

A Medicare for All Q & A

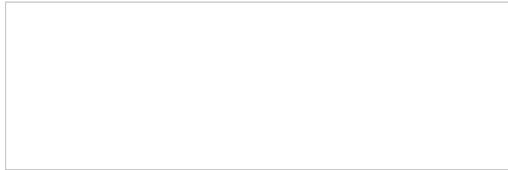
A free interactive ebook to promote single-payer healthcare for the United States

by

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1. What's the difference between health care and healthcare?

Health care as two words refers to provider actions. Healthcare as one word refers to the system. "We need the second in order to have the first," according to [Dr. Deane Waldman](#).

2. Why don't we already have national health insurance?

During the early years of the twentieth century, the U.S. surgeon general predicted the adoption of national health insurance for all Americans by 1910. After a dozen states attempted and failed to promote health insurance reform between 1915 and 1919, Social Security started in 1935 as part of President Franklin Roosevelt's New Deal in which national health insurance was discussed but never seriously considered.

President Truman put national health insurance at the top of his priority list in 1945. A national plan to be administered by the states was proposed in 1947 in the hopes of pacifying southern segregationists wanting to maintain racial discrimination in healthcare. It was defeated largely by the Dixiecrats and the American Medical Association (AMA). However it soon became clear that a secure retirement would have to include medical as well as social insurance.

Since the average life expectancy at the time was only 67 for men and 74 for women, the program was expected to cover only a small percentage of the population for a short time. To achieve the South's buy-in, a separate program, with eligibility and benefit levels determined by the states, called Medicaid was established for the poor. With this added control, Southern states could maintain their discriminatory practices against African Americans, who were mostly poor.

Medicare was started under President Johnson in 1965 over the strong objections of the American Medical Association (AMA) which deemed it "socialized" medicine. That labeling effectively stoked the public's fear given the extreme anti-Communist rhetoric of the time, so rather than become the basis for universal national health insurance, it was limited to a program for the elderly. Medicare's passage came only after three efforts to establish national health insurance failed (1912-1917, 1932-1938 and 1945-1950), because according to a spokesperson for Blue Cross, "Insuring everyone over 65 is a losing business that must be subsidized" (quoted by [John Geyman](#) in *Shredding the Social Contract*, p.32). Part A was created to help cover mainly hospital expenses, and Part B was to help with "reasonable" physician charges along with home health, mental health, and laboratory and ambulance services. This separation into two parts was done primarily so that physicians could continue to discriminate against certain patients while the hospital system could be officially desegregated under the Civil Rights Act of 1964.

The rollout in 1966 was smooth, thanks largely to the lack of cost controls, and most seniors have grown to love it, at least compared to the alternatives. In 2003 prescription drug coverage was added, but administered through private plans with negotiation of drug prices prohibited, adding greatly to its inefficiency and cost. But even today, CMS (the Centers for Medicare & Medicaid Services) spends over 97% of its total budget on clinical services, while the government under the Patient Protection and Affordable Care Act (ACA) is trying to force private insurance companies to get their [medical loss ratios](#), the amount they spend (lose) on clinical services, from 70-75% to above 80-85% of their premiums. This, however, has only encouraged companies to keep raising their premiums and offers no incentive to push prices lower. Medicare's low overhead is in part due to its utter simplicity: a single plan, covering a single large risk pool, defined by a single age category, and for most subscribers, a single rate for the Part B premium.

3. How does Medicare work today?

Initially Part A was open to everyone 65 and older, but in 1968 eligibility was changed to anyone 65 and over who also qualified for Social Security benefits. Part B is open to anyone eligible for Part A who pays the modest Part B premium. Both parts have relatively small deductibles, and some benefits are subject to small copays and 20% coinsurance. Patients can see any doctor they want and are not restricted to an insurance company network list, and they do not need referrals for specialists. In order to help guarantee a patient's access to dialysis, those with end stage renal disease were added to Medicare in 1972, along with the disabled, regardless of age.

Part A is funded through a payroll tax of 2.9% generally split between employees and employers with each paying 1.45%. (In 1966 the total tax was 0.7%.) Part B is funded by premiums (50% of the total costs) and the federal income tax. For 2019, the Part A deductible is \$1364.00 and no coinsurance for the first 60 days in the hospital. Between the 60th and 90th day there is a \$341 copay per day. After the 90th day, coverage (with higher coinsurance) will only last for another 60 days of the patient's life. The 2019 Part B premium is \$135.50 per month with a \$185 deductible and 20% coinsurance. (In 1966 the Part B premium was \$3.00 per month.) Medicare does not cap out-of-pocket expenses, but the ACA requires a cap for all Advantage Plans, so that is one advantage with Advantage plans.

Limited prescription drug coverage is available through Medicare Part D. Medicare Part C is not actually a part of the Medicare benefits program, but rather the nomenclature used to refer to expanded Medicare plans that are managed and offered through private insurance companies. Today, these plans are called Medicare Advantage Plans.

Supplemental or Medigap plans are also offered by private insurance companies, under rules established by the government, to cover Medicare deductibles and coinsurance costs. Contrary to heavy marketing efforts, for many relatively healthy seniors, Medicare Parts A and B are all that are really necessary. The two parts (three parts if Part D is added) together are known simply as *traditional* or *original* Medicare.

4. What is managed care and how did it start?

Due to the near immediate, rising, and seemingly uncontrollable costs for Medicare, Congress passed a series of Social Security amendments in 1972 which directed the Medicare program to develop contracts with private [Health Maintenance Organizations](#) (HMOs) and “managed care” was born. Rising costs were blamed on physician ordering of unnecessary referrals, tests and hospitalizations, and the hope was (despite the lack of evidence) that private enterprise would find ways to control and reduce expenditures, increase efficiency, and create greater value for beneficiaries.

The HMOs were initially paid a set “capitated” amount for a defined number of beneficiaries in advance, and they were required to share any profits with the government. Since this level of risk was deemed unacceptable by the private insurers, payment rates were set in 1982 at 95% of the HMO’s adjusted average per capita cost (Medicare’s estimated fee for service costs in the beneficiaries’ county), and the profit sharing was dropped. The HMOs’ costs did often turn out to be lower than Medicare’s expected costs and many generated substantial profits. They accomplished this primarily by marketing their plans only to the healthiest of seniors and disenrolling those who later required expensive care.

A 1989 report found that Medicare was paying 15-33% more for beneficiaries in the HMO program than in their traditional program, while the industry continued to lobby for higher payments. In 1994, only about 6% of Medicare participants were enrolled in private plans, but House Speaker Newt Gingrich and his Republican majority were determined to shift Medicare from an entitlement to a program completely managed by private corporations with only “premium support” from the government. Republicans are still trying to accomplish that goal. Because of abuses in the Medigap market (policies sold to supplement traditional Medicare), Congress passed the Baucus amendments in 1980, and then additional legislation in 1990 which mandated all [Medigap policies](#) fit one of ten categories (A, B, C, D, F, G, K, L, M and N).

5. What are Medicare Advantage Plans?

By 1997, over 1000 bills had been introduced into state legislatures attempting to counter the abuses of the booming, deregulated managed care, medical-industrial complex. Nevertheless, Congress passed the Balanced Budget Act of 1997, establishing Medicare Part C and three new types of private HMO plans known then as Medicare + Choice. Rather than a major additional benefits package, Part C is merely a repackaging by private insurers of Parts A and B along with a few minor additional benefits (such as Silver Sneakers) for marketing purposes.

By 1998, about 17% of all Medicare enrollees had switched to a private plan, but after almost 2.4 million beneficiaries were involuntarily disenrolled from their private plans between 1999 and 2003, Congress began to panic. To shore up the sagging market, Congress passed the Balanced Budget Refinement Act of 1999, but its provisions failed to entice, and the industry renewed its lobbying effort for increased payments. In 2000, the General Accounting Office found that Medicare was spending about 21% more on Part C plans than on traditional Medicare. Predictably, Congress obliged by *increasing* payments and reducing regulations in 2000, but after increasing premiums to maximize profits, companies continued to exit the market.

The climax came in 2003 with the [Medicare Prescription Drug, Improvement and Modernization Act \(MMA\)](#), which created Medicare Part D (an additional prescription drug benefit package). It was largely a Republican effort which passed by a narrow margin, with American Association of Retired Persons (AARP) support playing a decisive role. About 60,000 AARP members later quit the organization for its betrayal (about 60% of AARP's revenue came from the sale of Medigap insurance and related activities). With increased payments, privately controlled prescription drug coverage, a prohibition on government negotiated drug pricing, and a total absence of price controls, the law was a boon to the industry.

The Medicare + Choice plans were relabeled Medicare Advantage plans and many included Part D in their packaging. In 2004, payments increased an average of 10.9% over 2003 and brought the overpayments to between 107% and 132% of traditional Medicare's costs. In other words, rather than saving money, the government was paying substantially more for its Medicare beneficiaries than it would have without the private insurance programs. About 25% of Advantage plan participants lived in counties receiving overpayments more than 110%. In exchange, the industry promised more benefits, lower out-of-pocket costs, broader networks with substantial price discounts, expanded choices in rural areas, cost containment through care management, and much slower healthcare cost increases. Today, the opposite has occurred and overpayments to Medicare Advantage plans continue to be a significant problem.

A 2013 study found a total of \$282.6 billion in overpayments made by the government between 1985 and 2012. However about 31% of beneficiaries are now enrolled thanks to heavy marketing efforts made possible by the overpayments. In a poorly crafted effort to increase income for Medicare, "means testing" was also enacted under MMA. Under this provision, seniors with high incomes are required to pay higher premiums for Part B on a sliding scale.

6. What's wrong with Advantage Plans?

When seniors go on Medicare, they have three choices. They can get straight traditional Medicare, or traditional Medicare with a private supplemental policy, or a private Medicare HMO Advantage Plan. The first two options work reasonably well, but Advantage Plans go to the heart of our healthcare financing crisis. It began in 1972 when Congress passed several amendments to Social Security which allowed private insurers to offer HMO managed Medicare plans under the erroneous notion that private competing companies could offer greater value, efficiency, choice, benefits, and cost savings than any government agency.

Originally the government paid each company a set amount per beneficiary in advance based on its own cost experience, and any profits were to be shared between the HMO and the government. This arrangement proved to be too risky for the private companies so the profit sharing was dropped, and payment rates were set at 95% of Medicare's expected costs, assuming the remaining 5% and more would be gained in efficiencies. HMO costs *did* drop and profits soared, but only because the insurers learned to restrict care, cherry pick the healthiest of seniors, and lemon drop the ones who got too expensive, since they could always switch to a traditional Medicare plan (the only current public option).

Nevertheless, the industry continued to successfully lobby (including a fake grassroots campaign) for higher payments. By 1989, payments to the HMOs were 15-33% higher than what Medicare would have paid had the private insurers not been involved. A 2013 study reported that these "overpayments to Advantage Plans," as they came to be called, amounted to a total of \$282.6 billion between 1985 and 2012, and they remain a significant problem.

There's more. Most Advantage Plans charge a premium on top of the regular premium for Medicare Part B. For this, members get a few extra minor benefits, including Silver Sneakers (a free senior fitness program), and the ability to combine Parts A and B with Part D into a single policy. They also have the option of adding dental coverage for an additional premium. Private insurers use Silver Sneakers as one of their most effective screening tools for identifying healthier seniors. Those who are attracted by it are naturally those who are healthy enough to want to use it!

As seniors age and get sicker, they are **much more likely** than those who remain healthy to switch from Medicare Advantage to traditional Medicare. They often find that the specialists they need are not in network, or they have problems with costs, getting needed drugs, or access to procedures.

While some Advantage Plans have no additional premium, they still must cover the additional costs of any additional benefits. To do this, they bury the additional fees as deeply as possible such as by charging a \$250-\$450 copay for each of the first four days a patient is in the hospital. Four days just happens to be the average length of stay in an American hospital. Under traditional Medicare, there is no copay for the first 60 days of a hospital stay.

The main advantages for seniors are that even though the plan's list of providers is always limited and changing, at least the network physicians are required to accept new Medicare patients, and, thanks to the ACA, the plans are now required to cap out-of-pocket expenses. However, a big part of the reason why Medicare reimbursements to physicians have not kept pace with increasing costs is because of the overpayments to Advantage Plans!

7. What is the crisis in healthcare today?

Nationally we still have 9-12% uninsured and 26-30% who are underinsured. While the [studies vary](#), there are thousands of deaths per year in the U.S. related to lack of medical insurance. One in three Americans skip medical treatments because of the high cost and we go to the doctor far less than people in other countries.

About 18% of our gross domestic product goes to healthcare, which is the highest in the world, yet our life expectancy is five years less and we have the highest number of preventable deaths under the age of 18 than in other developed countries. Our infant mortality rate is nearly double the average rate in 13 other developed countries.

In 2014, 68% of Americans over the age of 65 were living with two or more chronic conditions, compared to only 33% in the UK.

We consistently rank 11th out of 11 in comparative health studies conducted by the Commonwealth Fund. Drug prices in the U.S. are far higher than in the rest of the world. Healthcare cost inflation is robbing disposable income from employees and investment and expansion income from employers.

Since 1969, private health insurance costs have risen seven times faster than other products and services and twice as fast as Medicare's costs. Over 60% of American bankruptcies are caused by medical conditions with the vast majority among people with health insurance. There are over 250,000 campaigns initiated annually on [GoFundMe](#) by people unable to pay their medical bills. Without reform the cost of the current system is expected to double over the next ten years. In short, we pay the most and receive the least.

