal portion of their respective state infrastructure costs (a potential solution to Congress's infrastructure financing issues). Ultimately, to determine the fairest way to finance the system (and it should be fully funded with a combination of payments), we should experiment with various funding methods using one of the econometric models currently in existence.

In the conversion, Medicare E will need its own trust fund to keep politicians from misusing the premiums and other new funding sources. To ensure proper management, Medicare E will need a board of trustees free from political manipulation, drawn from sources like the top charitable organizations, medical organizations, GSA, etc. with annual reporting and careful oversight and accountability. The current Medicare board of all Trump appointees is undermining the organization.

Transitioning to Single Insurer

Many have wrestled with how to manage the transition to a single payer system. Sen. Sanders' Senate Bill 1808 envisions a 4-year transition, phasing in coverage for tranches of age groups starting with the oldest. Delaying help for some of those most in need is a cruel way to start to a plan that otherwise has many strong ideas. A better plan would involve several simple steps promoting a rapid roll-out.

The acquisition of U.S. private HC providers will allow the assemblage of them into a giant insurance processing consortium. So instead of a slow 4-year phase-in to Medicare E, a smart plan would use the acquired insurers capabilities to "fast-phase" roll out. Begin by converting their existing customers to Medicare E with adjusted premiums. Use the same capabilities to rapidly enroll the uninsured and under-insured into the same plan with appropriate subsidies. Next, have Medicare E become the insurer for the Medicaid, CHIP and Federal employee populations, even providing the non-trauma coverage for Veterans. Next to last, absorb the private insurance company population into Medicare E and dissolve or, even better, sell off the entities as medical processors NOT insurers. (Note that Medicare E could repurpose parts of the acquired insurers to become private contract processors for Medicare E's outsourced functions.) And finally, incorporate the premiums and employer payments into the tax collection system to simplify the premium collection process. This would also allow the premiums to be fairly slanted upward for higher incomes and ensure that everyone with taxable income pays a reasonable premium. Label the tax a premium to remind people that it will only be used for

health care. Further analysis is required to figure out how to use the additional income taxes raised with the elimination of health care deductions to support Medicare E once bonds are retired.

Benefits of the Reform

Three things make the shift to single payer so financially compelling : 1) eliminating all the marketing, commissions, profit, duplicate managements, IT systems and claim approval bureaucracy of our private insurers, 2) allowing everyone to benefit from Medicare's lower but fair rates paid providers and reduced billing costs, together keeping costs and premiums low, and, 3) spreading the savings from the reform of our inefficient health care system into the pockets of citizens, businesses and local governments in what might be termed a verifiable "trickle-up" economics. Many providers agree that dealing with a single insurer would allow them to cut their billing staffs and costs by half or more and move many nurses out of billing and back to care-giving. Lower provider costs lead to lower medical billings and result in lower premiums, a virtuous cycle. Canadian medical providers have negligible billing costs and pay about one ninth of the amount that US doctors pay for medical liability insurance.

A reliable single-payer insurer may also stem the documented tide of medical graduates avoiding practice in favor of med-tech because of their aversion to a future of having to fight with private HC insurers to get paid for their work. Right-sizing costs will most certainly slow the growing trend of sending patients overseas for expensive treatments—job-killing medical tourism that will devastate hospitals. It should also provide big relief to citizens to see an end to the huge waste of their premium dollars being spent on media advertising rather than their health care.

Of course, as the current drug cost savings of VA and Medicaid demonstrate, allowing Medicare and Medicare E to negotiate drug prices will drop those expenditures of the system by several hundred billion annually. This would also be the time to benefit from the experience of others nations by incorporating the best practices from health care systems around the world. With intelligent reform, we have a chance to make American medical care the best in the world instead of the most expensive.

It should be noted that the elimination of private HC insurers will benefit old Medicare financially in many ways such as disposing of the Medicare Advantage plans which never achieved their purported goal of providing medical insurance cheaper than Medicare. These plans focus on enrolling the healthiest retirees and then subjecting them to narrow networks with a slew of co-pays and approval processes not found in Medicare and Medigap policies. Elimination would save the current $15 billion annual back-door subsidies Congress gives these insurers and improve Medicare's financial viability by broadening the Medicare risk pool with healthier citizens and potentially capturing some of the private insurer's profits in Medigap and Part D plans.

With the expensive private insurance company factor removed from health care, providers' costs dropping from reduced billing and administrative costs; large-scale cost spreading from the single, efficient risk pool; universal benefit from Medicare's fair but lower provider price schedules and drug prices dropping 30-50% or more if Congress grants Medicare E negotiating capabilities devoid of private middlemen, the United States will have tamed the raging medical expense monster, improved its global competitiveness and moved to the front of the world pack in efficient, equitable health care. This is a simple economic issue, regardless of how politicians try to spin it. Let the "trickle-up" economics begin!

Robert Messman ©
Director, Health Care for All Foundation
Denver, CO