

**Making the Case for Single Payer Health Reform:
It is Time for Medicare for All**

**Issued by the Citizens Action Coalition of Indiana,
in conjunction with Hoosiers for a Commonsense Health Plan**

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Executive Summary

The health care system in the United States is better described as a non-system of expensive illness intervention that covers too few and costs too much. The United States is the only industrialized nation that does not guarantee access to health care for all, yet we spend twice as much on health care as any other nation. Our high spending does not buy good health outcomes, as the U.S. ranks poorly in all basic indicators of health when compared to other industrialized countries.

Forty-seven million Americans are uninsured but the problems extend far beyond the uninsured population. According to Families USA, families with health insurance pay premiums that are \$922 higher each year to cover the costs of the uninsured. (Stoll)

Health care bills have become the number one reason for personal bankruptcies, although some people lose far more than their economic security. A study released by the consumer advocacy group Families USA in April of 2008 noted that 460 working-age Hoosiers die each year because they don't have health insurance. (Bailey)

Public opinion polls show that Americans are increasingly concerned about the health care crisis. Even those with insurance have begun to understand that they are vulnerable too, and a majority of Americans support sweeping changes to guarantee access to all.

Health reform proposals that attempt to work within the frameworks of the current, market-based system will not achieve universal coverage or control costs, two goals that must be paramount. The U.S. should use the Medicare program as its model and expand insurance to all Americans through a single payer system.

Research shows that a system funded and administered like Medicare would save at least \$300 billion annually. These savings provide more than enough funding to provide coverage for the 47 million Americans currently uninsured.

Even with a tax increase to fund a national health care program, the vast majority of Americans would pay less for health care than they do today, since premiums, co-pays, deductibles and other out-of-pocket costs would be eliminated. And, U.S. businesses that currently provide health insurance would no longer be at a competitive disadvantage because of their health care costs. Health care inflation would be controlled through budgeting and negotiated fee schedules.

H.R. 676, the National Health Insurance Act, is sponsored by Rep. John Conyers and 88 other members of Congress. It would use the Medicare model to create a publicly-financed, privately administered health care program to cover all Americans.

Citizens Action Coalition calls on the members of the Indiana Congressional delegation to sign on as co-sponsors to H.R. 676.

Introduction

Currently, 47 million Americans lack insurance coverage. (DeNavas-Walt, et al.) Just as many are under-insured; they have health insurance with such limited coverage it puts necessary medical services beyond their reach. Many with health insurance are not guaranteed coverage when they need it or offered any real choice in health care providers. Health insurance companies are making billions while Americans forgo needed tests, medications and doctor visits until the situation calls for immediate care and they end up in overcrowded emergency rooms. In January of 2008, the Urban Institute released a study estimating that at least 22,000 people die every year due to lack of health insurance, updating an earlier report from the Institute of Medicine. (Dorn)

The United States is the only industrialized country in the world that doesn't guarantee universal access to health care. In the U.S. health care is rationed based upon who can afford it, place of work and place of residence. Some of our largest employers are finding that the continual increase in premiums for employer-based health coverage is cutting into the bottom line and adversely affecting American companies' ability to compete globally.

Many proposals to address the health care crisis in the U.S. have been introduced - from health savings accounts to tax incentives to individual and employer mandates. However, these attempts to reform the system are half-steps and do nothing to address the real issues underlying America's health care system.

Americans need a health care system which guarantees universal access to all, regardless of ability to pay. We need a system that works to control rising health care costs while offering high quality care. Americans deserve comprehensive coverage which is separate from employment and portable, so no matter where in the country a person resides or works, they are covered.

Many proposals attempt to work within the same market-based health care system that is failing so badly. This white paper will show the adverse impact of the current system on everyone, the uninsured, under-insured and the insured, as well as the impact that large numbers of uninsured people have on society and how uncontrolled health care costs affect businesses and the economy. This paper also examines the different approaches to health coverage across the world and how current incremental reform efforts affect the uninsured and insured alike.

Citizens Action Coalition believes that five basic public interest criteria must be met in order to achieve a just and affordable health care system. This paper analyzes current approaches to health reform based on these criteria. In our view, a reformed health care system must:

1. Be universal and affordable;
2. Maintain high quality health services;
3. Contain costs;
4. Provide comprehensive coverage; and,
5. Unlink coverage from employment.

CAC has determined the only approach which meets all five criteria would be a national health insurance program administered as a single payer system.

Comparison of the United States Health Care System to Other Countries

Despite an abundance of health care programs, including Medicare, Medicaid, the Veterans Administration and thousands of private insurance companies, the U.S. health care system ranks behind most other industrialized nations. Every other industrialized country ensures universal health care access to all its citizens, most through a single payer system. (Mueller)

Americans spend more on health care every year than any other country in the world, yet 47 million Americans are without health insurance. Our problems with the uninsured and underinsured are unique to the United States. While other countries may struggle with how to fund necessary services and new technology, they have already figured out how to cover everyone. And, despite spending more per capita than any other country, U.S. health outcomes in critical areas are far lower than countries who spend much less.

Total health spending accounts for 15% of the Gross Domestic Product (GDP) in the United States. The Organization of Economic Co-Operative Development (OECD - an organization made up of 30 industrialized nations) average is 8.6% of GDP. Switzerland and Germany are the second and third highest with 11% and 11.5% of GDP. The United States spends \$728 on pharmaceuticals per capita, more than any other nation. 37% of health spending in the U.S. is through the private sector, 44% is funded through the public sector. The OECD average is 72% public sector spending on health care. In the Nordic countries, Sweden, Denmark and Norway, 80% of health care spending is through the public sector. The percentage the U.S. government spends on health care is less than any other OECD nation. (OECD)

Americans have higher out-of-pocket expenses for health care than people in other countries. Surveys of doctors internationally find that 61% of American doctors reported that U.S. patients have difficulty paying their out-of-pocket costs. Over half of American doctors have reported that they were very concerned that patients could not afford the care they need. Doctors in the U.S. have also reported that patients are getting sicker because they cannot get the care they need or do not have access to preventative care. These findings are significantly higher than Canadian, British and Australian doctors reported. America ranks low in financial fairness of individual financial contribution toward health, as measured by the equal distribution of health care costs among households.(Mueller)

The World Health Organization (WHO) ranks the United States as 37th for overall health systems performance, yet we rank number one in costs. (WHO) As far as non-health aspects of care, the U.S. does well. We take the lead in regard to respect for the patient as an individual, protection of confidentiality, opportunities to participate in choices of treatment and providers, and provisions of prompt attention and clean surroundings. (WHO) The OECD studies find that the U.S. health system is customer service oriented and there are few waiting lists for elective procedures. Unfortunately, while all of these attributes are positive, none helps to guarantee coverage for all Americans, nor do they improve our health outcomes. Despite all the medical technology and money spent per capita, Americans are far from ranking first in any basic health indicator.

The average American has 4.5 fewer years of good health than a Japanese citizen, despite the fact that Japan has more smokers than the U.S. America also has infant mortality rates as high as 7 deaths per 1000 births. This is above the OECD average of 6.1 per 1,000. In Norway,

Iceland, Finland and Sweden the average is the lowest at 3.5 deaths per 1000. Obesity rates in adults have risen all over the world. Obesity can lead to further health complications such as diabetes and asthma. America ranks highest in the rate of obesity among adults. (OECD)

A study conducted by Barbara Starfield compared 13 countries and 16 health indicators. America ranked among the worst in most categories and ranked 12th overall. The U.S. came in last on low birth weight, neonatal mortality, and infant mortality, as well as years of potential life lost. External causes, such as motor vehicle collisions and violence were excluded from the study. (IOM, 2004)

Not only does the U.S. spend more money on health care and have worse health outcomes, we also have fewer doctors and nurses than other OECD countries. Compared to the OECD average of 2.9 primary care physicians for every 1000 people in 2002, the US has only 2.3 primary care physicians per 1,000 people. (OECD) We do, however, have more specialists. (Mueller) The US also has only 7.9 nurses per 1000 people compared to 8.2 across OECD countries. (OECD) Over the past 20 years hospital beds have dropped from 4.4 beds per 1000 to 2.8. A number of factors contribute to this drop, among which are shorter hospital stays and an increase in outpatient surgeries. Even so, this is still below the OECD average of 4.1 beds per 1000 people. (Ibid)

Compared to Canada, the U.S. is losing doctors at a relatively high rate. A 2001 study of 2,300 doctors in California revealed that 43% planned to leave practice within the next 3 years. In Canada only 3.5% retire, emigrate or leave practice every year. (Mueller)

In the U.S., health care is treated as a commodity. Other industrialized countries view access to health care as a social necessity and a basic human right to which all citizens are entitled, much like public education or public safety.