8. Why didn't the ACA solve the problems?

While the 2010 Affordable Care Act (Obamacare) can be credited with increasing access for more people, ending exclusions for pre-existing conditions, ending rate discrimination against women, reducing overpayments to Medicare Advantage plans, and ending lifetime limits, it has so far largely failed to control the increasing costs of both insurance and health care, and it does not even begin to address the profit-driven corporatizing which treats sick people as commodities and providers as tools. This is not surprising given that only the insurance, pharmaceutical, and hospital industries and organized medicine (which frequently battled each other) were invited to negotiate the rules.

Even if improved in the ways that conservative Democrats have suggested, the ACA simply does not have the capacity to sufficiently reorganize healthcare financing, because the corporations will always remain in charge. In this case, private insurers have increased deductibles to the point that their so-called insurance is no longer useable by most people, and the same army of lobbyists remains in Washington to make sure corporate interests continue to be satisfied.

Today's American healthcare continues to be characterized by rapidly increasing costs and premiums, restricted provider choice, less value, poor communications, decreasing efficiency, unaccountability, lower quality, discontinuity of care, and extremely frustrated providers and patients. In fact, practically every other developed country in the world has better health statistics than we do, and they do it for far less money.

9. How does U.S. healthcare spending compare to other countries'?

Current U.S. spending on health care is about [\\$3.5 trillion per year](#). About 20% of American healthcare costs are paid by employers, 20% by individuals, and 60% by the federal and state governments. This is the world's highest at 18% of GDP. The next highest are Germany and Switzerland at about 11% of GDP. According to economist Gerald Friedman, a single-payer system will cost closer to \$1.38 trillion per year because of increased efficiency.

While the U.S. spends more on healthcare than any other country in the world, our health statistics are not impressive. For example, according to the OECD the more a country [spends](#) on healthcare, the greater the [life expectancy](#) of its people, except in the U.S. The World Health Organization (WHO) produced the first ever worldwide analysis of healthcare systems in 2000 and controversially declared the U.S. [number 37](#) out of 191 countries. The intention was clearly to promote the WHO goal for everyone to have access to quality health services without incurring the risk of financial strain. The report has yet to be updated, but it sparked the 2009 release by Paul Hipp of a [satiric rock video](#) that went viral.

Other organizations have done smaller studies more recently. Most notably the Commonwealth Fund published a [study in 2017](#) which ranked the U.S. number 11 out of 11 countries studied.

Of course it is also important to understand that most other developed countries spend far more on social services for their people than does the United States. If their people are healthier overall because of this, it could be another reason why they are able to spend less on their healthcare systems and achieve more.

10. What does *single-payer* mean?

Single-payer refers to a system whereby a single governmental or quasi-governmental non-profit agency is established to collect national premiums (taxes) and distribute reimbursements to private health care providers. The agency would negotiate fair and consistent payments and global budgets for hospital services, medical services and devices, long term care, dental and mental health services, and medications. It would completely eliminate the need for multiple, competing private insurance companies which are superfluous and are directly responsible for uncontrolled rising costs.

The easiest way to create a federal single-payer agency would be to modify the existing Centers for Medicare and Medicaid Services (CMS) and create a single-payer system by improving and then expanding the current Medicare program to every U.S. resident. This plan has become known as Medicare for All. Many states are also working on state-based single-payer systems.

11. Are universal healthcare, single-payer, public option, and Medicare for All synonymous terms?

No. Universal healthcare simply refers to the idea that all residents should have equal access to health care services. There are many ways to achieve this goal, including the use of multiple insurance companies. Single-payer systems eliminate the duplicative insurance companies and run all premiums and payments through a single agency with a single set of rules, benefits, and payment parameters.

Public Option refers to a government sponsored health plan offered in addition to those offered by private insurance companies. Medicare for All refers to the creation of a single-payer system by expanding *and improving* the current Medicare program to all residents instead of just seniors, based on the idea that health care is a basic need or human right and not a commodity that can only be utilized by those who can afford it.

12. How can we call health care a human right?

High quality, inexpensive health care should be the right of every citizen just as it is in most of the rest of the developed world. The right to health and appropriate health care has been enshrined by the United Nations. Article 25 of the Universal Declaration of Human Rights (adopted by the UN General Assembly, including a yes vote by the U.S. in 1948) states: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

The preamble of the World Health Organization (WHO) Constitution includes “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.” It further states: “Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.” A [WHO fact sheet](#) adds: “the right to health includes access to timely, acceptable, and affordable health care of appropriate quality.” The services provided must be affordable for all, including socially disadvantaged groups.

Americans, being more accustomed to procedural rights than physical rights, often find this approach problematic. It most likely would be a problem if it were interpreted as a legally enforceable right, since it could easily infringe on the rights of others, especially those of health care providers. However, the preamble of the U. S. constitution lays out the legitimate goals of the government as including promotion of the general welfare and insuring domestic tranquility.

Then of course there is the Declaration of Independence which declares life, liberty and the pursuit of happiness as inalienable rights. The Declaration goes on to say that “whenever any Form of Government becomes destructive of these ends, it is the Right of the People to alter or to abolish it, and to institute new Government, laying its foundation on such principles and organizing its powers in such form, as to them shall seem most likely to effect their Safety and Happiness.”

Modern health care could certainly be included under general welfare and the resulting domestic tranquility, but what is specifically the role of our government in protecting the rights of life and the pursuit of happiness? I believe that what these documents are saying is that properly functioning governments should do their best to ensure that everyone has reasonably available and affordable access to quality goods and services that make life possible and potentially fulfilling.

This does not mean ignoring those with an unhealthy lifestyle until they need emergency medical care or food handouts only when they are actually starving, but neither does it mean unlimited therapy sessions to treat depression and drug abuse or unlimited hospitalizations for incurable conditions. While different systems define essential care differently, when a basic level of health care, especially evidence based preventive care, is guaranteed for everyone through taxation, additional health care and insurance become far more affordable and the fear of bankruptcy from an illness dissipates.

Since the poor, the disabled, and the sick have never been profitable for business, theirs has largely been the domain of private charity. But when charity proves insufficient, the government has a responsibility to step in and ensure that services are available to meet everyone’s basic needs. So referring to health care as a human right is more of a shorthand way of saying: Ensuring affordable access to quality health care is part of the government’s responsibility. Apparently, over [90% of Americans](#) still believe this to be true, despite conservative rhetoric to the contrary.

However, we should not expect our government to ever consider health care a *legal* right, so framing it as a human right is not always helpful because it tends to spark a “right” vs. “privilege” argument with liberals identifying with the former and conservatives identifying with the latter. These kinds of dichotomies typically lead to dead end arguments. Framing health care as a human good or basic need is generally a more productive approach because it is something that virtually everyone, at least potentially, needs.

The objective is to develop a method of financing it for everyone that is economically fair. We know this can work well not just because so many other countries do it, but because we have our own experience with the public financing of roads, fire and police departments, the military, sanitation, libraries, and elementary education, not to mention the success of the VA and Medicare. This of course is not socialism in the historical sense, but it *is* the collection and spending of money by the government for the common good, which seems to be the 21st century definition of socialism. A hundred years ago, we were one of the first countries in the world to consider elementary education a public good, but we are among the last to do the same for health care. Our challenge is to convince people that health care should be added to this list and that Medicare for All will make this happen.

13. What's the connection between universal healthcare and the American lifestyle?

For an additional perspective on health care as a human right, consider that most everyone has both benefited from the advancements of industrialization and suffered from its negative health effects. At the same time huge profits have been made at the expense of the health of both employees and consumers. So, just as we have accepted our duty to address the health and rehabilitation needs of our combat veterans, we need to accept our collective responsibility to help heal those who are dying from the side effects of an excessive American lifestyle.

These side effects include heart and lung diseases (from cigarettes, air pollution, job stress, and the overconsumption of salt), liver disease (from alcoholic beverages), cancers (from toxic chemicals in the environment, in foods, and hundreds of household products), diabetes (from too much sugar in manufactured food), osteoarthritis and peripheral vascular disease (from too much sitting in front of TVs and computers), medical mistakes, car accidents, and numerous others. If healthcare is truly a societal responsibility, it should be a criminal offense to unduly profit from another's suffering.

Unfortunately, the opposite is now true in America. Healthcare (and other) executives are making far more than anyone deserves or needs during a time when the gap between the rich and the poor is still widening and wreaking havoc with our social stability. Americans are becoming increasingly desperate just to survive, and rather than being a place for comfort and healing, American healthcare has become just another source of deep frustration and potential financial ruin.

14. How much profit is the medical-industrial complex making?

According to the Sanders Institute, the top four US health insurance companies made \$60 billion in profits between 2009 and 2015. Stephen Hemsley, former CEO for United Health, made \$279 million since the ACA was enacted and \$66 million in 2014 alone. His replacement [David Wichmann](#) made a whopping \$83.2 million in 2017. During just the third quarter of 2015, UnitedHealth recorded \$1.6 billion in profit. Mark Bertolini, CEO for Aetna made \$41.7 million in 2016 and \$59 million in 2017. In general, insurer [CEO pay](#) was much higher in 2017 than 2016.

Pharmaceutical company profits continue to rise from the \$125 billion reached in 2015. Hospitals also reached record incomes under the ACA with administrator salaries pushing into 7 figures.

15. How are the two main ways of pricing health insurance different?

Medically underwritten premiums are based on the individual applicant's own health status. Detailed medical histories are collected by the insurance companies such that sicker people are charged higher rates than healthier people. Those with vaguely defined "pre-existing conditions" can be denied coverage. Not surprisingly this is a very time consuming and expensive way to determine the premium. It also carries a high risk for hacked data files. Prior to the ACA, all individual policies were medically underwritten, and many applicants were denied coverage.

Community-rated premiums are the same for everyone in a given risk pool (the community of people covered by the insurance), regardless of health status. This means that healthier people pay higher rates than they would under the medically underwritten system, but sicker people pay lower rates. Generally, the larger and healthier the risk pool, the lower the premium can be. All nations with universal healthcare have some type of mandate to participate in a community-rated program.

This redistribution of income from the healthy to the sick has irritated many people recently even though both Medicare and employment based policies use community-rated premiums. The irritation largely stems from the idea that personal responsibility and lifestyle should play a major role in determining rates, even though accidents, genetics, in utero factors, environmental influences, family background, educational opportunities, and racial and cultural issues probably play more significant roles.

Another problem is that healthier people have an incentive not to purchase insurance until they become ill. In doing so, they deprive the community of their premium until they start adding to the community's expenses. This effect has been called a death spiral for health insurance, and it is why the ACA had a mandate for purchasing coverage until it was removed by the Trump Administration as of 2019.

16. How is American health care rationed?

Numerous studies conducted since 1991 have shown that Americans are already paying more than is necessary for a universal single-payer system without getting it. The primary reason for this is the fact that Americans suffer from the most inefficient payment system imaginable. With some 1257 private companies (including multiple divisions of about 35 larger companies) all handling multiple insurance plans, the risk pool is so fragmented that there is no way that healthier people can adequately share the costs of sicker people to keep insurance affordable.

It is well known that about 20% of the population is responsible for about 80% of all healthcare spending and that private insurance companies attempt to minimize covering that 20%. As a result, one-third of Americans still can't get the health care they need: largely because so much money is being wasted and no company controls a high enough risk pool. Even when low income people have subsidized health insurance, they can't afford to use it because of the multiplicity of cost-sharing schemes (copays, coinsurance, deductibles, out-of-network charges, surprise billings, and non-covered services). Health care is in fact rationed in the U.S. to only those who are willing and able to pay its high costs.

17. Why should I have to pay for someone else's health care?

Another way to ask this question is: Are community-rated premiums fair? Most of the [rest of the world](#) considers them eminently fair. We all benefit from a healthy population in the same way that we all benefit from an educated population. Each individual's well being is inextricably bound with the well being of the entire nation. We were one of the first countries in the world to consider K-12 education a public good, but we are among the last to do the same for health care.

If just one person with a communicable disease is not treated, an entire community can become infected. Businesses and customers benefit from employees who do their best, most consistent work when healthy. Taxpayers benefit because they are already paying taxes to cover health care for the poor, and fewer public services are needed for the poor and healthy as opposed to the poor and chronically ill. The healthier a person is, the more likely it will be that s/he can get and maintain a decent job and succeed in a contributing family rather than one that is completely dependent on others.

Instead of preventive care, those without insurance tend to wait for a crisis and then go to the emergency room for treatment, since both public and private hospitals must provide care to anyone in an emergency, according to the [Emergency Medical Treatment and Active Labor Act](#). This is by far the most expensive way to obtain medical care, it does little to resolve underlying health issues, and it wastes resources. While charity covers some of these extra costs, rising insurance rates for everyone also contribute. One way or another, the bills must be paid. The challenge is to create a system that both reduces the cost and spreads it more evenly and fairly across the population, regardless of one's financial capability or one's current health status and need.

The late [Uwe Reinhardt](#) had a simple solution for those "rugged individualists" who did not want to pay for anyone else's health insurance. He proposed that by age 26 all Americans should be required to choose either to join a community-rated insurance arrangement or be on their own for the rest of their life. If on their own and the government had to pay for their care, an account would be set up and a lien placed against their assets for repayment in full.

18. What's wrong with high risk pools?

High risk pools have been used by many states for people with expensive so-called pre-existing conditions who have been excluded from the private insurance market. Prior to the ACA, these people could purchase policies with exceptionally high rates but with a state subsidy. Unfortunately the history of these programs is a story of failure due to chronic underfunding. If they were to be brought back, the details as to how they would maintain adequate funding for affordable rates for all those in need would have to be clearly spelled out in advance.

