The Single-Payer Amendment to HR 3200

Executive Summary

Overview:

The Single-Payer Amendment to HR 3200, introduced by Rep. Anthony Weiner[1] amends Division A of HR 3200 by substituting the provisions of HR 676, "The U.S. National Health Care Act" for its present contents. HR 676, introduced by Rep. John Conyers Jr., would create a single-payer National health insurance system – an expanded and improved Medicare for all.

The Single-Payer Amendment to HR 3200 would establish a single-payer national health insurance plan to provide comprehensive, high-quality health benefits to all Americans.

The plan would save enough on paperwork to cover all of the uninsured, thus requiring no increase in total health spending. In addition, it would put in place effective mechanisms to control costs in the future, making the system sustainable for future generations.

Last but not least, it would restore choice of physician and hospital to all patients.

Access:

Every person in the United States would be covered for all necessary medical care.

Patients would receive a National Health Insurance Program (NHIP) card entitling them to care at any hospital or doctor's office. Patients would not be billed for covered medical care and there would be no co-pays or deductibles for covered services. All costs for covered services would be paid by the National Health Insurance Program.

Benefits:

Coverage would include all primary care as well as hospital, mental health, long-term care, dental and vision services, and prescription drugs and durable medical supplies.

In effect, the plan improves on traditional Medicare's benefits and expands coverage to all Americans. It would eliminate co-pays and deductibles, cover all medications, and cover all physician and hospital care, including mental health care.

[1] Originally introduced by Reps. Weiner, Welch, Engel, Baldwin, Rush, Schakowsky and Doyle in the Committee on Energy and Commerce.

Administration/Administrative Savings:

The program would be publicly financed (like Medicare) and administered by regional boards.

Private insurance which duplicates NHIP coverage would be eliminated, saving tens of billions annually in insurance company profits and overhead. Removing the complex and redundant insurance bureaucracy would greatly simplify paperwork in doctors' offices and hospitals, generating additional savings. About half of the 31% of health spending that now goes for billing and administration would be saved under this plan. Total savings: more than $400 billion annually.

Effective Cost-Controls:

Coverage for all Americans is possible with no increase in total health spending

According to estimates from the General Accounting Office, the Congressional Budget Office, and several private consulting firms, savings on bureaucracy would allow single payer NHIP to cover all of the uninsured and upgrade coverage for the under-insured (including full drug coverage for seniors) without any increase in total health spending. Future costs increases would be contained by the NHIP's ability to set and enforce overall spending limits (see below) and improved health planning. This is the only proven method of controlling health costs over the long run.

- **Hospitals and health facilities would be on a budget.** Most hospitals and nursing homes would remain privately owned and operated, receiving an annual "global" lump sum budget from the NHIP to cover all operating costs. Capital funds would be distributed separately by regional NHIP boards on the basis of health planning goals.

- **Physicians would be paid based on a simple fee schedule covering all patients.** Private doctors would continue to practice on a fee-for-service basis with fee levels set in negotiations with the NHIP. Non-profit HMOs that actually own clinics and employ doctors. Such plans would receive capitation payments from the NHIP for each patient, with regulations to prevent skimping on care. Neighborhood health centers, clinics, and home care agencies employing salaried doctors and other health providers would be funded directly from NHIP on the basis of a global budget.

- **Medications would be purchased wholesale.** Medications and medical supplies would be purchased at a negotiated wholesale price as they are in the Veteran's Administration and in other countries.

- **Investor-owned delivery facilities would be phased out.** Numerous studies have shown that investor-ownership of hospitals and clinics raises costs and worsens care. These facilities would be gradually phased out in favor of non-profit delivery.

Financing

The program would be paid for by combining current sources of government health spending into a single fund. Administrative savings achieved through the elimination of private insurers would be redirected back into care, requiring no additional new sources of revenue. Premiums, co-pays and other out-of-pocket costs would be replaced by a modest progressive income tax. Ninety-five percent of people would pay less in taxes than they currently do for private insurance coverage.