Importance of Universal Coverage

Health insurance is important for a variety of reasons. People with insurance are more likely to have a regular primary care physician. Having a relationship with a regular physician allows for earlier detection of possible health problems. This established relationship helps in receiving appropriate care, even if one's insurance policy doesn't cover preventative care. Well-child care and a regular physician help to identify possible long-term problems and allow for appropriate preventative measures. (IOM, 2004) Insured individuals are more likely to receive timely appropriate care than uninsured individuals of comparable health.

Health insurance is a way to protect individuals from high medical expenses, especially in the case of a catastrophic medical event. Individuals benefit from their ability to be joined with others in insurance pools that spread the risk among many and also enjoy lower costs for individual services because of the insurer's ability to bargain collectively. The increased ability of early detection and availability of preventative care help to keep the long term cost of treating illness down for the individual and for society as a whole. Health insurance is most beneficial when coverage is continuous. (IOM, 2004)

With 47 million people lacking health insurance coverage the cost of the uninsured stretch farther than the individual. Families, communities and the economy are all adversely affected by both the uninsured and high insurance premiums. People with health insurance pay more for

health care services as providers shift the costs of providing care for the indigent and uninsured to those with coverage.

Impact of Rising Health Care Costs

Individual Impacts

Health insurance premiums are soaring. In 1998 the average national cost of health insurance premiums for a family of four was \$5,590 and for an individual the cost was \$2,176. In 2005 family premiums were \$9,249 and single coverage premiums were \$3,481, on average. Costs in Indiana are higher than the national average, with single coverage averaging \$4,042 and family coverage \$10,678 in 2005. (AHRQ, Tables II.D.1, II.D.2, and II.D.3) Nationally, between 1998 and 2005, family coverage premiums increased by 64 percent, and by 60 percent for single coverage.

Societal Impacts

The Institute of Medicine (IOM) commissioned economist Elizabeth Vidgor to do an analysis of the costs associated with poorer health and shorter life spans of uninsured individuals. The results, which were published in *Hidden Costs* (IOM, 2003, Appendix B), found that, “the diminished health and shorter life spans of Americans without health insurance are worth between \$65 billion and \$130 billion for each year spent without health insurance.” This analysis focuses only on the individual effects on families, and the society as a whole was not included in this analysis. This analysis did include individual losses in work, as well as the developmental effects of children in poor health. “If the uninsured were to gain coverage comparable to that of the currently insured population, this \$65 - \$130 billion in “*health capital*” would be an economic benefit rather than a cost.”¹ (Ibid)

This analysis only focuses on Americans up to the age of 65. According to the IOM, this figure is likely an understatement. “Additional positive effects on health and longevity after age 65 also would be likely if health insurance were continuous before this age. In addition there could be savings to the Medicare program.”

The same report states that, “Reasonable, conservative estimates of the total cost to society of forgone health are between \$250 billion and \$3.3 trillion, depending on assumptions about lifetime insurance status.”²

¹ At the time of this report, analysis was conducted using Current Population Survey estimates of insurance coverage for calendar year 2000.

² The methodology applied to this study was previously developed by Cutler and Richardson (1997) to measure “health capital,” following Grossman (1972). This measure applies several different dimensions of health to estimate the present value of stock of present and future quality adjusted life years. This analysis measures health capital empirically, using data on the length of life, the prevalence of various health conditions, and the quality of life conditional on having those conditions. The average health capital of the insured and the uninsured is estimated by first assuming perfect health, then incorporating morbidity. A lower bound estimate of morbidity-adjusted health capital is calculated by assuming no difference in morbidity between the two groups, and an upper-bound estimate is calculated by using observed cross-sectional differences in morbidity. The amount of health capital lost by not insuring the uninsured is estimated by examining two scenarios: One assumes that everyone who is uninsured today will remain so until age 65. The other assumes that the uninsured face an average probability being uninsured in a given year.

Impact of Rising Health Care Costs on Job Creation

“In Indiana, as nationally, the relatively fast growth of lower-paying service jobs will make the problems that low wage workers have in obtaining health insurance increasingly apparent.”(Chollet, et al.) Indiana has been losing high paying manufacturing jobs and replacing these jobs with low paying service sector jobs. Mathematica Policy Research released a report to the Indiana Family and Social Service Administration highlighting the effects of employment and the uninsured in Indiana. The report takes into account that the health care industry is a large part of Indiana’s economy. In fact, the health care sector accounts for 10 percent of private employment in Indiana.

The same report notes that with Indiana’s reliance on the health care sector for jobs, the issue of cost containment becomes a double-edged sword. On one hand, rising health care costs contribute to depressed employment and wages, fueling the uninsured rate in the state. On the other hand, reduced spending for health care services may lead to reduced income for health care providers and threaten jobs in that sector. However the negative effects of rising health care costs outweigh the economic benefit of revenues to health care workers. “Roughly estimated, lower health care cost growth that ultimately achieved expenditure levels that are 25 percent less than projected would result in a net job gain of about 2 percent in Indiana in 2002 equal to 52,000 net new jobs and a \$7.6 billion net increase in output and household income.” (Ibid)

Business Impacts

The majority of insured Americans receive their health care coverage as a benefit of employment. As costs increase, many employers have been forced to increase employee contributions, reduce benefits or drop coverage completely. Despite these efforts, the rising cost of health coverage is having a serious impact on the profitability of many American businesses.

Many small firms do not offer health coverage to their employees because of the high cost of premiums. When smaller firms do offer health coverage, they often spend more on premiums and get less coverage than larger firms. This sets the stage for inequality in health care coverage, even among insured Americans. Additionally, administrative costs and expenses other than benefits are much higher for smaller businesses than for larger ones. In fact, these expenses account for 10% of premiums for larger firms and 20-25% for small employers. (IOM, 2004)

Using benchmark assumptions of a 3 percent discount rate and a \$160,000 value of a life year, I estimate that the value of forgone health to an uninsured 45-year-old is between \$7,800 and \$83,000 using the years of life (YOL) approach. And between \$6,000 and \$102,000 using the quality adjusted life year (QALY) approach. The value of future forgone health to an uninsured infant is between \$3,800 and \$98,000 when morbidity is incorporated. These numbers add up to an extremely large societal cost. Reasonable conservative estimates of the total cost to society of forgone health are between \$250 billion and \$3.3 trillion, depending on the assumption of lifetime insurance status. If health insurance were extended to the currently uninsured population, the average gain in healthier years of life would be between \$1,600 and \$4,400 per additional year of coverage provided. “Coverage Does Matter: The Value of Health Forgone by the Uninsured,” Elizabeth Richardson Vigdor, Hidden Cost Value Lost: Uninsured in America (2003) Institute of Medicine.

Recently, some of America's largest employers with some of the best health care coverage have seen their bottom lines and ability to compete globally affected by the rising cost of premiums. For example, General Motors insures 1.1 million American workers and retirees. G.M. currently spends more on health insurance than it does steel for its cars. About \$1500 of the cost of every car produced goes toward health care. (Hakim) Toyota, one of GM's biggest competitors, spends about a third of what GM does on health care. (Ibid) GM has more retirees than it does workers. In fact, for every current GM employee there are 2.5 retirees. Per year, the company spends \$6 billion dollars on health care coverage; however the retiree portion is projected to cost the company \$77 billion dollars in liability and is covered by a mere \$16 billion in assets. (Porter) In response to the rising cost of health coverage, GM and the United Auto Workers union settled on a temporary agreement to cut \$1 billion worth of annual health care benefits for hundreds of thousands of retirees, (Hakim) and in 2007 struck a new deal to transfer responsibility for health coverage to a trust run by the union, with GM transferring \$30 billion dollars to the trust.

General Motors isn't the only company feeling the pinch of rising health care premiums. William C. Ford Jr., chief executive of Ford Motor Company stated in 2003 that the nation needs an entirely new health care system. In 2003, health care costs added nearly \$1,000 more to the cost of every Ford vehicle produced in the U.S. (Weisman)

In the nineties, health care costs remained relatively steady with less dramatic increases than had been experienced previously. However, beginning in 2001, premiums for health insurance rose 11% and have continued to rise rapidly. In 2002, they jumped 13%, in 2004 14%. 2005 marked the first year since 2000 that rates for job based health coverage did not see double digit increases. Premiums rose 9.2%, still three times the rate of general inflation. (Colliver)

Chairman Howard Schultz of Starbucks Corp. stated in September 2005, "Starbucks Corp. will spend more on health insurance for its employees this year than it does on raw materials needed to brew its coffee." (Daly) In a series of events on Capitol Hill, Schultz was joined by Costco CEO, Jim Sinegal and others to express concern about the nation's health care system and the effects on American businesses. Companies such as Costco and Starbucks recognize the importance of health coverage for their employees as it relates to the bottom line. Sinegal stated, "If you're going to get good people it only makes sense to pay good wages and provide good benefits." Schultz cites "low attrition and high productivity" as sound business reasons for offering medical insurance. (Pope)

Starbucks offers health coverage to all of its employees working 20 hours or more a week. Experiencing firsthand double-digit increases in health cost, Schultz realizes that the current health care system in America is "completely non-sustainable." (Daly)

In order to control health care spending, some companies are employing tactics that greatly concern advocates for senior citizens, people with disabilities and civil rights advocates. For instance, Wal-Mart, in an internal memo leaked to the press by anti-Wal-mart groups, proposed to its board of directors to "include some physical activity," in all positions of employment. (CSM) The memo suggests to the board in order to control health spending the company should "dissuade unhealthy people from coming to work at Wal-mart." It should be noted that Wal-Mart has not adopted such policies, nor are they the first to suggest health screening. For example, Union Pacific will not hire smokers. This practice is not illegal. However, with the workforce aging, if companies take health screening to the extent of "rejecting older applicants or a category of obesity covered by the Americans with Disabilities Act, that could violate federal anti-discrimination laws." (Ibid)

Voluntary wellness programs are becoming common in many workplaces. Often, participants get a reduction on their premiums or other health care costs if they quit smoking, exercise, get screened for certain diseases or switch to a healthy diet. Should business be put in the position of monitoring their employees' health habits in order to control health care costs? What are the consequences for employees who can't or won't participate?