19. Is health care a peace and justice issue?

Yes. Health care is very much a peace and justice issue. Some people need lots of health care while others get by with very little. **Poverty** however, is just plain unhealthy for lots of reasons. Higher income and better educated people are generally healthier, but genetics and raw luck also have a lot to do with any given person's needs for health care. So because everyone is potentially in need of expensive and prolonged medical attention, and one never knows when or if one will need it, it makes sense to now add basic health benefits to the list of basic needs so that their cost can be evenly spread across the entire population and no one is left out, due to their inability to pay. Of course, those with the interest and the ability can always supplement their basic health care with additional augmentations in the same way that people hire tutors to assist in education or security firms to help protect their businesses.

Healthier people tend to be happier people, and happier people don't tend to fight as much as unhappy people. Being unhealthy also adds a lot of stress, and the higher the stress, the greater the need for scapegoats and blame. The further we go in that direction, the more divided we become and the more we justify violence.

There is also a deep connection in health care to racism. The segregation of hospitals, either as an extension of residential segregation in the North, or as a matter of policy in the South, was persistent through much of the 20th century. This was because hospital activities tend to involve intimate bodily functions in which racial taboos were exceptionally strong. No white person, for example would have ever accepted blood from a black person let alone be confined to the same room with someone of another race. Medicaid is a state based system, not because financing health care for the poor is any different than for anyone else, but because Southern states would not pass on the federal Medicare program without the ability to maintain a separate, state controlled, segregated system for its poor (i.e. black) populations.

Similarly, Medicare was divided between Part A (inpatient services which were desegregated) and Part B (outpatient services) to preserve the ability of physicians to discriminate against black patients. Creating a single-payer, unified system for everyone was the original goal of national health insurance, but passage of our current Medicare/Medicaid system, limited as it is, was in part dependent on compromises grounded in racism. Martin Luther King, Jr. is famous for saying: "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." It's therefore time to erase those compromises with a single-payer, universal financing system.

20. Why is insurance not the right vehicle for healthcare?

In most other kinds of insurance, claims are relatively rare and tend to cover the more extreme situations. Premiums are relatively low because the costs are spread over a broad risk pool and the risks are fairly calculable. Purchasers tend to be in select higher income brackets such as professionals and home and business owners. But regardless of the type of insurance, all insurance companies make their profits by paying out less than they bring in and keeping the difference invested. Typically, the more claims a client makes, the more their premiums will go up, so that company profits remain stable.

With health insurance, it is the entire population that is in need, and the risks and costs are entirely unpredictable. Virtually all beneficiaries will make relatively frequent claims, including claims of prevention. In other words, with few exceptions, insurance policies are set up to encourage people not to use them, and this is not appropriate for healthcare. Insurance is simply not the right vehicle for promoting the health of a population.

21. How would administration be different under single-payer?

With multiple insurance company payers, the amount of duplication in administration is phenomenal and includes marketing, agent commissions, creating and maintaining separate provider networks, enrollment and annual renewals, collecting premiums, tracking deductibles, copayments and coinsurance, obtaining pre-authorization for medical procedures, adjudicating and appealing denials of coverage, paying claims, discouraging the submission of claims through bureaucratic red-tape and confusing terminology, not to mention outrageous administrative and executive compensation.

A single-payer system would standardize these procedures, streamline the process, eliminate the coverage arguments, second-guessing and needless delays, allow providers to focus solely on providing the best medical care possible, and greatly reduce administrative costs (by as much as \$476 billion per year). Single-payer would not only reduce cost, but perhaps more importantly, it would eliminate the added stress (when patients are already under a lot of stress) involved for patients and physicians alike.

Doctors typically accept over a dozen different insurance plans, all with different rules, and have several people employed just to fight the never ending nit-picking war with insurance companies. American hospitals generally employ 1 billing clerk per bed. In Canada, by contrast, billing clerks are no longer needed, since it requires a mere **14 seconds** for a doctor's office to submit the typical bill, with payment arriving within two weeks.

To maintain their "competitive" edge, most healthcare companies also require inflated executive compensation and huge profits. John Martin, former CEO of the pharmaceutical company Gilead Sciences, made **\$863 million** under the ACA, more than any other healthcare CEO.

Stephen Hemsley, former CEO for UnitedHealth, made \$66 million in 2014. UnitedHealth made \$1.6 billion in profit in the 3rd quarter of 2015 alone! In 2017 UnitedHealth withdrew from the ACA exchanges in most of the 34 states where it had previously operated, since the company was unable to make enough money. All of these additional costs and fickle operations would largely be eliminated under a single-payer system.

22. What would disappear under single-payer?

At least all of the following would eventually go away: deductibles, co-pays, co-insurance, annual premium increases and renewals, insurance policies tied to employment, pre-authorizations, denials of coverage, pre-existing conditions, second guessing, EOBs, DRGs, P4Ps, HSAs, ABNs, IDNs, COBRAs, donut holes, limited provider networks, Advantage Plans, multiple billing processes and coverage contracts, annual contract negotiations, rationing, excessively paid executives, administrative billing staff, for-profit hospitals, incompatible medical records, medical marketing departments, market-based disincentives for quality care, employer tax breaks for health insurance, tax deductions for medical expenses, taxpayer paid premiums for government employees, and separate systems for veterans, Indians, the poor, and the elderly, not to mention the health insurance companies themselves.

Private health insurance policies would completely disappear except for companies offering supplemental coverage for services not covered by Medicare for All. However, most state and federal single-payer proposals include very comprehensive benefits, so there would be very little to supplement if such proposals are fully adopted.

23. What are other ways that healthcare can be improved?

First and foremost we need to reorient healthcare from a profit generating business back to a service oriented profession.

As part of this reorientation, we need a nationalized electronic medical record (EMR) so that anonymous data can be collected on every patient for research on best practices. The EMR system needs to be designed for clinicians by clinicians of all kinds and not just by computer techs for administrators as is the case today. Each patient's complete, organized and searchable medical record needs to be readily accessible by any provider via a single identity card that the patient owns and a national data base as [HIPAA](#) (Health Insurance Portability and Accountability Act of 1996) originally envisioned.

We also need to eliminate the top down quality and cost control functions of Medicare which only generate more paperwork with little value. Cost savings need to be derived from a focus on quality and continuous quality improvement processes, not bean-counting. Quality needs to be defined by the absolute best practices as determined by the results of the extensive research made possible by the national data base, rather than through the fulfillment of complex administrative requirements.

According to [James Burdick](#), an inter-professional board of providers that is set up as a public/private partnership should be in charge of recommending best practices for every procedure. Best practice checklists could actually be included with every patient chart so that safety issues are never missed and unwarranted procedures are never left unchallenged. Standards, as determined and maintained by the Board would also be used at the local level for quality improvement programs. The vast majority of doctors and nurses truly want to provide their patients with the best possible care, but they are constantly being redirected by the avalanche of meaningless paperwork required by the insurers. They can also be redirected by patients who demand all possible treatments, even if they are of questionable value. Above all, decisions must be driven by data, not politics, advertising, or profits.

A third major improvement and cost saver would be the elimination of advertising for hospitals, drugs, medical devices, and medical screenings directly to the public. Again, the choice of treatments needs to be based on academic research applied to a specific patient by trusted, objective health care providers, rather than through misleading corporate marketing departments and expensive ad campaigns that often create unrealistic expectations for treatments among patients.

A single-payer will make each of these improvements much easier to implement because only it will have sufficient power to require these kinds of universal changes.

24. Other than administration, what are other sources of savings under single-payer?

There are numerous other sources for savings under a single-payer system. According to [Gerald Friedman's 2013 report](#), because of its sheer size, a single-payer system would have the ability to force prescription drug prices down about 60% to European levels, thus saving about \$116 billion. While drug companies might respond with raising prices for everyone, this would at least prompt higher degrees of resistance. Administrative expenses for Medicaid could drop by about \$26 billion. Eliminating employer costs of managing their employer sponsored benefits, including their share of premiums, would save about \$32 billion. Eliminating tax subsidies to employers who provide benefits and eliminating the deductibility of medical expenses could save another \$260 billion, and eliminating taxpayer-paid premiums for private coverage of government employees could save another \$177 billion.

Other sources for savings include eliminating the perverse business incentives which often motivate physicians to ignore evidence-based practice in favor of higher profits and unnecessary or more costly treatments; transitioning to a single electronic medical record to eliminate the extreme costs of purchasing and maintaining competing proprietary software systems which are unable to share data with outside systems; eliminating subsidized premiums enacted by the ACA as well as overpayments to Medicare Advantage Plans; and standardizing negotiated fees, global budgets, capital planning and the determination of appropriate costs for all services, equipment, medication, and facilities by a single national scientific body with public oversight that is also protected from political influence.

According to the *Christian Science Monitor Weekly* (6/26/17, p. 24-30), American health insurance companies are now losing about \$100 billion annually to health care scams and fraudulent claims, particularly associated with drug treatment programs. A single-payer system would also make our fraud enforcement program much more efficient and effective since it could then be centralized, eliminating the need to coordinate with hundreds of different insurance companies.

However, increasing quality also saves money. Try as they might neither insurance companies nor the government can force quality improvements and the reduction of unnecessary tests and procedures. As James Burdick explains in [Talking About Single Payer](#), only an interprofessional Health Security Board, with administrative support from the federal Health and Human Services, can do this. Driven strictly by national data (not politics) derived from a standardized electronic medical record, this quasi-governmental Board would transparently determine best practices and the details of essential care for the nation and oversee the health care choices that doctors and their patients make.

A single-payer system is needed to maximize the effectiveness of this approach in order to free providers from the confusion of differing quality guidelines and irrelevant insurance and governmental interference in practice decisions. Coupled with the elimination of mass advertising for drugs, products and procedures, a nationalized best practices approach would increase quality and reduce costs substantially.

25. If the government forces drug prices down, won't that mean pharmaceutical companies will have to cut back on R&D and innovation will suffer?

No. According to [Marcia Angell, MD](#), former editor in chief of the New England Journal of Medicine, “drug companies do not play anywhere near as large a part in research and development as they would have us believe,” and “contrary to industry propaganda, it [basic research] is almost always carried out at universities or government research labs” because it is the most time consuming and difficult part. In the U.S., most is supported by the National Institutes of Health.

Once the molecular biology is understood, then a search is started to find or create a molecule that will do the desired job. This is the *development* part and is divided into preclinical and clinical stages, with the drug companies usually only getting involved at the clinical stage. In 2001, the industry claimed it cost \$802 million for each new drug's R&D, but they have been very secretive about how this number was derived. Independent analysts have put the cost closer to \$100 million, and suspect that much of this money is spent on “[consulting fees](#)” and [stock options to NIH scientists](#).

However, only a tiny fraction of these new drugs are actually new molecular entities and most of those are simply acquired from university or government labs. The rest are just newer versions of the same drugs already on the market, the so-called “me-too” drugs. This is possible because at the industry's insistence, the FDA only requires that new drugs be effective in two clinical trials. They don't have to show any increased effectiveness or even the same effectiveness as what is already on the market, and suppression of negative results is very common. They just must be different enough to qualify for a new patent. So in most drug company clinical trials, “new” drugs are compared only to placebos instead of with the currently marketed products.

Big pharma is the most profitable industry in America and it is far from a high risk one, charging whatever the market will bear.

26. What will happen to all of the industry employees who will lose their jobs under single-payer?

Under most legislative single-payer proposals, displaced workers will be eligible to receive salary compensation benefits as well as assistance in retraining, relocation and job placement. However, many will already have transferable skills or will find new jobs within the single-payer system. The [PERI study](#) estimated that about 746,600 insurance workers will be displaced and will need new jobs. This is a significant number in light of the [6.8 million](#) who were displaced between January 2015 and December 2017 from all jobs in the U.S., so it's important to include these provisions in order to prevent a possible macroeconomic problem.

27. How did health insurance get attached to employment?

How health insurance came to be connected to employment is an interesting story. Providing insurance to cover sickness is not as straight forward and predictable as it is for other forms of insurance, so companies had to look for additional ways to reduce their risks and costs.

As healthcare costs began to increase in the 1920s, new markets among the middle-class opened and insurers began to experiment with employment based plans. Getting employers to deduct premiums from paychecks greatly reduced collection costs, and policies could be restricted to the employed, who tended to be healthier than the rest of the population. Those employment groups with low rates of illness and injury got premium discounts thru an “experience rating.”

This arrangement helped companies recruit and build loyalty among workers, particularly during World War 2 when wages were frozen by the Emergency Price Control Act of 1942. While unions were initially opposed because of fears that it would tie people to their jobs and weaken the union’s bargaining power, they eventually found that these “fringe benefits” could be beneficial for retaining worker allegiance when included in contract negotiations.

In 1954 the system became entrenched when the IRS declared that employers’ contributions to health benefit plans were tax exempt. Today, according to [Uwe Reinhardt](#), this represents a federal subsidy of about \$250 billion a year, and about \$300 billion if lost state tax dollars are included. To put this in perspective, subsidies to low income Americans under the ACA totaled \$110 billion in 2016. While this system definitely benefited the fully employed and provided a massive tax subsidy for corporate America, it hurt the retired, the unemployed, the self-employed, and those working for small businesses or in low wage jobs without fringe benefits. Individual policies became much more expensive both because of “community ratings” (based on the broader population that included more sick people) and because the employment based system stimulated healthcare cost inflation.

