

Single Payer, By Default:

CURRENT TRENDS, INCLUDING CDHC, WILL ONLY COMPOUND THE PROBLEMS

By Don McCanne, MD

Regardless of personal ideology or political persuasion, everyone in the policy community understands the strengths of the single-payer model of national health insurance. It would provide truly comprehensive coverage for absolutely everyone while putting into place mechanisms that would slow the rate of healthcare inflation.

There is no mystery about how this would be accomplished. Coverage would be automatic for everyone, from birth on. All reasonable, beneficial health services would be included. The current, highly inequitable mechanisms of funding care would be replaced with a single, equitable system of public funding. Numerous micro-simulations and the experiences of other nations have confirmed that replacing our highly inefficient, fragmented private and public insurance systems with a single, publicly administered program would free up more than enough wasted funds to pay for the deficiencies in healthcare coverage today.

The entire healthcare system would be placed on a global budget with adjustments made for demographics, inflation, and beneficial technological innovations, while maintaining reserves for surge capacity if needed. Hospitals would negotiate global budgets taking into consideration such factors as risk adjustment and complexity of specialized services. Physicians would enter collective negotiations with the single payer administrator, ensuring that legitimate expenses are met and that net compensation is reasonably generous.

Using our current level of spending — 16.5 percent of our GDP — as the base line for future budget adjustments, inadequate funding should never be an issue. That is more than enough to ensure adequate capacity to prevent excessive queues and to provide incentives for technological innovation.

The greatest concern in healthcare today is affordability. Employers are responding by shifting more costs to their employees or even terminating health benefit programs. The expanding numbers of uninsured are largely due to the decline in employer-sponsored coverage. Federal and state governments are struggling with their healthcare budgets, impacting the Medicaid and SCHIP programs. Innovations in insurance products threaten the financial security of patients, through reduced benefits and increased cost sharing.

We should ask whether our private insurance system is serving us well. Employer-sponsored plans cover 61 percent of the non-elderly, though

they fund only 19 percent of our total healthcare costs. Gainfully employed individuals and their families are a very healthy subset of our population. Because the healthcare needs of this sector are comparatively low, the insurers' exposure to higher risk patients is minimized. Much of the risk-pooling function is shifted to the taxpayers through programs that cover higher cost individuals such as Medicare, Medicaid, and the VA system. In fact, 60 percent of healthcare is already funded through the tax system.

The individual insurance market is even worse. The value provided is about 30 percent less than in the group market, largely because of higher administrative costs. Furthermore, the individual market is subject to medical underwriting, so the insurers are avoiding the risk of patients with significant pre-existing disorders.

Not only are the administrative costs of private plans higher than public programs, the administrative burden placed on the providers of care wastes resources that would be better used for healthcare. According to a recent study published in *Health Affairs*, over one-fifth of premiums paid to private plans are used for billing and insurance-related functions alone.

Since the failure of the politically inept Clinton attempt at reform, the consensus in the health policy community has been that we must continue on the pathway of incremental reform. The problem is that it isn't working. The numbers of the uninsured are increasing. Costs continue to escalate. The insured have less financial security. By international standards, the performance of our system is mediocre, ranked 37th by the World Health Organization.

Various incremental measures under consideration are quite flawed. An employer mandate to provide coverage would negatively impact small businesses, which are frequently operating with very small profit margins already. An individual mandate would not be effective for the large number of moderately low-income individuals who cannot afford to pay the high premium prices. Tax credits are an expensive method of expanding coverage because the net gain in the numbers of uninsured would be quite small, whereas the numbers receiving the credit would be large as employers drop coverage once their employees become eligible for the credits. Association Health Plans would limit benefits in order to keep premiums competitive, thereby potentially exposing employees to greater financial risk. Those with pre-existing disorders would be concentrated in plans that would become unaffordable because of the death spiral of escalating premiums.

Special mention should be made of the passing fad of consumer directed health care (CDHC), especially health savings accounts (HSAs), and high-deductible health plans (HDHPs). The HSAs are based on flawed tax policy, flawed health policy, and flawed pension policy. The accounts use regressive tax policies to fund them, benefiting the

wealthy but not individuals with lower incomes. People with significant medical problems rapidly deplete their HSAs — if they were even able to fund them in the first place — and then are left with financial exposure to continuing medical costs, potentially impairing their access to healthcare. The healthy would get to keep their HSAs to use as retirement accounts, but others who are unfortunate enough to develop medical problems would be penalized by losing these would-be retirement accounts. Also, there are many administrative fees associated with HSAs, not all obvious, that add to the administrative waste that already plagues our healthcare system.

Of greater concern is the HDHP component of CDHC. These plans have large deductibles, which may be a hardship for modest-income individuals with depleted HSAs. Also, patients lose their options in care since the HDHPs are PPOs (preferred provider organizations) that assess severe financial penalties if care is obtained out of the network. Frequently, they exclude benefits such as maternity services. Lower-income individuals may select these plans because that is all that they can afford, but the cost sharing associated with them may make healthcare itself unaffordable.

The real task before us is to ensure that the large number of us who are healthy pay into a fund that covers care for the 20 percent of individuals who use 80 percent of health services. The most equitable method of doing that would be to establish a single risk pool. A multi-payer system might work, but it would have to be so tightly regulated that it functions as a single-payer system. Furthermore, micro-simulations have shown that multi-payer systems are the most expensive method of achieving universal coverage, whereas a single-payer system actually reduces healthcare spending.

We've tried most everything else, but high costs and fragmentation grow worse. Current trends, including CDHC, will only compound the problems. Employers and patients want something done now. More voices are joining in the call for a "national solution." The nation is growing weary of waiting for someone to come up with a better solution. Since there really isn't any, we will soon have a single-payer program of national health insurance, even if only by default. Once Americans become comfortable with it, they will be as supportive as they are of our other social insurance programs: Social Security and Medicare. ~

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SINGLE PAYER vs. CDHC

To read a thoughtful exchange between Dr. McCanne and Dr. James Knight, SDCMS past president and CEO of Consumer Directed Health Care, Inc., go to: www.sdcms.org/pdf/mccanneknight.pdf