Health care costs are rising dramatically and all businesses small and large are affected. Jim Rogers, CEO of Cinergy stated in their 2005 Sustainability Report, "I am concerned about the rising cost of health care. Like other companies, we've been forced to pass more of our costs on to our employees. It's clearly an issue that demands more attention from Washington." (Cinergy)

Health Spending in the United States

Defenders of the status quo cry, "America has the best health care system in the world!" This statement is true only when talking about non-health aspects of care. The U.S. ranks highest in respect for the patient as an individual, protection of confidentiality and opportunities to participate in choices of treatments and providers, as well as provisions of prompt and clean surroundings. (WHO) While these are all aspects that Americans find important, they do not result in longer life spans or better quality of life. The reality is that the U.S. ranks low in health indicators as determined by the Organization for Economic Co-operation and Development (OECD), an organization made up of the top 30 developed nations. The fact that America ranks 28th out of these 30 nations for the number of uninsured doesn't help support the statement that America has the "best health system care in the world."

The U.S. currently spends \$1.9 trillion annually on health care. In 2004, we spent an estimated \$6,300 per capita on health care, in 2015 we will spend \$12,300 per capita. (CHCWG) We spend more on health care than any other developed nation and still have 47 million uninsured and just as many with health insurance who still cannot afford needed medical services. On average only 55% of adults in the U.S. receive the care recommended for common conditions. (Ibid) The U.S. publicly finances 44% of health care costs, 28% below the OECD average. (OECD) "Expenditures in the United States on health care were nearly \$1.9 trillion in 2004, more than two and a half times the \$717 billion spent in 1990, and more than seven times the \$255 billion spent in 1980." (CMMS; KFF, Feb 2006)

As stated, health care costs are rising dramatically and are projected to double in the next 9 years with the current rate of growth. A study done by the Institute of Medicine compared different economic scenarios and the effect on the growth rate of the uninsured. The study found:

- "Assuming continued economic growth and moderate health care cost inflation, the number of uninsured Americans will rise to more than 48 million in 2009.
- In the event of a recession, the number who lack coverage will reach 61 million by 2009.
- Rapid economic growth coupled with rapid health care cost inflation as in the 1980's, would lead to roughly 55 million uninsured in 2009." (IOM, 2004)

Uninsured Americans

Who are the uninsured?

The problem of the uninsured continues to grow in urgency. This is not only due to the economy and increasing number of uninsured Americans, it is also due to the fact that insurance is vitally important because of the effectiveness of medical interventions, particularly pharmaceuticals and medical technologies, on positive health outcomes. (IOM, 2004) Over 47 million Americans are uninsured. Over 90 million Americans lack dental coverage and more than 40% of Medicaid patients lack any out-patient prescription coverage. (Mueller) Only 86% of Americans had insurance coverage and 24% were covered by public insurance in 2000. (IOM, 2004) African Americans are nearly 2 times as likely as non-Hispanic whites to be uninsured. Latinos are more than 3 times as likely as non-Hispanic whites to lack coverage. (Ibid)

Nine million children in the U.S. are without any form of health insurance. (KFF, Jan 2006) A significant portion of these children are eligible for but not enrolled in public programs or do not maintain eligibility over time. This diminishes the effects of public programs such as State Children's Health Insurance Program and Medicaid. (IOM, 2004) With welfare reform in the late 1990's, many women lost their Medicaid coverage as a consequence of employment. Currently one third of all working women previously on Medicaid are now uninsured, as are one out of every four of their children. (Mueller)

In Indiana more than 750,000 people, about 4% of the population, are without health insurance. Indiana ranks 23rd in the number of uninsured in the country. Of those families without any form of health coverage, 70% have at least one full time worker in the household. (KFF, Jan 2006) The population of the uninsured in Indiana is growing twice as fast as the national average. (FSSA) At least 1.4 million people in Indiana are currently enrolled in some form of public coverage. (KFF, Jan 2006) 158,900 children in Indiana lack any form of health insurance. Indiana has the highest per capita rate of medically bankrupt families in the nation, over 77,000 Hoosiers. Indianapolis is the second most expensive city in the nation for family health insurance premiums. (FSSA)

The more money a household earns the more likely they are to have insurance. Twenty four percent of households earning less than \$25,000 per year are uninsured. (Mueller) Of those households earning \$75,000 or more pre year, 8% are uninsured. A family with a single wage earner earning more than \$50,000 per year is more likely to have health insurance coverage than a family with two wage earners each earning \$25,000 per year. (IOM, 2004) Sixty-nine percent of uninsured Americans have full time jobs or live in a household where at least one person is working a full time job. (KFF, Jan 2006) Full-time, full-year employment offers families the best chance of acquiring and keeping health insurance, as does an annual income of greater than 200% of the federal poverty level. (IOM, 2004)

Without insurance, people have less access to new services and drugs, exposing the inequality of our system. As the Institute on Medicine report points out, "This disparity in access to health care violates generally accepted American values of equal consideration and equal opportunity." (IOM, 2004)

Why Are People Uninsured?

The majority of Americans with health insurance receive coverage through their employer. Premiums for job-based health insurance rose 9.2 percent on average nationwide in 2005, about three times the general rate of inflation, according to the annual health coverage survey of the Kaiser Family Foundation and Health Research & Educational Trust. Nonetheless, that increase marked the first year since 2000 in which the increase was less than 10 percent. (Colliver) Only 56.2 percent of companies in the U.S. offer health insurance to their employees. (AHRQ, Table II.A.2)

In Indiana, 59% of those with health care coverage receive it through their employer. (KFF, Jan 2006) Only 53% of companies in Indiana offer health care coverage to their employees. (AHRQ, Tables II.2.A)

According to the Institute of Medicine report *Insuring America's Health: Principles and Recommendations* (2004), "Fewer people have coverage at work, more people find the costs of private coverage too expensive and others lose public coverage because of personal circumstances, administrative barriers and program cutbacks. The situation is even more dire now than when the study began and is expected to worsen in the foreseeable future because of federal and state budget constraints, limiting public coverage programs, increasing costs of health care and insurance premiums and continuing high rates of unemployment."

Study after study show that the number one barrier to gaining health care coverage is cost. National statistics show that, on average, premiums for family coverage run \$9,249 per year, with employees contributing 25%. Single coverage averages \$3,481 per year, with 17% employee contribution. (AHRQ, Tables II.D.1, 11.D.2, and II.D.3)

In Indiana, costs are higher than the national average. (Health Evolutions) Family coverage in Indiana costs on average \$10,678 with 25% employee contribution. Single coverage runs \$4,042 with 21% employee contribution.

A job change is the most common reason for losing coverage. The Institute of Medicine conducted a study in which the researchers followed a cohort of adults between 21 and 60 for four years. A job change was more often the reason for loss of coverage than was the loss of public coverage. Portability of health insurance is of growing concern. Americans frequently move from job to job throughout their lifetimes. Outsourcing, layoffs and corporate bankruptcies are all too common in today's economic climate. Few Americans maintain employment with the same employer for all their working years. The federal government has tried to address this problem through incremental reform efforts such as COBRA, HIPAA and the Trade Act. However, these initiatives have done little to reduce the number of uninsured. The lack of regulation to make premiums affordable to unemployed workers has seriously impacted the effectiveness of COBRA and HIPAA. (IOM, 2004)

Over a four year period from June 2000 to June 2004, Indiana lost 138,000 jobs. On average Hoosier income is \$0.91 cents for every \$1 of the average American. (FSSA) High paying manufacturing jobs are being replaced by low wage service sector jobs. In January 2006, 2,206,100 Hoosiers were employed in the service sector while only 569,300 people were employed in the manufacturing sector. Food service workers are among the most likely to not be offered health coverage or to find it unaffordable. In January 2006, 232,500 Hoosiers worked in the food service sector and earned an average of \$7.61 per hour.