However, many families could now afford more medical care, providers had a guaranteed payment source, and hospital beds filled to capacity. By 1958, nearly two-thirds of Americans had some type of insurance for hospital costs, and this was enough to temporarily prevent any further movement toward national health insurance.

28. How do high costs affect American business?

For American employers, healthcare premiums annually increase and have more than doubled since 2005 to the point where these excessive expenses are undermining their ability to function, let alone compete. Small businesses have complained for the last 25 years that their top concern has been the cost of health insurance, and large businesses have been at a severe disadvantage with their international competitors who don't have those costs. Recently, executives for Ford, GM and Chrysler plants in Canada announced that Canadian health care created a huge competitive advantage for them, yet Canadians pay roughly the same tax rates as Americans do.

According to [Warren Buffett](#), "Medical costs are the tapeworm of American economic competitiveness," and American CEOs need to pay much more attention to reducing those costs than to reducing the corporate tax rate. High health insurance costs distract companies from their primary business and they preclude accurate budgeting while adding no value to a company's bottom line. Money that could have gone for employee raises, product development, or infrastructure improvements goes for rising health insurance premiums and internal administration instead. Even large companies that are self-insured don't always get away unscathed. They always run the risk of encountering a million dollar medical bill from an employee or a dependent that has to be deducted from their annual profits.

29. How does employer-provided health insurance affect employees?

Employees typically find out too late that their coverage is not what they thought it was, and most are one accident away from financial disaster. Over 60% of American bankruptcies are caused by medical conditions, and the vast majority of those people are employed and have health insurance. Employers decline to hire older, more experienced workers because they cause higher premiums since they are at higher risk for catastrophic illness. Many people stay in jobs they are not suited for because they can't afford to give up the health care benefits. People changing jobs find that they have suddenly lost the health insurance they had previously relied upon and come to know. Others find that their new employer-provided insurance doesn't cover what they need, and they might have to pay a much higher share than in their previous job.

Many people lose their jobs due to health issues, so they lose their insurance at the same time. Then to qualify for Medicaid to pay their bills, they need to spend down their life savings, provide massive amounts of documentation, and endure long wait times only to receive some of the poorest care in the industrialized world.

This completely unjust, unproductive system is allowed to continue largely because it is invisible to the majority of Americans whose health insurance is paid in large part by their employers (and not disclosed until it's reported on the employee's W-2), who rarely need to actually use it, and who have far too many other things on their minds. It is not until people are faced with the task of buying either their own or their company's insurance and dealing with the system directly, that they begin to understand the complexities, the incredible expense, the lack of value, and the real life consequences of our entanglement with the medical industrial complex. Health insurance simply must be divorced from employment, as in the rest of the world. While traveling, I have often had discussions with foreigners about the U.S. system and they always respond in utter disbelief.

30. Don't lots of studies prove that single-payer will cost more?

No. There really is no doubt from all of the studies that have been done over [the last 20 years](#), that Medicare for All will save tremendous amounts of money. So what's up with the four relatively recent studies that appear to contradict these findings? The 2018 [Mercatus study](#) is the easiest to refute, because buried in Charles Blahous's Table 2 is his key finding that Medicare for All will actually [save over \\$2 trillion](#) in ten years. Of course you have to do your own arithmetic to discover this, and he didn't bother to explain how much money we expect to be spending in ten years on our current course compared to the projected \$32 trillion cost of Medicare for All. It was an extremely careful obfuscation of his own data to advance the political agenda of the libertarian Koch family which largely funded it.

Then there is [Ken Thorpe's 2016 report](#) from Emory University. In this study, Thorpe completely contradicted his earlier findings showing how Medicare for All would substantially cut costs, yet the facts have not changed. In 2016, he [grossly underestimated](#) the administrative cost savings by using Vermont's modified single-payer proposal instead of the actual experiences in other countries such as Canada and Scotland. He also assumed huge increases in utilization not seen in other countries due to capacity constraints. In other words, when you only have so many doctors, you can only see so many patients. He completely ignored the trillions of dollars in cost savings to federal, state and local governments stemming from their relief from the outrageous costs of private coverage for public employees. He also ignored the proposed termination of huge tax subsidies currently enjoyed by private insurance companies, and he grossly underestimated the cost savings on prescription drugs that every other government administered system has gained.

Finally, there is the 2016 study from the otherwise highly reputable [Urban Institute](#). Why did they project that Medicare for All would break the bank? Citing Thorpe's study, they committed many of the same [errors](#), plus they completely ignored the huge savings to doctors and hospitals from the super streamlined billing system. The UI authors later admitted that they were assuming that major health insurance companies would continue to play an administrative role, which no single-payer proposal has ever suggested.

The Urban Institute published [another study](#) in 2019 that compared eight different reform approaches, starting with incremental proposals for improving the ACA and ending with a "single-payer-type comprehensive reform similar to the Medicare for All Act of 2019." Again, the researchers apparently discounted the administrative savings and substantially over estimated the projected increased utilization. Their estimate that a single-payer program would increase health spending by \$719.7 billion is therefore [seriously flawed](#).

Several theories have been advanced as to why these researchers might have done such misleading work and agree to its political use. Unfortunately not all researchers are able to prevent their own biases or those of their bosses and funders from contaminating their findings. This of course only adds to the confusion between facts and "alternative" facts.

The bottom line, as Uwe Reinhardt said, is that universal healthcare is not a matter of economics...it's a matter of soul.

31. What did the recent PERI study show?

The Political Economy Research Institute published a [major study](#) in November 2018 called Economic Analysis of Medicare For All, specifically S. 1804 as introduced by Senator Bernie Sanders. It concluded that the dual goals of significantly improving outcomes for all residents and establishing effective cost controls were both achievable.

Among the findings is that Medicare for All could reduce total health care spending in the U.S. by nearly 10 percent, to \$2.93 trillion, while creating stable access to good care for all U.S. residents. In particular all businesses could get an immediate 8% cut in whatever they are paying now for employee health insurance plus substantial administrative savings. The authors also addressed a range of issues that still need to be considered for any single-payer system in the U.S., including a possible funding mechanism. The study has been widely circulated and has received [praise from PNHP](#).

32. What are some realistic sources of revenue for single-payer?

In addition to the billions of dollars in savings, according to [Gerald Friedman](#) and other economists, additional modest sources of revenue would likely be required. A realistic package to primarily tax those with higher incomes could include: a 0.5% tax on stock trades and a 0.01% per year to maturity on bond trades; a 6% surtax on household incomes over \$225,000; a 6% surtax on property income from capital gains, dividends, interest, and profits; a 6% payroll tax on the top 60% of employees with incomes over \$53,000; and a 3% payroll tax on the bottom 40% of employees with incomes under \$53,000.

Senator [Sanders has proposed](#) a 7.5 % income-based premium paid by employers (with small businesses being exempt), a 4 percent income-based premium paid by households, ending the tax breaks on capital gains and dividends for households with incomes above \$250,000, and ending the corporate tax exemption for employee health benefits.

Whole Washington, a universal healthcare activist group in Washington state, is suggesting a 10.5% assessment on an employer's gross payroll with up to 2% of it being paid by the employees, as well as an 8.5% assessment on long term capital gains earned by state residents.

These are *not* skyrocketing new taxes as many opponents would claim. In the absence of private taxes (premiums, deductibles, co-insurance and co-pays) they will in fact save everyone substantial amounts of money. Most employers would jump at the chance to only pay 6-10% of their payroll in health benefits despite having "new taxes" to pay!

33. Can you provide a payroll example?

To use a personal example, in 2015, my employer spent \$13,039 on premiums for my basic health insurance. If instead of insurance, they had paid my proposed 6% payroll tax, they would have saved \$10,168 just on me! Of course this does not include the employer tax break for health care benefits, but additionally, I would have saved \$4,068 on my share of the premiums that were deducted from my pay. So even with the new taxes, most likely all Americans would see their overall expenses significantly reduced, while their needs would be completely covered without the additional expenses incurred with high premiums, deductibles, copays and coinsurance. The greatest benefit of all would be the peace of mind that would be provided, which is priceless.

I retired in December of 2015, not yet eligible for Medicare. As a result of electing the [COBRA](#) policy which extended my employer sponsored health insurance with its \$200 deductible and 10% coinsurance for another 18 months, my premium for my spouse and myself increased to a rate of \$13,855.68 per year. When the COBRA ran out we were forced onto the individual market bronze plans and the premium with the same company (Kaiser Permanente) went down slightly to \$13,268.88 but with a \$7,150 deductible without coinsurance. This is what is known as being underinsured, because after paying the premiums, few can afford the high deductible. So just as the insurance company intended, we did not make any more claims until we were both on traditional Medicare.

34. Why isn't the competitive marketplace driving down costs?

We have thoroughly tried the deregulated, free market approach for decades and it has not worked. Markets don't work for healthcare because they need to keep expanding and attracting more customers. However in healthcare, success is measured by improved overall population health and therefore a shrinking market. Markets are also unable to distribute healthcare rationally. In our current system, the people who need care the most, have the most difficult time getting it.

Because the price of everything in healthcare is still a well guarded secret (despite the 2019 [chargemaster disclosure requirement](#)), costs for the same procedure can vary widely even within the same community, so providers and suppliers can and do charge whatever they want. Even if price transparency were to actually become accurate, limited provider networks would inhibit its usefulness. Insurance carriers can reduce the inflated price of a procedure to a certain degree, but if they go too far, like Medicare is often accused of doing, providers can stop accepting those carriers. But insurers are not even motivated to try to reduce costs, because when prices increase, all they need to do is raise their premiums to maintain, or even increase, their profits.

If nobody can compare prices before getting the service, comparison shopping by consumers is impossible and competition is essentially meaningless. Additionally, after a patient's deductible is met and insurance is paying 80% of the costs, there is little incentive for comparison shopping. Meanwhile, hospitals, pharmaceutical companies and medical device makers have responded to the ACA and other market forces by increasing consolidation to monopoly levels as a means of pushing insurance carriers to pay ever higher prices, while the insurance companies seek their own monopolies by operating in communities with little or no competition. Bulk purchasing can't be sustained at high enough levels to bring down costs because the financing system is much too fragmented. As mentioned earlier, negotiating the bulk purchasing of drugs was even prohibited by the 2003 [Medicare Prescription Drug, Improvement and Modernization Act](#).

When people are seriously ill, uncertainty predominates, and they typically do not have the time, the capacity, or the desire to comparison shop for treatments that they know next to nothing about, even if it were possible. Bargaining down the price or deciding not to buy are not viable strategies, as they are for other consumer products. Instead patients rely on their physicians, who don't have ready access to prices but who may have undisclosed vested interests in over-treatment, to direct them. The idea that patients overuse health care resources by their own initiative just because they have insurance (moral hazard) was discredited long ago. The Great Depression, the Roaring Nineties, and the Recession of 2008 (among other economic disasters in American history) should leave no doubt that the pursuit of self-interest does not reliably lead to economic efficiency, let alone social justice or quality health care services.

According to the New York Times (3/23/17), consumers "can easily compare the prices charged by competing insurance companies. This asymmetry induces companies to compete by highlighting the lower prices they're able to offer if they cut costs by degrading the quality of their offerings. For example, it's common for insurance companies to deny payment for procedures that their policies seem to cover. If policy holders complain loudly enough, they may eventually get reimbursed, but the money companies save by not paying others confers a decisive competitive advantage over rivals that don't employ this tactic. Such haggling is uncommon under single-payer systems like Medicare (though it is sometimes employed by private insurers that supplement Medicare)." Where free market competition should be maintained is in the choice of one's providers, instead of allowing insurance companies to decide and continually change who is on the network provider list.

35. Wouldn't allowing insurance companies to write policies across state lines help?

No. It will likely make things worse because it will motivate companies to establish their plans in states which are trying to attract more business with minimal coverage regulations. It will also impede other states from maintaining stricter regulations, such as covering pre-existing conditions. The companies would then cherry pick customers from neighboring states and offer them reduced rates while denying policies to sicker people.

Policy holders in states where the insurance company is not based will have a much harder time filing insurance complaints against those companies since they will also have to deal with an out of state insurance commissioner whose priorities are in state. State lines are simply not the cause of high premiums and insurance companies are not pushing this legislation.

36. How do insurance company PR departments distort reality?

According to [Wendell Potter](#), a former director of PR at the health insurer CIGNA, corporate public relations has evolved into an extremely powerful yet largely invisible force in our society. The job of the PR “spin doctors” is to use every medium possible to build and maintain a strong public image for their clients, but it often crosses a vague line into misleading propaganda, including the use of fearmongering and distracting people from the real problem, non-specific language such as “the American way of life,” hired testimonials including the creation of front groups, name-calling, pitting one group against another, the false identification with average people, euphemisms that obscure meaning, manipulated polling, creating doubt in the results of scientific research, saying one thing in public and working behind the scenes to accomplish the opposite, the perception of approval by a widely respected person, sticking to talking points regardless of what questions are asked, deflecting blame to other entities, and the repression of information that could be harmful to a client.

Potter quotes Adolf Hitler, one of history’s most effective spin doctors, in *Mein Kampf* as saying, “The receptivity of the great masses is very limited, their intelligence is small, but their power of forgetting is enormous. In consequence of these facts, all effective propaganda must be limited to a very few points and must harp on these in slogans until the last member of the public understands what you want him to understand by your slogan. As soon as you sacrifice this slogan and try to be many-sided, the effect will piddle away, for the crowd can neither digest nor retain the material offered.”

