Revised 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 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.

The large part of the prize for converting to a national single Insurer can be estimated from various comparative analyses of US spending versus other developed countries. For instance, a 2017 Journal of American Medical Association article notes that the US spends 8% of its GDP on administration versus 3% for other developed countries. That 5% of our 2017 $19.39 trillion GDP wasted on administration equals (.05 X $19.39T =) **$970 billion per year.**

Replacing Private HC Insurers with a Single Insurer

Three major benefits of the consolidation to single insurer are 1) the creation of one large risk pool to effectively spread costs and thus lower rates and 2) the efficiencies from the use of Medicare's rock bottom 3% overhead, and 3) universal access to Medicare's lower negotiated rates with most providers to generate massive annual health care cost reductions in addition to administrative savings. By replacing private HC insurers with a national single insurer, 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 since providers all remain private enterprises. To speed the roll-out of a single insurer (Medicare E), it would make sense to contract with the private insurers to convert their customers to Medicare E and to enroll the remainder of the population in the new plans. Thereafter, the private HC insurers would wind down their operations except for those who continued to provide services to Medicare E under various contractual relationships or offer coverage for optional procedures or Cadillac treatment. Within old Medicare, heavily subsidized Medicare Advantage Plans should be discontinued and Medicare should offer all Medigap and Part D Medicare plans.

A key step to reform is to require that everyone participate in at least the minimum level of Medicare-modelled plan covering 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—lots of choice for rock-solid plans. Just like auto insurance, 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 low premiums and the reduction or elimination of medical coverage in auto insurance, workman's comp and doctor liability insurance. Currently, when people with inadequate insurance fail to pay or declare medical bankruptcy, the rest of society pays.

Financing Medicare E

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. With medical expenses drastically and uniformly reduced for everyone, the tax deduction for medical expenses should be eliminated to add back taxes to the General Fund which might then lead to an income tax rate reduction if and when the yearly budget deficit is eliminated.

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, as in House Bill 676, 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, administered like taxes, will need to be large enough to support subsidies for children and lower income individuals. With over $900 billion per year of administrative costs eliminated from the system and low Medicare rates charged by providers, premiums should be a fraction of what a credible private insurance plan costs now.

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 and hiring pool, they should definitely contribute to the funding through something like a payroll tax and would then be excluded from the income tax-like premiums levied on other income. Since state governments will shed the medical costs of Medicaid potentially totaling over $60 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 from a combination of sources), we should experiment with various funding methods using one of the econometric models currently in existence.

In the conversion, Medicare E will need to have all its revenues deposited into its own trust fund to keep politicians from misusing the premiums and other new funding sources. The current Medicare board of all Trump appointees is undermining that organization. To ensure proper management, Medicare E will need a board of trustees free from political manipulation, drawn up from a couple Congressional appointees and then 4 or so from regional state groupings—all monitored with annual reporting and GSA reviews available to the public.

One thing is clear, well-meaning but impractical proposals for reform should be ditched. HR 676, though well-meaning, in many ways loses all contact with financial reality. Its requirement to buy out for- profit providers is economically inane and would certainly doom it because it would cost trillions. Its blanket coverage for long term care without cost analysis or limitations is a reckless fantasy. The Sanders Senate bill, with many smaller flaws, expands Medicare coverage without new funding, delays access for the most needy through its age-based 4 year roll out and fails to eliminate the costs for medical treatment in workman's comp insurance. In Canada, businesses save on workman's comp insurance because the single payer automatically covers workplace-related medical issues except occupational and rehab therapy.

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.

Contracting with decommissioned 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 contract with private insurers to "fast-phase" the 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, possibly even providing the non-trauma coverage for Veterans. Next to last, absorb the private insurance company population into Medicare E and allow private insurers to downsize operations to become Cadillac plan providers and contract medical processors for Medicare E --NOT insurers. 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 income-- with appropriate upper limits-- 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.

When private health care insurers are replaced by a more efficient single-payer, the value of their stocks and bonds, which includes some other unaffected parts of their businesses, will definitely decline from a 2017 estimated $700

billion. Not a happy event for their investors. But the massive medical insurer-driven administrative waste, totally about 31% of total US medical spending, will be largely eliminated, offsetting the stock loss and dropping an estimated $970 billion PER YEAR in windfall savings back into the hands of the rest of the economy. The fate of the private insurers would be a fitting end to inefficient middlemen who relied too heavily on massively lobbying our Congressmen and too little on system efficiency and serving their customers.

Benefits of the Reform

Three things make the shift to single payer so financially compelling : 1) eliminating the need for all the marketing, commissions, profit, massive funding of lobbying, 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 if unchecked will surely 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 overhead like big executive salaries and media advertising instead of their health care services.

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 many billions in annual back-door subsidies Congress gives Advantage 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!

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