Other barriers to coverage include under-funded state Medicaid programs with overly restrictive eligibility requirements. With the economy worsening, states and the federal government have limited spending on public coverage programs, despite rising demand from increased numbers in need. Administrative barriers and restrictive eligibility requirements make applying for these programs difficult. Those with public coverage can lose it due to changed personal circumstances, administrative barriers and program cutbacks. (IOM, 2004) As mentioned previously, a large number of the uninsured lost health benefits in the 1990s when they lost eligibility for welfare benefits. (Mueller)

Life changes impact one's ability to maintain or gain health coverage. Typically, young adults are dropped from a parent's coverage at age 19, or when they leave college, although a new Indiana law allows some to stay on their parent's policy until age 24. Marriage is associated with job and career choices that lead to an increased likelihood of having employment based health insurance for the whole family. Becoming separated or divorced or widowed are other examples of life transitions that can increase the risk that family members will lose coverage. When a person age 65 retires, a younger spouse is often left without coverage. (IOM, 2004)

Age and health status have a big impact on health insurance affordability. Older people and those with significant previous illness are likely to pay as much as 40% more for an individual policy than a younger or healthier person. (IOM, 2004)

The chronically ill are less likely to gain coverage through the private insurance market. Many people are denied coverage because of preexisting conditions. Those people in the most need are least likely to receive comprehensive coverage. State programs have been created to cover high risk individuals but they are typically unaffordable for those who qualify. Without healthy people paying into these programs to help spread the risk and subsidize the cost, these programs will remain on shaky financial footing and helpful only to the small percentage who can pay the exorbitant premiums.

Growth Rate of the Uninsured

One would assume that when the economy is strong and unemployment and underemployment are down, the number of U.S. citizens with health insurance would go up drastically. History has shown that this is not the case. In fact, "the number of uninsured is large, growing and has persisted even during times of strong economic growth." According to the Institute of Medicine the uninsured population had grown by more than 6 million during the 1990's, despite a decade of strong economic growth. Between 1998-2000, the uninsured rate dropped by less than a million due to state expansion of existing public coverage programs. In 2000, the uninsured rate began to grow again." (IOM, 2004)

Health Outcomes of the Uninsured

The uninsured have less access to quality health care, resulting in poorer health outcomes. This has a dramatic effect on individuals, families and businesses. The cost of health care as a whole goes up, even for those with health coverage, because of cost-shifting. Uninsured citizens are left with under-funded public clinics and emergency rooms, straining the nation's already struggling safety net system. The answer is not strengthening the safety net system alone. People need health insurance coverage to gain access to preventive services, which can often be life saving and cost effective.

The Institute of Medicine estimates at least 18,000 people die every year as a direct result of not having health insurance. (IOM, 2002) Estimates of the number of people between the ages of

18 and 65 with various diseases who were uninsured for at least one entire year include 528,000 with diabetes, 1.8 million with high blood pressure and 1.5 million with high cholesterol. (Mueller) Over 100 different studies document that uninsured patients suffer worse medical outcomes when compared to the insured. (Mueller)

The National Institute of Health Statistics estimates over 200,000 people die annually without seeing a doctor in the previous year. (Mueller) Nearly 4 of 10 uninsured working age adults failed to see any doctor in the previous year, compared to less than 1 in 10 insured adults. The chronically uninsured in poor health are even worse off, with 7 of 10 failing to see a doctor in the previous year. (Mueller) Unlike those with public or private insurance, the uninsured are less likely to have any medical contact than the insured and on average have fewer visits for care. As a result, chances to diagnose illnesses and manage the progression of existing conditions are missed. (IOM, 2004) When hospitalized, the uninsured are 2-3 more times likely to die than the insured because they seek and receive care later in the course of their illnesses. (Mueller)

According to a population-based study of persons with breast, cervical, colorectal, and prostate cancer and melanoma, uninsured patients with cancer are more likely to die prematurely than insured cancer patients. This is most likely due to delayed diagnosis. (IOM, 2002) Insurance increases access to preventive screening. An early diagnosis often allows for the use of less invasive treatment techniques, keeping the cost of treatment down and increasing the patient's chances for survival.

According to a study by the Institute of Medicine,

“Uninsured adults with hypertension or high blood cholesterol have diminished access to care, are less likely to be screened, are less likely to take medications if diagnosed, and experience worse health outcomes.

“Uninsured adults with diabetes are less likely to receive recommended services. Lacking health insurance for longer periods increases the risk of inadequate care for this condition and can lead to uncontrolled blood sugar levels, which, over time, put diabetics at risk for additional chronic disease and disability.

Uninsured adults with HIV infections are less likely to receive highly effective medications that have been shown to improve survival and die sooner than those with coverage.” (IOM, 2002)

Emergency Rooms: The Uninsured's Primary Care Provider

As discussed earlier, the uninsured are less likely to see a doctor on a regular basis and receive preventative screenings. As a result, illnesses are usually caught in the later stages. Often these illnesses are diagnosed when they have become so much of a problem that people wind up in an emergency room. Emergency rooms have become clinics for the uninsured which is unfortunate, since they are not designed for primary care and are extremely expensive care delivery settings. Even when a person is treated in the ER and problems, especially chronic conditions, are detected, the patient's ability to access adequate follow up care is not guaranteed. This creates a revolving door with the patient coming into the ER to get treatment whenever the condition worsens. This further strains the already struggling safety net system and imposes high cost on those least able to afford it.

The Commonwealth Fund, a private philanthropic organization, found 75% of all emergency

room visits in New York City were for non-emergencies. A spokesman for the American College of Emergency Physicians stated, "The situation is grave. We are a symptom of the disease that is the health care system." (Mueller)

Strengthening safety net services is not the answer to expanding access to health care. For example, federally funded primary care clinics, including community health clinics, have a heavy caseload of uninsured clients but serve only 6.5 to 10 percent of the uninsured population since most citizens lack access to one. People receiving primary care in such centers often have difficulty obtaining specialty, diagnostic and behavioral health services for which they are referred. (IOM, 2004)

The nation has been facing an emergency room crisis for several years. Overburdened and understaffed emergency rooms are frequently turning away ambulances due to the lack of space. People who have made it into the ER sometimes wait long times for treatment, often in crowded conditions. As stated in a Los Angeles Times article in 2001 "America's dwindling capacity for emergency care is being outstripped by America's demand for it. And this time the victims are not just the poor, who have suffered for decades at the counties cash strapped public hospitals. This time the danger threatens almost everyone who takes ill or sustains a tragic injury." (Grosslin) From the inner cities to the suburbs, this problem affects everyone.

ER's are closing their doors to patients at alarming rates. According to the same article, "Metropolitan Phoenix's 29 emergency rooms were simultaneously closed on eight occasions between January and April 2001, according to Dr. Todd B. Taylor, an official with the Arizona College of Emergency Physicians. Metropolitan Cleveland's 22 ER's were simultaneously shut almost 10% of the time in May 2001, according to Cuyahoga County emergency services manager Murray A. Withrow. Simultaneous shutdowns set off a mad scramble among emergency officials to dole out patients to hospitals that already have said they can't handle them." ³ (Ibid)

The crisis in the ER can be attributed to a number of factors. Looser management by health maintenance organizations (HMOs); stricter enforcement of the Emergency Medical Treatment and Labor Act (EMTALA)⁴; and more patients without insurance seeking care, (Brewster, et al.; Brophy-Marcus) have all helped to break down America's primary health care safety net.

According to the authors of a recent health care assessment done by Health Evaluations for the Indiana Family and Social Services Administration, "There continues to be significant gaps in available services and the growing number of uninsured is straining the capacity of safety net providers. In the absence of health care reform or government initiatives to address the uninsured, the demands on safety-net providers will continue to grow."

³ Throughout the 90's, state and federal governments and insurers pressured hospitals to jettison excess capacity, even paying hospitals to close wards. The number of beds nationwide dropped 8% from 1994-1999, according to the American Hospital Association. Medicare and Medicaid payments were trimmed to help balance the federal budget, shrinking a cushion that hospitals once used to subsidize care.

⁴ Emergency Medical Treatment and Active Labor Act: passed in 1986 in response to reports that hospitals were turning away uninsured patients. The act guarantees treatment for anyone who can get themselves to the hospital. In 1996, with increased funding under the Health Insurance Portability and Accountability Act (HIPAA), the Office of the Inspector General (OIG) strengthened enforcement of EMTALA.

Cost differences between the insured and uninsured

Without health insurance, patients are likely to pay more for care and get less of it. Out of pocket spending for the uninsured is nearly two and a half times that of privately insured patients. (Commonwealth Fund) According to a report by the Commonwealth Fund, uninsured cancer patients under age 65, for a 6 month period, paid \$1,343 out of pocket compared to \$549 paid by privately insured patients. The uninsured patients incurred just \$1,454 in inpatient treatment costs compared to \$5,643 incurred by the privately insured patients. (Ibid)

The uninsured do not have the benefit of collective bargaining that insured patients have. As a result, uninsured patients are subject to hospital list prices. "List prices," more commonly referred to as gross charges, are a standard set of prices established by hospitals annually for their services. Insured patients usually pay the "net-price." The net price is the negotiated price that the insurance company pays the hospital for services. The net price is usually far below the list price. Many patients with insurance never see the list price. Some hospitals do have policies that allow for discounts on the list price for uninsured patients.