37. What are “Consumer-driven” health plans?

To quote [Wendell Potter](#), “*Consumer-driven* plans started appearing in the early 2000s when it became clear that the techniques of managed care—the insurance industry’s silver bullet of the 1990s—had not lived up to expectations.” They are now touted as *part of the solution* to rising costs and the increasing numbers of uninsured. In essence they are high deductible, limited coverage plans with somewhat lower premiums. The term was invented by insurance PR executives in an effort to create the myth that consumers were demanding more *control* and *choice* over their healthcare spending.

According to the industry, the *real drivers of healthcare costs* are the patients who receive care that they don’t really need. Insurers have *admitted* that the *mistake* of managed care was separating the consumption of health care from its costs, which were hidden behind small copays. So their updated solution is to *give* people more *skin in the game* by placing more of the responsibility for the cost of care on the policyholders (blaming the victim), and giving them new *options* for less coverage that supposedly will only be used for care that is really necessary. Proprietary *studies* are frequently cited to support the lie that these *consumer activists* are saving money and also becoming healthier.

This latest spin by the insurance industry has in fact led to a new crisis: millions of underinsured. The reality of having more *skin in the game* is either not seeking needed care at all, discovering that your new health issue is not covered, or paying all of your own medical bills (because you are not yet sick or injured enough to meet your ridiculously high deductible) plus your insurance premiums and copays as well. This is all so distant from the original concept of insurance that even the term *insurance* no longer applies.

The industry also claims that patients will save money by *shopping around*, but the urgent need for most medical care, the lack of transparency in pricing, and the highly technical nature of the decisions, make shopping unrealistic if not impossible. The top priority for any insurance CEO is to keep profits and share prices up, and so far, *consumer driven plans* are accomplishing that objective. These kinds of plans will quickly disappear under a single-payer system.

38. Won't utilization drastically increase under single-payer?

Probably not. When the Canada Health Act was implemented in 1984, the number of doctor visits in Canada stayed about the same, with slightly fewer visits from healthier and wealthier people and slightly more visits by poorer and sicker people. Less unnecessary and more essential care was provided. But to say that we should not institute a program because it might be popular is like saying department stores should not have a sale because the stores might become crowded.

More Americans defer needed health care because of cost than in any other developed country and as a result, we are 19th among those nations in preventable deaths. Financial barriers to care, such as high deductibles (\$7-8,000 are now common), copays, and coinsurance encourage people to defer attention to injuries and disease. These cheaper “consumer driven” plans are typically purchased by healthier people, and while they can save money on premiums, if they defer needed care, they are more likely to face an expensive crisis. By both eliminating barriers and making screening easier through patient portals, email, and consulting nurse services, we enable people to seek appropriate care earlier, reducing costs and suffering in the long run.

Both when Medicare/Medicaid was started and when the ACA was implemented, there was a backlog of people in need of health care. Utilization increased somewhat in both situations but stabilized once those newly on insurance had their needs met. For example, diabetics need extensive training, supplies, and follow-up in order to manage their condition successfully. When this medical care is inadequately provided, a diabetic crisis in the ER is the typical result. A [new study](#) has helped to confirm this dynamic, and also found that Medicare for All is not likely to create a surge in hospital use.

39. Doesn't cost sharing prevent people from seeking unnecessary care?

No. There is no evidence that people will seek more services than they need in the absence of copays and other cost sharing devices. People are simply not that in love with medical procedures, and this is not a significant problem in other countries. Unnecessary services are ordered by medical providers, not patients, so it is the system that needs additional motivation to behave responsibly. While a small copay might discourage a low income person from seeking medical attention that might be considered unnecessary, it will have no effect on a wealthier person and it will cost more to administer than it is worth. Health economist [Dr. Rashi Fein](#) spoke to this and other economic aspects of universal healthcare in 1975. He concluded that private financing of healthcare cannot meet the needs of the people. According to Fein, “we are not so poor that we cannot afford one of the hallmarks of a civilized society—the right to health care regardless of income” (p. 11).

40. Isn't single-payer socialized medicine?

While both the Veterans Health Administration (VA) and the British National Health Service could be considered truly “socialized” because the government owns the hospitals and pays the staff, single-payer is much less so, because it is merely a payment and cost control system. All providers practice independently, and patients are completely free to visit any private practitioner or hospital that they choose.

Before the Canadian government passed the Canada Health Act in 1984, opponents, especially the Canadian Medical Association, claimed national health insurance was communistic and a threat to freedom. There were even three doctors' strikes during a 25 year period in protest. Editorials proclaimed it would lead to the total destruction of the Canadian economic system. Instead, the exact opposite happened. Within ten years, public health insurance arguably became an icon and a right of national citizenship rivaling only hockey for what ties Canadians together as a nation. The underlying value in Canada is that access to health care should be based on need rather than the ability to pay.

The origin of the term *socialized* medicine goes back to the early Cold War when the American Medical Association and others claimed that President Truman's health plan would eliminate the freedom of patients to choose their doctors and doctors to determine which patients they treated. They insisted that the government's objective was to dominate the medical care of every citizen. Despite the complete inaccuracy of the claim, the term “socialized medicine” continues to create fear in the minds of many conservatives, in part because the language of “choice” and “states' rights” was critical to maintaining racist practices in the southern states. In [Canada](#), “choice” referred more to how doctors would be compensated than to which patients they would see.

While many conservatives still try to denigrate the word by labeling any public good on which the government spends money as socialism (assuming everyone understands the term pejoratively), younger Americans are beginning to embrace the term as a key to reducing inequality. Why not devote more of our resources to our own people such that we lead the world by a good example with *social* force rather than our excessive military force?

41. Won't single-payer dangerously limit choice?

No. A state Republican legislative aide recently commented to me that the dangers of over centralization in healthcare may pose more risk to Americans than the status quo, since people won't have the option of switching to a competitor if they don't like the government's decisions. Competition in healthcare financing is largely a fallacy. In reality there is very little difference in the way coverage decisions are made between the different companies, since all need to maximize profits. Most people care much more about choice of providers than choice of insurance companies, and a single-payer system, including Medicare, provides the ultimate in free choice of providers. Plus most subscribers are essentially locked into their plans for at least a year and can't just switch at a moment's notice. All will incur costs and inconveniences regardless of when they switch plans. Unlike the private plans, benefits under Medicare are relatively clear in advance and arguments over coverage decisions rarely happen.

Certainly, problems can develop when government run services are not funded adequately, such as is often the case for the British National Health Service or the Veteran's Health Administration in the U.S. However, when the health services are privately managed and only the financing is government controlled, as is the case in most of the developed world, services tend to be quite stable. Plus, preventive services are much more likely to be sought under a single-payer system, since in the absence of deductibles, coinsurance, and copays, people are more likely to seek attention earlier and avoid the more costly and questionable procedures.

According to Wendell Potter, the entire concept that single-payer would [limit choice](#) was a corporate PR ploy that he himself helped to devise.

42. Doesn't private insurance guarantee more freedom?

No. On the contrary, single-payer will absolutely guarantee increased freedom, for example:

- Freedom to choose any provider.
- Freedom from the fear of financial disaster.
- Freedom from losing insurance and providers because of changing jobs or unemployment.
- Freedom to choose a career path without regard for health insurance benefits.
- Freedom from having to guess what is covered and what isn't and fighting over denials.
- Freedom from having your insurance denied or canceled because you are too sick.
- Freedom from unpredictable deductibles and coinsurance as well as under-insurance.
- Freedom from unpredictable reimbursements.
- Freedom from means testing and third-world quality care due to poverty.
- Freedom from faceless, private insurance bureaucrats controlling who you can see, how long you can stay in the hospital, and what procedures and drugs you can have.
- Freedom from a commodity based, profit driven system the top priority of which is to keep insurance company stock prices high.
- Freedom from rushed doctors stuck in a high pressure, unfulfilling, profit driven, productivity rat race with no time to truly listen to their patients.
- Freedom from harassment by private insurance billing agents when you are sick.
- Freedom from useless, time wasting preauthorizations.
- Freedom from the need to maintain one billing clerk for every practicing physician and hospital bed.
- Freedom from proprietary EMRs designed for administrators instead of clinicians.
- Freedom from the constant threat of further privatization of public services needed by everyone.
- Freedom from misleading, expensive insurance and drug company marketing campaigns.
- Freedom from the greed of exorbitantly paid insurance company executive managers who can offer nothing of value to our health care.
- Freedom from the tyranny of private company closed door decision making.
- Freedom from government overpayments to Medicare Advantage Plans.
- Freedom from the most expensive and worst healthcare system with some of the worst outcomes in the developed world.
- Freedom from an unpredictable and out of control private tax system.
- And freedom from dying because of no insurance!

And what do we give up to gain all this freedom? We give up having a choice between duplicative, horribly overpriced, and frustrating insurance policies designed to discourage use, and we give up having lower government imposed taxes.

43. Don't lots of Canadians come to the US for health care?

No. There is a persistent myth that Canadians still come to the U.S. in droves for health care because of long wait times in Canada. A 2002 study published in Health Affairs laid the myth to rest but it has been hard to kill. The study found that Canadians do come to the U.S. for health care for a variety of reasons, primarily for faster service on elective procedures and MRIs, but numbers are extremely small, and the wait times for elective procedures do not necessarily translate to poor outcomes.

However, despite its popularity, [the Canadian system](#) still has room for improvement and expansion. Medications, dental and vision care, home care, and long-term care are still not covered and too many Canadians find supplemental insurance to be unaffordable or inaccessible. It should also be recognized that many Americans go to other countries for health care because it is so much less expensive, and that wait times in the U.S. can be long for some specialists. Also interesting is that Canada officially records wait times and has a wait time guarantee while the U.S. does not.

44. Won't out of control immigration overwhelm Medicare for All?

No. The fear is that the taxes that immigrants pay, because current policy tends to favor low wage earners, will not cover the costs of their eventual claims on Medicare and Social Security as they grow older, and they will therefore be too expensive for Medicare for All to cover them as well.

A [study from 2013](#) addressed this issue and found that “between 2002 and 2009 immigrants’ cumulative surplus contributions [to Medicare] totaled \$115.2 billion,” and that most of this surplus was from noncitizens. The study also found that most immigrants are relatively young, and that the ratio of young to old remained stable between 1995 and 2010. Most will not reach retirement age for decades, and some of them will return to their country of origin for retirement, while others will be ineligible for Medicare.

In a [follow-up study](#) the authors found that between 2008 and 2014, immigrants paid \$174.4 billion dollars more in private insurance premiums than they received in benefits. Per enrollee, this “subsidy” remained consistent even after ten years of residence in the U.S. as compared to an average deficit of \$163 per U.S. born enrollees. Several studies have shown that immigrants tend to enter the U.S. healthier and use fewer medical services than the native population regardless of their insurance type.

A [study from 2018](#) found that immigrants make larger out-of-pocket health care expenditures and that both public and private insurers pay far fewer claims on immigrants than for U.S. born residents. While our immigration system is also in dire need of improvement, the concern that immigrants are driving up health care costs or that Medicare for All will be unable to cover them need not be among the chief motivators for change.

45. Are physicians supporting single-payer?

The American Medical Association, with a membership of less than 30% of all practicing U.S. physicians, remains officially opposed to national health insurance (although that may be shifting), as it has been since 1920. But fortunately, most other physician and nursing organizations (including the American College of Physicians and National Nurses United) are in support of single-payer. It is in fact [physician groups](#) which are currently spearheading the advocacy and the detailed proposals for single-payer. Some physicians, particularly surgeons with the most lucrative practices, will likely see their incomes drop slightly under single-payer, but those who have been chronically underpaid, such as family physicians and those who treat Medicaid and Medicare patients, will likely see their incomes rise.

Canadian physicians have generally done well under single-payer, but even if physician reimbursements dropped slightly, single-payer will [save physicians vast amounts in overhead and time](#) during which they can see more patients. A [Health Affairs study in 2010](#) determined that American physicians spent an average \$82,975 per year dealing with insurance issues. In Canada it was \$22,205.

Medical malpractice suits and insurance rates should drop with single-payer since those with negative results (whether actual malpractice or not) will be guaranteed ongoing treatment without the need to find the deepest pockets to pay for it.

Certainly government spending priorities change frequently for various reasons, but our government is already spending more than it needs to for health care and is not getting near the return it could be getting under a single-payer system. While we are struggling to pay the cost overruns now, we should be able to pay for a much less expensive program, while increasing payments to providers, well into the future without difficulty.

46. What about Health Savings Accounts (HSAs)?

Many Republicans are touting HSAs as major cost saving tools, which they are not, nor will they do anything to lower costs. HSAs (created in 2003) are not insurance plans; they are merely savings accounts into which people can deposit pre-tax earnings to be used solely on health care related expenses. Deposits are limited to annual maximums and are portable, and all unused funds can be rolled over to the next year. However, if the money is used for any non-medical reason, the person must not only pay the deferred tax, but also a 20% penalty. HSAs can currently only be used with high deductible health insurance plans (HDHP).

The theory is that using one's savings will motivate consumers to shop for less expensive providers and services, and that HDHPs will motivate consumers to cut back their utilization, thereby reducing overall costs. What the research is showing, however, is that people with HDHPs are no more likely than anyone else to "shop around," probably because it is nearly impossible to obtain prices in advance. HDHPs are also forcing people to be their own physicians in making the extremely complicated decisions about what care is necessary and what is not. Even physician consumers have trouble with this, because the wrong cutting back choice can have disastrous consequences with much higher costs in the long run.

It is often claimed that HSAs work well in Singapore so they should work well here too, especially if expanded. However the government pays for catastrophic coverage for every Singaporean, such that their citizens are not dependent upon their own funds to see them through a crisis.