In his testimony before the Subcommittee on Health of the House Committee on Ways and Means, on March 9, 2004, Glenn Melnick, Ph.D., Director of The Center for Health Financing stated, "Since most hospitals can increase their net revenue (from private insurers, Medicare, and worker's comp plans) by raising their list prices, there is a strong incentive to keep increasing list prices. Indeed, data show that list prices have increased rapidly and substantially in recent years." (Melnick)

The dramatic differences in pricing between the insured and the uninsured have led to a number of lawsuits across the country. Lawsuits have been filed against Tenet Healthcare Group in 2003, Greenville Hospital System in South Carolina in 2004 and Our Lady of Resurrection in Illinois in 2005. All have been sued for unfair billing practices of the uninsured. Greenville Hospital System is one of a dozen lawsuits filed in South Carolina.⁵

⁵ In 2003, James Garcia of Miami, Florida filed a lawsuit against Tenet Healthcare Corp. The class action lawsuit charges Tenet Healthcare Corp. with charging higher rates to patients who have no insurance coverage than to those with coverage. It claims Tenet rates are twice the industry norm and higher than the actual cost of procedures. This practice violates the Florida Deceptive and Unfair Trade Practices Act (FDUTPA) and the Florida common law of unfair competition. The bill and lawsuit highlight the discrepancy between what insured and uninsured patients are charged for hospital care. Like some 47 million Americans, Garcia has no health insurance. The case was filed by Freedland, Glassman, Farmer & Sheller of Weston, Fla., Sheller, Ludwig & Badey and Hoffman & Edelson, of Philadelphia, and Hagans Berman of Boston, MA. ("High Hospital Bill Leads To Class Action Law Suit Against Tenet," eMediaWire.com <http://www.emediawire.com/releases/2003/9/emw80679.htm>.)

In 2004, a lawsuit was filed against Greenville Hospital System (GHS) alleging that it charges uninsured patients much more than it charges insured patients, a practice that the attorneys who filed the suit called "discriminatory pricing." The suit was filed by the Columbia law firm McCutchen Blanton Johnson & Barnette on behalf of uninsured patients. GHS is the latest of about a dozen hospitals across South Carolina to be sued, said attorney English McCutchen. (Osby, Liv. September 20, 2004. *Lawsuits Target Hospital Pricing Policy*. The Greenville News).

In 2005, A Cook County Illinois judge refused to dismiss a lawsuit that challenges a nonprofit hospital's alleged unfair billing charges for uninsured patients. Circuit Judge Stuart A. Nudelman ruled that Our Lady of the Resurrection Medical Center's policy of charging uninsured patients more than insured patients may constitute an unfair practice within the meaning of the Illinois Consumer Fraud Act. The plaintiffs, represented by the Legal Assistance Foundation of Chicago, contend that the hospital has a policy of charging uninsured patients two to four times what it charges insured patients. Nudelman

Underinsured/Insured Americans

Underinsured Americans

While the uninsured face the most hardship in our current health care system, being underinsured is a real problem facing millions of Americans. It has been estimated that there are just about as many underinsured citizens in the U.S. as there are uninsured citizens.⁶ The cost of health care premiums is rising fast. As a result, more employers are shifting more of the cost to employees or paring back benefits to control costs. When employers scale back benefits, those needing services that have been discontinued must pay out of pocket.

In the report, *Indiana Health Care Sector and Insurance Market*, done by Mathematica Policy Research Inc, the authors state, "Lack of coverage and inadequate coverage among those who remain insured are likely to reduce the use of preventative and chronic care (which may already be lower than desirable in Indiana), contribute to low population health status, and increase avoidable hospital admissions." (Chollet, et al.)

Insured Americans

The Organization for Economic Co-operative Development (OECD), in their health data 2000 report, estimates that only 45% of Americans have guaranteed comprehensive health coverage comparable to OECD standards. (Mueller)

For most Americans with private health insurance, employer sponsored plans are the most affordable option. Generally employers contribute 75% toward the cost of the policy and employees contribute 25%. (AHRQ, Tables II.D.1, II.D.2, and II.D.3) Individually purchased health insurance policies cover 7% of individuals under age 65. (IOM, 2004)

rejected Resurrection's argument that hospital billing practices did not constitute "trade or commerce" under the Consumer Fraud Act. Nudelman ruled that hospital billing practices are commercial aspects of medicine and, therefore, do fall within the definition of "trade or commerce." (Quinn, Kelley. January 10, 2005. *Hospital To Face Uninsureds' Suit Over Charges*. Chicago Law Bulletin.)

⁶ Based on a study of unmet medical needs, the number of underinsured Americans is approximately 42 million, similar to the number of uninsured. The 1993 National Health Interview Survey (NHIS) asked questions about unmet medical needs in the population age range 18 - 64 (inclusive). The responses were distributed in various ways including those who had no insurance and those who had public, private or "other" insurance. Based on population as reported in Statistical Abstract of the United States of 1995 (Table 16 for 1994) and the total of uninsured persons in Table 169, the total number of uninsured persons was 29.8 million in the age group (18.7%). There were 114.9 million with private insurance and 15.8 million with Medicare disability or Medicaid. 41.7% of the uninsured, 14.4% of the privately insured, and 32% of the government insured reported an unmet medical need. This bears witness to the OECD data 2000 report that in fact 55% of Americans are not fully insured. In the age group the total number of uninsured with unmet medical needs was 12,426,600. The total of insured was 21,601,600. These were 7.8% and 13.6% of the total of the age group respectively. To estimate the number of seriously underinsured the percentage of those needing immediate care but could not get it was used. The projections of the sample were that 3,129,000 uninsured persons could not get such care and 3,545,000 with insurance were in the same circumstance at least one time during that year. There is no clear data for the young people and children under 18. Additionally, well over 10 million Medicare patients lack any prescription drug coverage. Thus, the estimate of the total number of underinsured Americans (42 million) is nearly the same as the number of uninsured Americans (47 million). (Mueller, Rudolph, M.D. 2001. *As Sick As It Gets: A Diagnosis and Treatment Plan*. Olin Fredrick, Inc. Dunkirk, New York.)

The likelihood of being offered more than one plan to choose from at work is slim. Of workers given access to health insurance through their job, 42% are offered only one plan. (Mueller) In order to control health insurance premiums, many employers shop for insurance frequently and often switch plans, which can further restrict choice for their employees.

When participating in an HMO, patients are restricted to those doctors who participate in the network. Patients have a choice as long as their doctor is a participant in the network. If not, the patient can either pay higher out-of-pocket costs or switch doctors. In a survey of patients who switched doctors, 74% did so as a result of changes in employment or insurance companies. (Ibid)

The majority of seniors age 65 and older get their health care coverage through Medicare. Traditional Medicare is portable, no matter where in the country the enrollee goes they are covered. However, Medicare HMOs are not portable from state to state. This presents a problem for those seniors with Medicare HMOs who travel or reside in warmer climates in the winter months. If a member of a Medicare HMO is out of their primary state for more than three months, they may lose their coverage. (Ibid)

Those with employment based insurance stand the risk of losing it when their life changes. The most common reason for loss of insurance is a job change or job loss. Other factors include rising health insurance premiums making health insurance unaffordable; an older spouse retiring and leaving a younger spouse without insurance; becoming separated, divorced or widowed. (IOM, 2004) Many young adults lose coverage when they "age-out" of their parent's policies, often at age 19. (Ibid)

Conclusion

The U.S. health care system is broken. Forty seven million Americans lack insurance coverage and just as many do not have adequate coverage to allow them to access all their health care needs. (KFF, Jan 2006) Combined with yearly double digit increases in job based premiums and rapid overall health care inflation, the current system will bankrupt our country and millions more individuals if change does not come soon.

Important Indiana industries, like the auto and steel industry, will continue to suffer competitively if the burden of health insurance is not lifted. More Americans will suffer ill health and some will even die because they lack access to care. We cannot wait any longer to reform the system.

Health Care Reform Efforts and Shortfalls

Our current health insurance system has its roots in the Industrial Revolution, when death insurance began to be sold to workers. With the shift from an agrarian society, the traditional family as economic unit gave way to the individual as an economic unit, meaning families relied completely on the paychecks brought home from the factories. The industrial workplace was extremely dangerous and if a worker was maimed or killed it put the economic viability of the whole family at serious risk. Workers bought death insurance in order to protect their families in the event of an accident. Death insurance proved so lucrative that insurance companies began selling sickness insurance. Because millions of Americans left the factories for the armed services in World War II, and because wage freezes were in effect, more and more companies competed for workers with fringe benefits such as health insurance. Today's market based system was created in this unplanned, accidental way.