HSAs are not particularly attractive to people in low tax brackets, since the tax breaks are minimal, only available on an annual basis, and not really worth the added complications involved in filling out the returns, which are complicated enough for the average person. However, for the healthy and wealthy, they can act as another 401(k), a pleasing scenario for both investors and Wall Street. But if people have an emergency which is not a medical emergency (such as their house burning down), they are forced to pay a high cost and navigate another complicated process just to access their savings to pay for it.

Why would anyone of moderate means want to use a savings plan that restricts how they can use their hard earned money, and why does government want to sell the notion that medical emergencies are more important than any other kind of emergency? The goal for HSAs is to transfer more responsibility for health care financing and its risks to individuals and away from the government and larger pools of insured and make it more difficult to ever convert to a national plan. Additionally HSAs will help pave the way for "premium support" plans and the eventual elimination of Medicare. Under this idea, the government could substitute actual Medicare benefits for a cash sum with which to purchase private health insurance, and then gradually eliminate the support completely.

47. Does a single-payer program have to be government managed?

No, but if it is privately managed, it must be strictly regulated by the government and the private managers must be not-for-profit. The government will also need to establish the global budgeting and cost controls, and establish the rules and conditions under which the program operates, including ensuring universality, uniform benefits, portability, affordability, and accessibility.

Since its beginnings Medicare (CMS) has subcontracted the day-to-day administration of original Medicare to private regional (generally Blue Cross and Blue Shield) organizations now known as Medicare Administrative Contractors (MACs), and in doing so has surrendered direct control of the program and its costs. This was done in exchange for the initial support of doctors and hospitals and, according to [Gerard Boychuk](#), to “assuage the concerns of southern Democrats regarding federal control” (p. 71).

Under this decentralized system, local coverage decisions vary widely around the country, and it is frequently much easier for new treatments and devices to gain coverage at the local level than at the federal level. The General Accounting Office has recommended abolishing this system because of inequities and inefficiencies.

48. Can we trust the government to manage our healthcare?

Yes. From transportation to sanitation to public safety to law and justice to financial security to civil rights to education to national defense and on and on, we all trust our government with our lives on a daily basis. If we had a truly corrupt government like many dictatorships around the world, trust would be a major issue, but we don't, so the concern is not really trust but something else.

It's not easy to clearly articulate what that something else is, but I think it has more to do with a fear of change and of not getting it right. It points to a lack of confidence stemming from the perceived failures of other grand programs such as the war on poverty or the war on drugs, and of course the real wars on Vietnam, Afghanistan and Iraq. While understandable, this fear needs to be put in perspective. There are many reasons why government does not always perform the way it should. Chief among them is that government is composed of human beings. While private companies are also composed of humans, a government's responsibilities are much more complex and prone to corruption, and there is a natural tendency to hold government to higher standards.

Despite the apparent failures, progress on such things as civil rights, poverty reduction, rising living standards, personal freedom, public health, and improved public safety cannot be denied. Few would be anxious to return to life as it was 100 years ago, with government being due much of the credit. Unfortunately there continue to be those within our government who would reverse this progress for their own personal gain. A favorite tactic is to use agency budget cutting to foster lower quality work so that government agencies can then be labeled incompetent and their eventual elimination or "privatization" can be justified.

Prior to 1984 and passage of the Canada Health Act, Canadians also lacked confidence in their government's ability to manage a nationwide healthcare financing system, but now they can't imagine living without it. Major changes are never easy, but when necessity dictates them, sticking with the status quo out of fear usually leads to even greater failure.

49. Is the U.S. government good enough for single-payer?

Once upon a time, from the 1930s through most of the 1960s, the phrase “good enough for government work” was meant as a compliment for a job *well* done. Its connotation is much different today, and far too many potential supporters of federally managed Medicare for All have little confidence in the effectiveness of government programs.

While it is tempting to assume that efficiencies from a private sector competitive market model produce the most effectively run healthcare system, this is demonstrably not the case in actual practice. Medicare is currently split between traditional Medicare (administered by the federal government) and Medicare Advantage Plans (privately administered with federal funding). Traditional Medicare provides universal coverage for all qualifying seniors over the age of 65 and all those from whom a profit is not feasible, including the permanently disabled and those on renal dialysis. It also covers the 68% of seniors who do not have Advantage Plans and who are generally the sickest such that private companies avoid insuring them.

The Centers for Medicare and Medicaid Services (CMS) accomplishes this amazing feat by spending less than 3% of its budget on administration and with much lower premiums and far fewer complaints than the private sector. Private insurers have claimed since 1972 that they could run Medicare more efficiently than government, but that has never happened. In fact, CMS has spent billions of dollars more to finance Advantage Plans than it would have spent without them, mainly because of their exorbitant private administrative costs and need for substantial profits.

Both Medicare and Social Security (which has also run like clockwork on a lean budget for over 80 years) have had a profound effect on the poverty rate, while private insurers continue to drive businesses and individuals into bankruptcy. Quite simply, the reorganization of the current CMS into a single-payer, government managed system will undoubtedly be much more effective than the current hodgepodge bureaucracy of expensive private companies financing healthcare today. Since the average life span of an S&P 500 corporation is now [only 20 years](#), governmental management will also be important for long term stability of the system.

Another important factor for critics of publicly managed systems to understand is that government was never designed to be run like a business. Its three branches were established as checks and balances to prevent tyranny and give all people in our very diverse society a voice in self-government. According to UCLA law professor Jon D. Michaels in his new book [Constitutional Coup: Privatization's Threat to the American Republic](#), the same system carries over into the executive branch where a rather bewildering array of agencies is charged with creating procedures to adjudicate and enforce the laws made by Congress. Each agency is led by a director appointed by the president and subject to his priorities, but actually run by tenured civil servants who provide the continuity, the expertise, and typically the strength to resist any partisan directives that might upend the will of Congress. The third check on power is a watchful public that is always ready to “constrain, prod, or redirect agency officials” (p. 62).

When it comes to expanding Medicare to everyone, having a transparent system subject to these checks and balances is critical for success, because policies for the common good have the best chance of being achieved once these multiple parties reach their slow, evolving consensus. Privatization of government services removes these protections and dilutes the goals to mere profit making and shareholder satisfaction. Government is essential for balancing public and private interests. Fortunately as American citizens we have both the right and the ability to keep pushing our government to perform at its maximum effectiveness for the common good.

Most of the accusations of incompetence tend to be exaggerated by those whose profits are at stake. In reality the private sector has proved itself incapable of creating an efficient system, so government must intervene. In this case, the government is the only entity large enough to include everyone in the same risk pool, streamline the system, and amass the negotiating power to the degree necessary to drive down costs and make universal coverage truly affordable.

50. Shouldn't we be trying to prevent the further expansion of government?

No. Blaming problems with government on increasing size is a common and easy way to avoid taking responsibility for the hard work of determining genuine causes and cures. However, the appropriate role for government in any problem needs occasional reassessment. Had the private sector been successful in managing healthcare such that the 20% of our population that is regularly in need (the chronically ill, the elderly, the disabled, and those with mental illnesses) were able to routinely receive quality care at a reasonable cost, there might not now be such a need for the government to assume more control.

Understandably, private insurance companies have always only wanted to insure the relatively healthy, preferring to leave the rest of the population to the government to cover with Medicare and Medicaid, because unlike other forms of insurance (such as homeowner's, automobile, life, or professional liability insurance) health care is largely unpredictable and is increasingly more widely utilized than the benefits provided by more traditional insurance types. It is also much more complex in terms of determining what should and should not be covered. As costs rose, it was thought that competition between private insurers would provide some relief, but in fact the increasing number of companies has only fragmented the size of each company's risk pool, meaning that fewer and fewer subscribers pay for more and more claims.

On the public side, by insuring mostly only high-risk people, the government programs have become overstretched, facing ever higher costs, as more people enter the poverty ranks due to their inability to pay their insurance premiums and medical bills, and more people live longer. Obviously this is not a sustainable situation, and it is simply wrong to claim that government programs are less efficient when their financial burden is so much greater. Government is the only entity capable of resolving these kinds of problems when the conflicts between private business and the public interest are otherwise intractable.

51. What about government corruption and overreach?

The two biggest problems with governmental intervention are corruption and overreach. Government officials have always been tempted to look for personal gains while still claiming to appropriately regulate business, and while deplorable, reducing the size of government will have no effect on reducing corruption. But governments may also try to do too much, either because officials take their jobs to protect the public too seriously, or because they merely want to *appear* seriously concerned.

While the intent is commendable in some situations, overreach often leads to reporting nightmares that cost far more time, frustration, and money than the effort is worth. Every health care provider is familiar with how Medicare and Medicaid requirements have become unbearably tedious, especially as they have become computerized, to the point where many providers, including myself, have taken early retirement just to escape the frustrations. Typically, approaches and remedies are introduced with inadequate research and preparation.

The current emphasis on pay for performance (P4P) initiatives (replacing the Diagnostic Related Groups payment system), for example, is without a solid research base and does not appear to be improving outcomes, but it has succeeded in dramatically increasing provider anxiety and resentment. In response, many providers and insurance companies have further limited their treatment for high risk patients while others resort to “up-coding,” a practice of making patients look sicker on paper than they really are in order to receive a higher reimbursement.

The solution to these kinds of problems is *not* reducing government’s size, but rather improving the quality of government services, while more clearly defining the limits to which government can effectively protect the public and guarantee human rights. A renewed emphasis on professional ethics would also help immensely, as we put the emphasis on patient needs rather than business outcomes.

While the initial conversion to single-payer is bound to be challenging, and the unexpected is always to be expected, Medicare has a long track record of success relative to commercial health insurance. By streamlining the payment process and leaving the treatment decisions to providers, and by setting aside our pride and being willing to learn from the experiences of practically every other technologically advanced country in the world, we should be able to expand and improve Medicare without undue stress.

With single-payer, the situation could almost be guaranteed not to be any worse than it is now, since the basic structure of Medicare has been established for decades. On the other hand, if in fact we as a nation continue to ignore what is best for our country as a whole by continuing to favor the elite 1%, we surely risk serious cultural disintegration and fiscal collapse. Americans simply cannot afford to give up on their government. The answer is not to give more and more responsibility to private, commercial interests, but to press harder in holding government accountable to serving the common good.

52. Aren't there alternative plans that would be easier to implement?

No. There are many alternative plans, but none that will fix the underlying problems. For example, Avik Roy, of the Manhattan Institute, has proposed what he calls the [Universal Exchange Plan](#) that claims to provide near universal, affordable coverage while keeping the ACA and private insurance exchanges intact. While he has several ideas that would no doubt improve the current system, his plan still amounts to tinkering around the edges.

Additionally, three Republican senators have proposed the Patient Choice, Affordability, Responsibility and Empowerment Act which would repeal most of the ACA and replace it with tax credits for low income people to purchase insurance. More recently, the Republican "A Better Way" replaced the 1994 "Contract With America." It is yet another move to further privatize healthcare financing by repealing the ACA and creating a more competitive environment with HSAs, association and individual health pools, the ability to purchase insurance across state lines, more employer self-insurance, more employer sponsored insurance, premium support, and increased control by the states. While these alternatives might contain some worthwhile components, all remain overly complicated and leave the underlying medical-industrial complex (the source of the problem) untouched.

However, the Bismarck Model used by Germany and Switzerland is a multi-payer model that could work for the U.S. It is much simpler and cheaper to operate than the current U.S. system, but its major disadvantage is that cost controls are relatively weak, even though they are much more effective than anything in the U.S.

In this model, the existing insurance companies could be left intact, but they must convert their health insurance programs to non-profit entities, and they must accept all applicants, regardless of age and health, and pay all claims without deductibles or co-pays. Subscribers are free to go to any health care provider, and pick any insurance company from an ACA-like exchange system. All insurers are required to provide the same basic plan, but they can compete with supplemental benefits or gap plans, user friendliness, and efficiency. There are no varying tiers of care such as for the wealthy, the poor, the elderly, veterans, government employees, or Native Americans. The premiums are standardized based on income, not age or gender, and those premiums can be either submitted directly to the company or deducted from an employee's pay. Portability is assured, and unemployment benefits cover the premium. The tax break for employers is eliminated. Everyone is required to purchase insurance under this model, and if someone chooses not to, they are assigned to a plan and the premium is deducted from their pay or other source of income as in a garnishment.

On a regional basis, the insurers negotiate prices with hospitals, drug companies and professional associations so there is a set price for every service and medication. Since premiums are based on a subscriber's income and not whatever the insurer can get away with, budgets will always be more limited and insurers are more motivated to negotiate for lower prices. Multiple payers have less negotiating power than single-payers, but working together increases their leverage. Regions might even compete with each other for lower prices (or they might collude for higher prices!). Despite the additional administrative hassles, Germany has recently added a small quarterly co-pay at the time of service as an additional cost control measure and incentive to reduce unnecessary provider visits. The country has also added global budgeting, but this technique has proven much more effective in single-payer systems.

Even though the Bismarck Model has worked reasonably well in several countries, it is no longer considered the best model to follow. The single-payer system is far simpler and much more cost effective.

53. Wouldn't adding a public option to the ACA help?

No. A public option will likely make things worse because private insurers will continue to find ways around any regulation to prevent them from cherry-picking their subscribers and sending the most expensive subscribers to the public option. Private insurers will continue to attract the healthiest subscribers by granting the best deals to employers with the youngest employees, and offering free fitness center memberships which appeal only to healthy people. They will also continue to place all of the medications needed by the sickest people, such as HIV drugs, on the most expensive copay tier to prevent the chronically ill from applying, or they will continue to exclude the big cancer centers from their networks in order to send those with cancer to other plans, especially the public plan. Medicare Advantage Plans already do this. When beneficiaries get too expensive, they are notified that the plan can no longer serve them, or coverage is suddenly eliminated in counties where there are too many unprofitable enrollees. But, they are told, they can still obtain Medicare through a traditional plan!

No insurance plan will survive if its only subscribers are the seriously ill. Additionally, no public option plan is capable of saving the hundreds of billions of dollars per year that are wasted in private insurance and provider overhead. So costs will not go down, and millions will remain uninsured. If the public option fails, the private insurers will then point to government incompetence as the cause (when no private insurance company in the world could do any better), falsely creating additional resistance to single-payer. The single-payer needs to cover all levels of risk in order to survive financially.

54. How many Americans support single-payer?

In June 2017, a [PEW Research poll](#) found that 60% of Americans say that it is the government's responsibility to ensure health care coverage for all Americans, with 33% of those people favoring single-payer, 25% favoring a mix of government and private insurance, and 2% having no opinion. On the flip side, a full 39% said that health care is not the government's responsibility, even though most of those people still approved of Medicare and Medicaid.

While the total percentage of people favoring single-payer was far lower than 60%, it nevertheless increased substantially since 2013. Support for single-payer among Democrats was at 52% with support being much greater among younger Democrats. While support among Republicans was only at 12%, lower income, younger Republicans were more likely to support the government's continued role in healthcare than higher income Republicans.

The fact that the polling indicated that 60% of the public believed that the government has a responsibility to ensure health care coverage for all Americans is great news, but it does not equate to the same support for single-payer. However, only 5% of the respondents opposed all government involvement in healthcare, which means that over 90% of Americans wanted to see Medicare and Medicaid continued. That kind of an approval rating is still a major accomplishment for our government!

So according to this research, the vast majority of Americans are at least open to the idea that government still has an important role to play in healthcare. They just need to be convinced that its role should be expanded, given the reality that the 45 year old private sector experiment in "managed care" has failed miserably. At this point, there is really no other option.

55. How might single-payer help rural hospitals and underserved areas?

A single-payer, Medicare for All system, will, for the first time, require hospitals to operate on a budget, and they will not be permitted to commingle operational funding with capital expenditures. They will also be pushed from for-profit to non-profit entities. Currently hospitals pay for expansion projects and new equipment out of their profits or operating margins after completing a minimally effective certificate of need process.

The new system will require hospitals to demonstrate the need before a separate allocation is granted for these new expenditures. So instead of basing these decisions on competitive or profit generating interests, hospitals will be forced to study utilization trends and adapt to changing community needs. This will likely mean that small hospitals will be assisted with increased federal funding to convert inpatient space to more outpatient services, or even to long term care, that better addresses the local needs. Such activities as telemedicine, partnering with regional medical centers, adding a pain clinic or a drug and alcohol unit or dental services, and improving the access to primary or urgent care might all be facilitated by single-payer.

Plus, with every local resident having health care benefits, people will not have to forgo care due to an inability to pay, so utilization should increase, and it won't be as difficult to recruit physicians and others to serve these communities. Those states which have expanded Medicaid have already experienced some of this, while those that refused to expand Medicaid have generally experienced ongoing rural healthcare decline.

56. What are the obstacles to passing single-payer legislation?

The number one obstacle is the corporations which are dependent on the status quo, particularly the insurance companies and their myth-creating spin doctors as explained by [Wendell Potter](#). The second biggest obstacle is the public's fear of change. People need to be convinced that single-payer will provide far better benefits for less money than any existing insurance policy.

The third obstacle is widespread, uncritical belief in the myths themselves. In 2018, an alliance of pharmaceutical, hospital and insurance lobbyists formed the [Partnership for America's Healthcare Future](#). The group's goals are to "change the conversation around single-payer Medicare for All" and "minimize the potential for this option in health care from becoming part of a national political party's platform in 2020." The group is particularly interested in convincing Democrats to reinforce the ACA rather than promote single-payer. It highlighted their top talking points as follows:

- The current system provides world class care.

Response: Yes, but it's only for those who can afford it, and [our outcomes](#), especially life expectancy, infant mortality, and the high prevalence of chronic disease, are worse than most other developed countries'.

- Any move away from the ACA would be "ripping apart our current system."

Response: After trying for 45 years to improve it, the [current system is beyond repair](#).

- Bureaucrats in DC have no understanding of a person's medical situation and will be making decisions about your healthcare instead of doctors.

Response: Private insurers and hospital administrators now make many more important decisions based on the [profit motive](#) than the government ever will.

- Nobody wants a government-controlled health insurance system.

Response: [Polls](#) indicate a government-managed system is in fact very popular.

- Government-run systems are horrific as proved by YouTube videos.

Response: We are not advocating "government-run" as in the United Kingdom or the V.A. We want a privately run system with [government-managed financing](#). It's not hard to find isolated examples of poor service regardless of the industry, and there is not a healthcare system in the world that hasn't neglected some of its people. There is, however, no excuse for our non-system that continues to neglect millions.

- Private health insurance is the only positive solution to America's healthcare woes.

Response: The rest of the world strongly disagrees and can't believe we are so obstinate.

- Now the latest claim is that Americans love their health insurance.

Response: This is pure industry exaggeration designed to instill fear of change. At best, [Americans tolerate](#) the current system simply because the vast majority have never had anything resembling a complex interaction with it. According to Representative Jayapal (D-WA), over 30 major labor unions, including the UAW, now support Medicare for All because they are tired of continually siphoning off higher wages to increasing healthcare benefit costs.

The fourth major obstacle is the conservative Democrats who want to pacify the medical-industrial complex through [watered down proposals](#) that won't address the underlying causes. The bottom line is that single-payer Medicare for All will provide access to health care as a basic need for all people. It will streamline the system, cost a lot less, eliminate deductibles and coinsurance, eliminate restrictive networks, cover all pre-existing conditions, add dental/vision care, hearing and long-term care, provide fair reimbursements, and have a goal of increasing quality while decreasing unnecessary procedures.

57. Do the Democrats have to admit that the ACA was a failure?

No. The ACA is not a failure, but it could have been much more effective had not the private insurance, hospital, drug company, and AMA lobbies consistently thwarted cost controls and a single-payer program for decades. The ACA is unsustainable because only the *big four* were invited to the negotiating table to formulate the law. Single-payer was not included as an option, and no patient or consumer groups, unions or professional associations were involved. Expanding the ACA is likewise not sustainable because covering everyone, expanding benefits and increasing reimbursements would require an additional massive outlay of government subsidies without the corresponding savings that make universal healthcare possible under a single-payer system.

Now polls show that a majority of Americans, including health care providers, are strongly in support of national health insurance. The best way to improve the ACA is to incorporate many of its provisions into a single-payer system that provides complete universal coverage and markedly reduces costs. Such a system will prove that our government truly believes that public health is more important than corporate profits, and that health care is not a business but a service.

58. Are individual states making any progress?

Yes. It is likely that before any federal single-payer legislation will pass, the concept will first need to be tried by a few states. This is how the Canadian system got started when the Saskatchewan government started a very impressive province-wide universal hospital insurance program in 1947. To that end, state-level single-payer legislation has been introduced in 26 states, and many state campaigns are currently [very active](#). Those include New York, Massachusetts, Pennsylvania, California, Minnesota, Oregon, Colorado, Washington, Vermont, Maine, Michigan, Missouri, Illinois, Hawaii, New Mexico, South Carolina, Rhode Island, Iowa, New Jersey, and Ohio. However, federal cooperation will be necessary to make any individual state system work well. That is what [HR 5010](#) seeks to accomplish.

59. What is Washington state doing?

Much is happening in the state of Washington! [Health Care For All-Washington](#) (HCFA-WA) is a non-profit organization that has been actively promoting state and federal legislation that would create a single-payer, universal healthcare system for many years. It is a member of the Health Care is a Human Right Campaign and one of 20 states active in the One Payer States Network. Its primary focus has been to create and promote the Washington Health Security Trust bill which would create a state based single-payer system. More recently, another group called Whole Washington has organized to push for similar legislation.

Whole Washington hired Dr. Gerald Friedman, Professor of Economics at the University of Massachusetts at Amherst, to do an economic analysis of single-payer in the state to consider its context, savings, costs, and financing. [Friedman's report](#) was made public at the end of 2017.

The report detailed five main areas of savings as follows: 1) reduced provider billing and authorization administration, 2) reduced prices for hospital services and pharmaceuticals through negotiated bulk pricing, 3) elimination of private insurance administration, 4) elimination of employer insurance administration, and 5) fraud reduction through the enhanced subpoena power of a single payer. These savings total \$16.423 billion.

Friedman also projected that the cost of improvements with a single payer system would total an extra \$7.327 billion. Thus by subtracting the new costs from the savings, the single-payer system would cost about \$9 billion less. It is a savings that is shared across the entire system, not just within state government. However, being one of the largest employers in the state with almost 112,000 FTE employees, state government, like every other employer providing health insurance benefits, stands to save a lot.

Friedman's net projected total cost of the single-payer program in Washington is \$70.885 billion. When the available revenue of \$42.660 billion is subtracted, the balance still needed is \$28.225 billion. That total cost includes the \$9 billion in savings, so that savings will still be spent on health care. While \$28 billion sounds like a lot of money, it is considerably less than what Washington residents are currently spending on premiums, coinsurance, deductibles, copays, and non-covered health care (about \$41 billion). To raise these additional funds, Whole Washington originally suggested an 8.5% payroll tax, an 8.5% capital gains tax, and a 1% income tax. However, after a ballot initiative campaign (I-1600) failed to gather enough signatures, and since the state does not currently have an income tax, the group changed its funding proposal (see SB 5222 below).

For the 2019-2020 biennium HCFA-WA is promoting HB 1104 (formerly HB 1025 and HB 1026 and originally written by HCFA-WA) which would create The Washington Health Security Trust (WHST), a single payer health financing agency administered by the state. It would eliminate excessive administrative costs and generate savings sufficient to cover all Washington residents with a comprehensive uniform package of personal health services. Residents will have a full choice of providers within private health care facilities. A committee is required to submit a separate funding plan to the legislature. It will likely contain an assessment to be paid by all employers and a monthly premium to be paid by all residents with some exceptions, as well as other funding sources, but it leaves the financing specifics to the Joint Select Committee on Health Care Oversight. The prime sponsor is Representative Sherry Appleton. No action is expected soon.

Whole Washington is promoting SB 5222 to create the Whole Washington Health Trust which would be very similar to the WHST. This bill contains much more specific language concerning how the trust is to be funded. It calls for a 10.5% assessment on an employer's gross payroll with up to 2% of it being paid by the employees. It also calls for a 8.5% assessment on long term capital gains earned by Washington residents. It was written by Whole Washington and is being supported by HCFA-WA. The prime sponsor is Senator Bob Hasegawa. No action is expected soon.

HCFA-WA also promoted SB 5822 (HB 1877). This is called the Pathway to Universal Healthcare Bill. It is designed to move legislation toward some kind of universal coverage system, if HB 1104 becomes stalled, by setting up a work group to study the options. The bill passed as part of the [state budget](#) with \$500,000 dedicated for the project. Its prime sponsors were Representative Nicole Macri and Senator Emily Randall. The Work Group's progress can be followed [here](#).

Governor Jay Inslee, Representative Eileen Cody, and Senator David Frockt also advocated a bill called [Cascade Care](#) (HB 1523/SB 5526) to expand subsidies to those being hurt by the current ACA exchange rules and create up to three standardized health plans (each with three metal tiers) to reduce deductibles and other barriers to care. The goal beginning 2025 is that no private carrier would offer any non-standardized health plans on the exchange. This bill passed with HCFA-WA support and

was signed by the governor. It is [being applauded](#) as a modest but important step for advancing genuine healthcare reform.

At the end of the 2017-18 session the legislature approved \$100,000 for a feasibility study of single-payer and other universal healthcare systems to be conducted by the non-partisan Washington State Institute of Public Policy. The [interim report](#) was published December, 2018. It covers policies to promote universal healthcare, outlines healthcare coverage and expenditures in Washington, examines potential effects of implementing single-payer healthcare, discusses challenges to implementing it, and summarizes characteristics of national and state single-payer proposals. The [final report](#) was published May, 2019 and covers universal coverage and single-payer systems in other countries and reviews evidence regarding differences in healthcare costs, access to care, and health outcomes.

State legislators can be contacted through www.leg.wa.gov.

60. How did current federal single-payer legislation evolve?

The Expanded and Improved Medicare for All Act (HR 676) was initially introduced in Congress in 2011, reintroduced in 2015, and gradually attracted 124 co-sponsors. The American Health Security Act (H.R. 1200) was introduced in the House in 2013 and reintroduced in 2015 by Rep. Jim McDermott (D-WA). It was introduced in the Senate (S. 1782) in 2013 by Sen. Bernie Sanders (I-VT). Senator Sanders then introduced his own Medicare for All Act (S. 1804) in 2017, garnering 16 cosponsors. In February 2019, Rep. Pramila Jayapal (D-WA) greatly expanded HR 676 from 30 to 120 pages calling it the Medicare for All Act of 2019 (HR 1384).