Who benefits from the status quo?

The health insurance industry has become one of the most profitable industries in the U.S. The business principle behind health insurance is quite simple. The insurance company collects premiums and pays claims, assessing and assuming the financial risk in the event of a catastrophic event. In order to stay in business and make a profit, the insurer must take in more in premiums than they pay out in claims. Over the past two decades, the industry has been successful at advocating for dramatic changes in how they determine whom to insure and what to cover. As summed up by Rudolph Mueller M.D. in his book *As Sick as it Gets*, "Some economists might say that the 'market' motive of the HMOs and the insurance companies is to delay payment and treatment in hopes that the patients will have to pay out of pocket or die." (Mueller)

Nearly two-thirds of health insurance companies in the U.S. are for-profit. (Ibid) In 2005, Indianapolis based Anthem acquired Wellpoint Health Networks Inc., changing its name to Wellpoint Inc. The acquisition proved to be a very profitable move for the company. At the end of 2005, Wellpoint had 33.9 million members and had net income totaling \$2.5 billion. (Wellpoint)

Aetna Inc., another one of the countries leading insurance companies had net income totaling \$1.6 billion in the year ending 2005. Aetna became even larger in 2005, when it purchased the assets and operations of Magellan Health, as well as a joint venture called Aetna Specialty Pharmacy. In addition it acquired HMS Healthcare, Active Health Management Inc. and Strategic Resource Company. (Aetna)

"Humana achieved record levels of revenues, net income and membership in 2005, as our Medicare business grew significantly and our commercial profits improved. But the real story of 2005 was our successful preparation for unprecedented Medicare expansion in 2006 and beyond. We are now superbly positioned to take advantage of this multiyear growth opportunity," stated Michael B. McCallister, Humana's President and CEO, in the company's 2005 annual report. The company's net income increased from \$280 million in 2004 to \$308 million in 2005. (Humana)

In order for the free market in health care to work, real competition must exist among insurance providers. However, companies are becoming larger through acquisitions and buy-outs, leaving less choice for purchasers and thus, less competition. In 2004, Fortune 500 magazine ranked health insurance the 4th fastest growing industry in profits over a 5 year period. (Fortune 500)

Individuals at the top ranks of this industry have seen their incomes skyrocket. In 2004, Larry C. Glasscock, former President and CEO of Indianapolis-based Wellpoint Inc. raked in \$16,713,605 in total compensation including stock option grants. Glasscock also has an additional \$22,616,000 in unexercised stock options from previous years. When he retired as President in 2006, Glasscock was paid \$12.8 million in salary and he began to sell off the more than \$41 million worth of shares and stock options he owns.

Also in 2004, John W. Rowe, CEO and chairman of Aetna Inc., received over \$10 million including stock option grants. In addition he cashed out over \$18 million in stock options from previous years and still has over \$164 million in stock options from previous years. Michael B. McCallister, CEO and President of Humana Inc., received over \$5 million in total compensation including stock options and an additional \$24 million in unexercised stock options from previous

years. (AFL-CIO)

The average median income in Indiana is \$41,567. (U.S. Census Bureau) The average Hoosier would have to work 282 years in order to make what Larry C. Glasscock made in 2004.

The insurance companies aren't the only ones benefiting from the status quo. Pharmaceutical companies are making billions and with the passage of Medicare Part D, pharmaceutical companies and insurers stand to make even more money. "The Medicare Part D bill included over \$40 billion in excess payments to HMOs. Because the Medicare Part D bill prohibits the government from negotiating with the drug companies for lower prices, it will provide a windfall to the drug industry – a windfall worth at least another \$40 billion." (Husseini, et al)

Medications are much more expensive in the United States than in any other country. The U.S. is also the only country that allows direct marketing of prescription drugs to consumers. Annual prescription drug sales have climbed 12 percent per year since the approval of direct marketing to consumers, a rate much greater than before direct marketing. Direct marketing costs exceed billions of dollars a year. (Mueller) Twenty-two percent of drug company revenues go toward marketing, the highest of any industry. (Ibid)

Generic drugs are often touted as a key way to contain spending on pharmaceuticals, since they can be as much as 90% cheaper than name brand medications. (Ibid) Getting generics to the market quicker would help millions of people lower their prescription costs. Drug patents can last as long as 17 years, with savvy companies extending patents far beyond original limits. Drug patents last a long time so the company which did the research and development can recover the cost. Generic drugs are usually created by pharmaceutical companies which do not do research and development. These smaller companies use the "recipe" for the name brand drug, and are able to sell it at a lower cost. Most countries have patent laws; the length of the patent varies from country to country and obviously impacts the availability and use of lower price generic alternatives.

The pharmaceutical industry is also very profitable. Pfizer, makers of Celebrex, Zoloft, Viagra and Zyrtec, reported net income of over \$8 billion in 2005. (Pfizer) Merck, makers of Singular and Vytroin, reported net income of over \$4.6 billion for 2005. Their income was less than in 2004, mostly due to the Vioxx lawsuits. (Merck) Indianapolis based Eli Lilly and Company, makers of Prozac and Cialis, reported net income of almost \$2 billion in 2005. (Eli Lilly)

Just like the health insurance CEO's, pharmaceutical company executives enjoy big paychecks. In 2005, Sidney Taurel, former CEO of Eli Lilly and Company, made over \$11 million, including stock option grants and cashed out over \$9 million in stock option exercises. In addition Taurel had over \$3 million in unexercised stock options from previous years. Richard V. Gilmartin, CEO of Merck and Co. Inc., received over \$1.9 million in total compensation, including stock option grants. Henry A. McKinnell, CEO of Pfizer raked in over \$16 million in total compensation including stock option grants. From previous years' stock option grants, the Pfizer Inc. executive cashed out over \$6 million in stock option exercises, and he has over another \$5.7 million in unexercised stock options from previous years. (AFL-CIO)

The average Hoosier would have to work 287 years to make what Sidney Taurel made in 2005.

Reform Efforts

The U.S. health care system is broken. Growing numbers of Americans either uninsured or underinsured and no end in sight to rising health care costs. Fortunately, most policy makers have acknowledged the problem and are working on reform. Current reform efforts range from health savings accounts to tax subsidies and individual mandates. None of these proposals adequately address the issues concerning universal access and cost containment. All of these proposals aim to work within the same market-based system which is currently failing.

Health Savings Accounts

Health savings accounts (HSAs) have become the latest “big idea” to reform the health system. Health savings accounts are a part of a larger push toward “consumer directed health care.”

Essentially, an HSA is a tax-free savings account for health related expenses. These plans can be stand alone savings accounts or be combined with a high deductible insurance plan. For maximum tax benefit, these plans must be accompanied by a high deductible insurance policy. (Robertson) The individual spends the allotted dollars in the health savings account first and once the savings account has been expended, the individual must pay out of pocket until the deductible is met. The insurance then kicks in, however the patient must still share the cost with the insurer and pay for treatments out of pocket if they are not covered by the plan. According to Physicians for a National Health Plan, “The rules about what HSAs can cover and what expenses apply to the deductible are so complicated that Bruce Bodaken, CEO of Blue Cross of California, stated that he can’t understand his own plan.” (PNHP)

Insurance companies and even banks advocate that health savings accounts are the solution to the health care crisis. The theory is that “consumer directed health care” will lower health care spending because people will become more cost conscious and “responsible” as health care consumers if they assume more responsibility for paying the bill.

This thinking assumes that consumers don’t realize that health care costs are increasing. According to a poll of consumers conducted by Forrester Research, 52 percent of people have seen their out-of-pocket expenses increase. (Hendrickson)

A major problem is that the concept of comparison shopping for health care is relatively new. Tools for this purpose are still in their infancy and for the most part offer little or no real help in comparison shopping. Often these tools are offered by health plans, which in general report only their negotiated prices and offer these tools to members only. Third parties offering such tools usually do not display specific plan pricing, the information is generally not available publicly, if a patient is not a member of a health plan the patient, in most cases, must pay a fee for these tools. Almost all of these tools are available online only.⁷ (Ibid)

Price transparency is an important concern when creating methods for consumers to

⁷ The authors of the study *Health Care Cost Comparison Tools: A Market Under Construction*, conducted by Forrester Research and published by the California Health Care Foundation, interviewed entities that have online cost comparison tools or simply asked them what types of tools they offer. Of these entities, four were vendors that sell their cost tools to health plans and/or employers: Health Grades Inc., Ingenix Inc., Subimo LLC., WebMD (Select Quality and Cost Care Indicator). Three were health plans that built their own tools: Aetna, Blue Cross Blue Shield North Carolina, and Blue Cross Blue Shield Tennessee. Three were major insurers whose tools were developed in-house or by third parties: Blue Cross of California, Blue Shield of California, and Kaiser Permanente. One was a State Hospital Association: Wisconsin Hospital Association.