HR 676 (and its successor HR 1384) is most closely based on [the proposal](#) of the Physicians' Working Group for Single-Payer National Health Insurance (an advocacy group now known as Physicians for a National Health Program) written in 2003 and updated in 2016. It would establish a single authority responsible for paying medically necessary health care costs for all U.S. residents, eliminate copayments and deductibles, eliminate the need for basic private insurance plans with their highly variable and complex rules and hidden costs, divorce health insurance from employment, phase out for-profit delivery systems, enhance reimbursement for providers serving the indigent, improve benefits for everyone, reduce prescription drugs costs to European levels, annually negotiate reimbursement rates, and provide funding for retraining displaced employees.

None of the bills so far have specified exactly how the single-payer program should be funded. While numerous options have been proposed, those details have been deferred to future legislation so that the goal of universal healthcare is not sidelined by payment issues.

61. What is the current federal single-payer proposed legislation?

HR 1384—[The Medicare for All Act of 2019](#). The Expanded and Improved Medicare for All Act (HR 676) was revised and expanded by Rep. Pramila Jayapal (D-WA) from 30 pages to [120 pages](#) and given this new name and number. [The bill](#) would create a publicly financed, privately delivered healthcare system that builds on the existing Medicare program. Not only would it expand Medicare to all U.S. residents, but it would greatly improve it, including negotiating fair reimbursements to providers and budgets for hospitals. Interest groups involved with the drafting included the Consortium for Citizens with Disabilities, National Nurses United, Physicians for a National Health Program, Social Security Works, Public Citizen, and the Center for Popular Democracy. Insurance and big pharma played little to no role.

S 1129—[The Medicare for All Act](#). This is the single payer bill sponsored by Senator Bernie Sanders in 2017 and reintroduced with expanded long term care coverage for 2019. It has 16 cosponsors. There are several important differences between the House and the Senate bills and the [House bill is significantly better](#).

[HR 6097](#)—The State Based Universal Healthcare Act of 2018 sponsored by Rep. Pramila Jayapal (D-WA) would allow states to create their own universal healthcare plans such as the Washington State Security Trust. The provisions for state based innovations included in the ACA are proving to be inadequate for states wanting to set up a full single-payer system. So this bill seeks to replace the ACA Section 1332 state innovation waivers with a provision allowing states to combine several federal funding streams if the state offers a universal plan. It would also prohibit barriers to affordable plans such as work requirements for Medicaid, and it would allow states to apply for an ERISA waiver to prevent self-insured employers from opting out. The bill was reintroduced as HR 5010 by Ro Khanna (D-CA) in November 2019.

The original ACA Section 1332 waivers only authorize states to waive mandates, certain benefits, limits on cost sharing, metal tiers, some standards for state exchanges, and premium tax credits and cost-sharing reductions. States can only request an aggregate payment of what residents would otherwise have received in premium tax credits and cost-sharing reductions, and the waivers cannot be used to change Medicaid program requirements.

The first Congressional hearing on Medicare for All occurred on April 30, 2019 in the House Rules Committee. Several single-payer advocates provided some powerful [testimony](#) in favor of HR 1384. A second hearing was held by the House Budget Committee, but with unremarkable testimony. A [third hearing](#) was held June 12, 2019 by the House Ways and Means Committee. Former CMS Administrator Donald Berwick and patient advocate Rebecca Wood provided a strong case for Medicare for All. Dr. Berwick summed it up best by saying: “Medicare is not an end in itself. It is a means to achieve what we care about: better care, better health, lower cost, and leaving no one out. I am open to any proposal that moves our nation fast and well toward those goals. Compared with Medicare for All, I see none better.”

Two single-payer advocates, Representative Pramila Jayapal (D-WA) and Jean Ross (President of National Nurses United), also testified before the House Committee on Energy and Commerce Subcommittee on Health on December 10, 2019. This was the [fourth hearing](#) concerning Medicare for All in one year!

62. How much health care is too much?

Obviously healthcare resources are limited, but it is not easy to determine when an individual or society in general has crossed a threshold for what is reasonable or cost effective, especially as one becomes elderly, acquires multiple, coexisting diseases, or sustains a permanent injury. Atul Gawande has written an excellent book for initiating this analysis called *Being Mortal: Medicine and What Matters in the End*. The question he wants people to ponder is: When does life cease to become worthwhile?

The idea that we could have too much health care is a relatively new one for Americans, since the main fear for most providers and families is doing too little. But for the person who is essentially reduced to dealing with one-damn-thing-after-another, from which only temporary relief is possible, a conversation about refusing health care can be a welcome change and lead to a much more satisfying end of life. According to Gawande, rather than the default mode of aggressive treatment, what is most needed when a patient is experiencing complex life and death choices is a frank discussion with their doctor regarding their fears, hopes, and end-of-life preferences, given realistic expectations. Some research has shown that patients who have these discussions are much more likely to die comfortably at peace, stay in control, spare their families needless emotional and financial stress, and even live somewhat longer.

Inappropriate and excessive health care not only contributes to higher costs for everyone, but more importantly, it contributes to a lower quality of life, and at no time is this more important than at the end of life.

63. Why do we still have such a dysfunctional system?

That is the question that all of our Congressional representatives need to answer. A small army of insurance, hospital conglomerate and drug company multi-millionaire corporate executives who consider health care a commodity instead of a basic need have convinced our government that their profits are more important than our physical, mental, and financial health. Unbelievably they have also convinced our government that their outlandish profits are more important than America's overall business climate, its international competitiveness, and its global reputation as a democracy where people who work hard and play by the rules are generally rewarded and where everyone is appropriately cared for.

There are over 20 think tanks, mostly funded by the Koch brothers and other billionaires, pumping out a steady stream of corporate propaganda in opposition to national health insurance. Their objective is to perpetuate the profits for those doing well under the status quo as long as possible, regardless of the effects on everyone else. They accomplish this in part by disseminating disinformation about the Canadian system. Perhaps if Congress people had to purchase their own health insurance on the open market instead of having premium [taxpayer subsidized plans](#), they would have a much better understanding of what the average citizen must endure, and things would change much more quickly.

The issue is not and should not be a partisan one (Republicans, and even Richard Nixon, have supported national health insurance in the past), but it certainly does represent the failure of America's so-called representative democracy. When corporate elites are permitted to pursue unlimited profits at the expense of the majority of the population, government has failed. As Sheldon Wolin explains in *Democracy Incorporated*, what we have is "a politics of dumbed-down public discourse and low voter turnout combined with a dynamic economy of stubborn inequalities to produce the paradox of a powerful state and a failing democracy" (p. 259).

In fact the situation is even worse, because even our global power and influence has weakened as a direct result of our domestic failures to adequately care for our own people. While there are numerous democracy movements around the world, few if any consider the U.S. a serious model because it is so obvious that we simply do not practice what we preach.

As a dysfunctional Congress continues to bicker like children and ignore the needs of the 99%, we the people need to take it upon ourselves to fix the system and then give it back to the government to run. Nothing short of a political revolution is needed, and that is exactly what is starting to happen. Stimulated by the ACA which granted states a waiver from ACA and certain ERISA regulations if they create their own innovative healthcare financing system, individual states continue to press for their own single-payer programs, despite recent setbacks in Colorado and Vermont.

While the legalities are complex, and progress is slow, the tide is definitely turning toward pairing healthcare with justice. As Winston Churchill famously said: "You can always count on Americans to do the right thing, after they have tried everything else." In this case, we have definitely tried everything else!

64. What is Senator Warren's healthcare plan?

Senator Elizabeth Warren released the first comprehensive [plan](#), by any 2020 presidential candidate, for financing Medicare for All on November 1, 2019. She prefaces her plan with an important memory: “My daddy’s heart attack nearly sent our family skidding over a financial cliff.” She then describes how she spent her early career building the “largest and most comprehensive database of consumer bankruptcy data ever assembled,” finding that “the [number one](#) reason families were going broke was health care — and three quarters of those who declared bankruptcy after an illness were people who already had health insurance.”

After accounting for significant savings of about \$7 trillion in efficiencies and \$6 trillion redirected to the federal government from state healthcare spending, Warren estimates that switching to Senator Bernie Sanders’s Medicare for All will cost the country (from all payment sources) almost what our current system will cost over the next ten years: \$52 trillion. However, unlike our current system, all 331 million people will receive full benefits, and everyone will get greatly expanded coverage including long-term care. Under the status quo for the next ten years, the federal government is expected to spend an estimated \$31.5 trillion, employers will spend about \$9.5 trillion, and consumers will spend about \$11 trillion. What will change under Medicare for All is not so much the amount expended, but who will pay it, who will collect it, and what taxpayers will receive in return. Instead of sending their \$20.5 trillion to corporate insurers, employers and consumers will direct their portion of the funding to the single-payer federal government, for redistribution to healthcare providers at fixed, pre-negotiated rates.

While there are numerous ways for the government to collect the additional funds, under Warren’s plan, the \$20.5 trillion will come from eight primary sources. The biggest share (\$8.8 trillion) will be paid by large employers, who will be enjoying a huge discount over what they are currently paying for employee health insurance. The program will financially encourage employers to direct their savings toward higher wages, thus potentially increasing income tax revenue by \$1.4 trillion. Another \$2.3 trillion can be added to the program by partially closing the huge gap between income taxes that are owed and those that are actually collected. IRS enforcement will be directed primarily at the wealthy. Additional small fees on various financial firms and special fees on big banks could bring in \$0.9 trillion. Tax reform for large corporations could add \$2.9 trillion. Wealth taxes and closing capital gains loopholes on the top 1% of households would add another \$3.0 trillion. A more humane immigration policy could deposit \$0.4 trillion with the addition of new tax payers. And finally Warren envisions another \$0.8 trillion through eliminating wasteful and unneeded defense spending. According to Warren, her single-payer healthcare plan will lead to “one of the greatest federal expansions of middle class wealth in our history.” Plus it would be a major step towards reducing our ever widening wealth inequality.

Because fully establishing all eight sources of supplemental income is likely to take a few years, Warren envisions a three year [transition period](#) before her Medicare for All plan can be completely enacted. During her first 100 days as president, however, she intends to initiate several reforms including closing the revolving door of lobbyists, taxing excessive lobbying, ending “lobbyist bribery,” limiting corporate influence on elections, breaking up hospital consolidation mergers, and reversing President Trump’s actions that have increased costs. She also expects to lower prescription drug prices, include dental coverage under Medicare, broaden Medicaid eligibility, stop up-coding fraud, create an advisory commission to protect workers for the transition, establish uniform billing and electronic medical records, create a centralized repository for claims data, end surprise billing, and increase NIH research.

At the heart of this initial work is her transitional public option. This plan will offer full benefits, including long-term care, and cover 90% of costs (consumers pay 10%). There will be no premiums for kids under 18 and people at or below 200% of the federal poverty level. Scaling will occur above that level to be capped at 5% of income, and no one will have a deductible. In subsequent years, cost sharing will be reduced to zero. Employers and unions will be able to opt in, with employers paying a discounted contribution to the extent that they pass along the savings as increased wages or other benefits. In addition, anyone over 50 will be eligible for existing Medicare with expanded benefits, a \$1500 cap on out-of-pocket costs in parts A and B, and a \$300 cap on part D. In subsequent years, premiums will drop to zero. The ACA will also be strengthened by broadening the limit on eligibility for Premium Tax Credits and allowing states to pursue single-payer waivers. Warren expects tens of millions of people to choose the public option as soon as it becomes available, since its affordability and provisions will be far better than any corporate option.

65. Who are you?

I am the author of this ebook and the author of *Mount Spokane State Park: A User's Guide* and *Spokane's History of Skiing: 1913 to 2018*, both published in Spokane, Washington where I live. I have been president of the Friends of Mt. Spokane State Park for over 20 years. I grew up in Indiana where I received a BA in biology from Earlham College and was also active against the Vietnam War. Later I earned a BS in nursing from Creighton University. In between working as a staff hospital nurse and a home health nurse, I started and co-directed Spokane's first community mediation program in 1987 and earned an MA in conflict resolution from Antioch University. I was also president of the Washington Mediation Association for three terms. I retired from nursing at the end of 2015.

66. How were you activated on this issue?

My experience as an RN since 1979 has culminated in a passionate activism for single-payer. I started in a Sisters of Providence hospital, and while not a Christian, I resonated with the Catholic commitments to self-sacrifice and to serving others, especially the most vulnerable. When the hospital converted to “civilian” management, the guiding values remained the same only on paper, and hypocrisy eventually infected what became one of the largest “non-profit” healthcare conglomerates in the country. While the marketing claimed that it was our mission to put patients first, it became obvious that profits were what really mattered most and that patients were way down on the priority list, even though most individual employees wanted them to be at the top.

I was working in home health when the electronic medical record was introduced. It was and still is a disaster, because it is not designed to facilitate efficient patient care, but to make it easier for administrators to file reports to insurance companies that will maximize reimbursements. The illegal practice of “upcoding” went rampant to make patients look sicker than they were so reimbursements would be higher. The room where we stored wound care, diabetic, physical therapy and other supplies that we took out to patients got smaller and smaller. Because we were spending too much, it was eventually locked, and we had to get permission from a supervisor to take out even the most basic supplies. At the same time, 19 executive managers were making well over \$1 million per year. No Catholic sister ever even desired to make that much, and I began to uncover the injustice and the real reasons why health care is so expensive in this country. It made me angry.

When I retired, I wasn't quite old enough for Medicare, but I couldn't stand working in such a corrupt system anymore, and I was truly shocked at how expensive health insurance is for those not fortunate enough to work for a large employer. That was the final straw that pushed me from disgruntled employee to healthcare activist, and I got involved with Health Care for All-WA. I wrote this book because as a writer and historian I want to do all that I can to ensure that healthcare is linked to justice in America.

67.

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