comparison shop. Hospitals, doctors and health plans do not agree on what sort of information should be available to consumers. Hospitals for instance may offer tools that rate quality but not price, since some prices are procedure specific and vary for other reasons. Some incorporate all cost of a treatment episode (inpatient and outpatient care, test, doctors and drugs), some just report hospital charges. According to the report *Health Care Cost Comparison Tools: A Market Under Construction* published by the California Health Care Foundation, "One health plan said its providers were concerned that consumers would judge health care based on cost alone." The report also stated, "Hospitals' response conceptually has been that it makes sense to get the quality information out there but they are not sure about the cost information. They worry about people judging quality based on price and that patients will go to a less expensive hospital, thinking that some hospitals are just high cost, as opposed to being better." (Ibid)

Consumers are reluctant about the concept of shopping around for health treatments. The survey of consumer reaction to comparison shopping conducted by Forester Research found that consumers see choosing among treatment options difficult. Fifty six percent of consumers cite unclear medical trade-offs and risks, 55 percent are unclear about medical terminology and 51 percent find determining financial tradeoffs and risks complex. (Ibid)

Aside from the complexities of comparison shopping for health care, there are a number of reasons why health savings accounts will not lower costs and expand coverage. Proponents of consumer directed plans claim that health care is just like any other commodity and consumers armed with information and incentives will consume health care wisely. However, most economists have concluded that basic rules defining supply and demand don't work in the health care system. Patients don't "decide" what to "buy," they rely on doctors and nurses to guide their treatment decisions. (PNHP)

As for controlling costs, the evidence so far suggests that rather than controlling costs, HSAs have been more successful at shifting the costs and risk from insurance companies to the patient. In addition they, "increase administrative costs, further segment individuals according to health care risk and subsidize the highest income individual the most." (Blumberg) These plans "increase incentives for [higher income] individuals to purchase coverage individually instead of a group employer plan and are likely to decrease insurance coverage for high health care cost and low income workers and their dependents." (Ibid) Since these plans expose people to high health care costs, this leads people to rationing their health care based on costs, discouraging people from getting preventative screenings and can result in worse health outcomes. (PNHP)

Health savings accounts have been attractive to higher income people in good health because of the tax savings they provide. This feature is unlikely to attract many of the currently uninsured, since more than half have no income tax liability. Studies estimate that mass usage of HSAs would only reduce the uninsured population by less than 100,000. (Ibid)

Findings from an Employee Benefits Research Institute (EBRI)/Commonwealth Fund survey of health insurance consumers found that fifty-six percent of all patients with HSAs are dissatisfied with them. Findings from this survey confirm that under these plans, consumers are paying more and getting less. The survey looked at high deductible health plans (defined as those that qualify under the HSA qualifications of \$1000 deductible for single coverage and \$2000 for family coverage). The survey found that only 33% of enrollees in these plans are "very satisfied" with their insurance, compared to 63% of individuals with comprehensive health insurance. The survey also found the out-of-pocket costs for people with consumer directed health plans were much higher than those with comprehensive health insurance, 42% of

consumer-driven health plan (CDHP) holders spent more than 5% of their income on out-of-pocket costs compared to 12% with comprehensive plans. Those with CDHPs are more likely to delay or skip care due to cost: 31 percent reported doing so. (Collins)

Additionally, advocates for health savings accounts ignore the “80/20 rule.” In the U.S. health care system, each year only 20% of very ill consumers generate 80% of the cost. Health savings accounts do little to control costs among the chronically ill who incur the bulk of health care spending. Health savings accounts control costs only by discouraging care, and some of the care discouraged will turn out to be needed, adding costs in the long term.

Tax Incentives

The system of employment-based health insurance we currently have exists because of tax incentives. During World War II, President Roosevelt passed price and wage legislation to control inflation. Since employers could not attract or reward employees with raises, they began offering benefits like health care coverage. In 1942, the War Labor Board established a rule allowing employers to exclude employment based health coverage from taxable income. Between the 1940's and 1960's, the population with health insurance grew from 9 percent to 68 percent.

Leonard E. Burman, Senior Fellow of the Urban Institute and Co-Director of the Urban-Brookings Tax Policy Center, testified before the U.S. Senate Committee on Finance on March 8, 2006. He said, “Some observers have suggested that the tax subsidies are a significant part of the problem. The subsidies encourage people to get insurance at work, stifling the individual non-group market, and they encourage employers to provide overly generous insurance since the cost is subsidized. What's more, the subsidy is upside down - aiding most of the high-income families that would probably purchase insurance under any scenario, and providing little aid to those of modest means.” (Burman)

In the same testimony Burman went on to explain why an “unfettered” free market health system won't work. Without tax incentives, the current system of health care administration would be too expensive for four reasons:

1. The very act of having insurance increases utilization. People spend more when someone else is writing the check, but this causes insurance to be more expensive than it might be (a phenomenon known as moral hazard);
2. Insurance is most attractive to people who expect to benefit most from it - such as those with chronic conditions and people who plan to have children. Because insurers can only imperfectly match premiums to expected utilization, they have to assume that purchasers have higher costs than the population average. That means that healthy people get a relatively bad deal from insurance - unless they can align themselves with a large group. (This feature of insurance is called adverse selection.);
3. The existence of “free” - even if inadequate - emergency health care for those with low incomes serves as a deterrent for purchasing health insurance, both because the “free” care provides a safety net and because uncompensated care raises the cost of care for those with insurance;
4. Healthy people - especially in the non-group market - can only imperfectly insure against the costs of developing chronic illnesses, because premiums for non-group health insurance increase over time for sick people.

Tax incentives and employer sponsored health coverage are essential to maintaining the current system of health insurance administration. However, increasing tax subsidies for employment-based health insurance or individually purchased insurance policies is not the answer to the health care crisis we face. Tax subsidies for employment based health insurance will reduce federal income and payroll tax revenues by over \$200 billion in the year 2007. (Ibid) Tax incentives do nothing to control overall health care costs, nor do they ensure access to health coverage for all Americans. Increasing tax incentives do not provide any incentives to reduce health care inflation or reduce premiums. Indeed, it can be argued they encourage inflation.

Individual Mandates

Some policy makers and other health reform advocates have suggested making health insurance universal through an individual mandate to purchase coverage. The most recent example of an individual mandate is the legislation passed in Massachusetts in 2006. The new law attempts to cover all state residents by requiring they purchase health insurance. If residents do not comply, a series of penalties will be imposed.

The law extends Medicaid coverage to children in families with income up to 300% of the federal poverty level, provides sliding scale subsidized insurance for individuals and families up to 300% of the federal poverty level and creates the Commonwealth Insurance Connector, a program designed to help small businesses purchase health insurance for their employees. (ACT)

Residents were required to purchase health insurance coverage by July of 2007. Penalties for employers who fail to provide insurance for workers include a \$295 annual fee per worker for businesses with 11 or more employees. The law states that all residents must obtain health insurance coverage by July 2007 if *it is determined that people in their income bracket can afford insurance*. If an individual cannot prove that they have health insurance in 2007 they will lose their personal tax exemption. In 2008, if an individual cannot prove that they have health insurance they must pay half of the cost of the lowest available yearly premium. (Ibid)

The law attempts to reduce barriers to obtaining health coverage by “encouraging” insurers to create plans with lower premiums. These plans must provide comprehensive benefits and meet current health coverage requirements, such as coverage for mental health services. (Ibid)

“We insist that everybody who drives a car has insurance,” stated Governor Mitt Romney of Massachusetts in support of the law, “and cars are a lot less expensive than people.” (Farenthold) His analogy is flawed for a number of reasons, including the fact that mandatory auto insurance laws have not rid the highways of uninsured drivers. Despite far greater penalties than those included in the Massachusetts health insurance mandate, thousands of people operate vehicles without insurance every day. And, driving an automobile is most certainly a privilege, not a basic human right like health care.

As discussed earlier, free market economic theories are a poor fit for funding health care. Individual mandates like the new Massachusetts law attempt to work within a market based system. To achieve its goal, large government subsidies are needed to help cover those that are under 300% of the poverty level. The Massachusetts legislation estimated that there are 500,000 uninsured individuals in Massachusetts; this is 248,000 short of the number of uninsured reported by the Census Bureau. The state expects to subsidize insurance using

sickness funds, which currently fund uncompensated care in hospitals. However, the law increases the reimbursement rates for Medicaid to hospitals and the funds needed to do this are to come from the same sickness funds that will be used to subsidize insurance. The bill raises only an additional \$170 million per year to help cover the subsidies. Funding for the subsidies is projected to fall short by 20% in 2009 when the program is to be fully implemented.

Massachusetts residents above the 300% poverty level are left on their own. According to the U.S. current population survey, in 2004 there were 42,784 uninsured individuals in Massachusetts with incomes above 300% of the federal poverty level, roughly \$30,000 a year for a single person. (Himmelstein) The bill states, "those who are in an income bracket in which health insurance has been deemed affordable must purchase insurance even if it is not offered at work." The question remains: what is affordable and who decides? What may be affordable to a person making \$30,000 a year with good credit, little debt and great health may not be affordable to someone making the same amount with high debt, bad credit and so-so health. The bill does nothing to control the rising cost of premiums or high out-of-pocket spending.

The law "encourages" health insurance companies to create "low cost" health insurance policies while providing comprehensive coverage. Without specific cost controls on the insurance providers this opens the door to high deductible, minimum coverage plans that just meet the definition of coverage, not the actual health needs of an individual. In order for people to comply with the mandate regardless of health status, insurance companies will have to accept everyone, no matter what the risk. This alone threatens to drive up the cost of health insurance, since health insurers are free to pass on their increased costs to policy holders.

In his statement before the United States Senate Committee on Finance, Leonard E. Burman stated, "Simplistic market-based solutions, though appealing, are likely to come up short. Market reforms that ignore adverse selection, for example, or the fact that a growing fraction of Americans simply cannot afford to pay for health care and meet other basic needs are bound to fail." (Burman)

Employer Mandates

Another approach to covering the uninsured is an employer mandate, also known as "pay or play." A few states have considered mandating that employers offer health insurance to all workers. Hawaii is the only state currently requiring employers to offer health insurance. Employers in Hawaii must offer health coverage to all employees working 20 hours a week or more for four consecutive weeks. (Yelowitz) As a result, the state has one of the lowest uninsured rates in the country. In the 1970s Hawaii was the only state to be exempted from ERISA, the federal law which forbids states from requiring employers to provide health insurance. (IOM, 2004) Not many states have attempted to challenge this law. However with the growing number of uninsured, a few states have considered taking the employer route. In 2003, California passed the Health Insurance Act, which was short-lived. The law was quickly repealed by a narrow vote when a referendum was placed on the ballot in November of 2004. (Yelowitz)

California's Health Insurance Act of 2003 would have required employers with a certain number of full time employees to offer family or single coverage insurance. The legislation defined full-time as 23 hours a week. Firms with 200 or more employees would be required to offer health insurance to employees and their dependents. Firms with 150-199 employees would have to offer health insurance to their employees, but not dependents. If a tax credit were established, employers with 20-49 workers would have to provide individual insurance. In addition to the

mandate to offer health insurance, employers were required to pay at least 80% of the premium; employers with less than 50 employees would have to pay 64% of the premium. (Ibid)

The logic behind this type of reform is that while only 56% of all companies offer health insurance to their employees, (AHRQ, Table II.A.2) most people with private insurance get it through their employer. This approach only addresses increased access to health insurance and fails to address the major reason why businesses don't offer and employees don't purchase insurance, which is the cost. Pay or play does not address the rising cost of premiums, out-of-pocket spending, portability, rising cost of health services or what to do about the thousands of people who work full-time by piecing together multiple part time jobs. This approach will not help business, labor or people who are already insured.

Many companies are already dropping health coverage due to rising premiums and the impact this cost has on the bottom line. If companies don't drop coverage completely they often trim coverage or increase deductibles, co-pays, or premiums in order to control costs. Possible effects of an employer mandate can have dramatic repercussions on the labor market. In order to protect profits, employers may reduce real wages. This would make it even harder for people to afford their share of the premium, defeating the purpose of the mandate. Reducing real wages would create even more economic problems for the states and for individuals. Companies could also choose to lay workers off, cut back hours, or eliminate other fringe benefits. Those with operations that are able to be relocated could move operations out of state or out of the country. (Yellowitz)

It is true that productivity increases with health insurance coverage. However, if a company starts using capital dollars to cover increased labor costs, business growth and profitability are limited. Some firms that may accept lower profits would more than likely pass the increased costs onto customers. Businesses that are unable to absorb the increased costs or pass them onto consumers may be forced to shut down if profits become losses. Dr. Aaron Yellowitz, from the Department of Economics at the University of Kentucky, stated in his 2005 report, *Are Employer Mandates a Viable Policy Option*, "from the larger firm's economic decision-making perspective, its own cost, not the net social costs, are what is important." (Ibid)

The 80% cost sharing mandate called for in most employer mandate proposals could potentially hurt those who already have employer sponsored coverage. Some firms that currently offer health insurance offer it only to certain categories of workers. Typically, employers offer insurance to full time workers working 30-40 hours or more a week, The California legislation mandated that workers who are working 23 or more hours a week be offered insurance. At the time the legislation passed, some large California employers were paying as much as 87% of the premium cost. (Ibid) If a large employer had a big number of part time workers working 25 hours a week, in order to cover the cost of the increases in health spending those employers could lower their cost sharing on premiums, resulting in those currently insured paying more for the same coverage. Another possible scenario involves those companies currently offering comprehensive coverage to their employees at a cost sharing percentage lower than the 80%. In order to comply with the cost-sharing requirement of 80% and not face dramatically increased costs, employers could switch to lower priced, stripped down plans. While this could reduce employee spending on premiums, out-of-pocket spending would likely increase because of reduced coverage and increased deductibles and co-pays.

Another problem with employer mandates is that it traps us in the same employer based system that is already failing. These mandates do nothing to guarantee universal coverage to all citizens regardless of employment status, nor do they address the issue of portability, cost-

containment, comprehensive and affordable health coverage or quality health care. Employer mandates do not limit premium increases or out-of-pocket spending. Employer mandates continue wasteful private insurance administrative spending, crippling the health care system with unnecessary costs. Health insurance coverage should be unlinked from employment in order to guarantee access to coverage for all Americans.

Of the states considering employer mandates, New York's "The Working New Yorker's Health Insurance Act," closely resembles California's Health Insurance Act with different thresholds. Other reform attempts that further link health coverage and employment include "fair share" legislation. Under "fair share" proposals (proposed in California, Michigan, New Jersey, New York, Ohio, Pennsylvania, Maryland, and other states) companies with a certain number of employees, anywhere from 2,000 to 10,000 or more, must spend 6% or more (depending on the state), of their payroll on health coverage or pay the state the difference. "Fair share" legislation came about in response to an internal memo released by anti - Wal-mart groups showing the company's intent to encourage employees to apply for Medicaid and other public health care programs.⁸ Since Wal-mart is the largest employer in most states, and in some the only employer with 10,000 or more workers, they are an obvious target.

Some states are also attempting to require a minimum health care wage per hour, which companies must spend on health care per worker. New Jersey and New York have considered such legislation. The minimum health benefits wage in legislation such as this equates to about \$4.19 an hour. For a small business unable to offer health insurance because of cost in the first place, this increase in labor costs could be difficult to absorb. Employers would be motivated to lower wages to control labor costs.

Conclusion

Insurance and pharmaceutical companies amass huge profits every year and the CEOs of these companies are some of the highest paid executives in corporate America. These companies lobby heavily in order to maintain and increase their bottom lines, perpetuating the status quo of the U.S. health financing system. Most current reform efforts maintain the current market-based system that is failing millions of Americans. As a country we cannot guarantee comprehensive, high-quality, affordable and portable health care coverage for all Americans by tweaking the current system.

⁸ Documents bearing the Wal-Mart logo reveal that the company issues paper "Instructions for Associates" which direct them in applying to public assistance programs.

[Wal-Mart Social Services Documents, undated] Document #1: The Wal-Mart "Instructions for Associates." This document bears the Wal-Mart logo and contains a section entitled, "Applying to a Social Service Agency?" The section instructs associates who are applying for social services to tell their caseworkers to verify employer information with Wal-Mart's outside contractor, The Work Number.

[Wal-Mart Social Services Documents, undated] Document #2: Wal-Mart Memo. This document is a Wal-Mart memo, again bearing the company logo, and informs recipients that the company uses The Work Number to verify employment and income for associates. The memo provides "Special Instructions" for social service agencies.

[Wal-Mart Social Services Documents, undated] Document #3: The Work Number Services. This document is a page from The Work Number website detailing what services it provides for employers. The Work Number can "save time and money" for employers by verifying employee information for the following public programs: TANF (Temporary Assistance to Needy Families), Food Stamps, Social Security and Medicaid. <http://walmartwatch.com/pages/healthcare#background>

A national health insurance plan administered through a single payer system would take the financing of health care coverage out of the hands of insurance companies. Through a national health insurance plan, all Americans could be provided comprehensive health insurance while health costs could be contained with global budgets and negotiated fees. A national health insurance plan unlinks coverage from employment, releasing business from the burden of rising health care costs. It guarantees comprehensive coverage regardless of employment, health or income status and allows patients to choose their doctors and other providers.

The Need for National Health Insurance

How National Health Insurance Meets the 5 Criteria for Health Care Reform

With 47 million uninsured Americans the need for health coverage has never been more critical. Universal health insurance is an absolute necessity if we are to have a healthy and productive society. National health insurance is the only system of health coverage which is:

1. Universal and affordable;
2. Maintains high quality health services;
3. Contains costs;
4. Provides comprehensive coverage; and,
5. Unlinks coverage from employment.

Universal and Affordable

A national health insurance plan would cover all Americans regardless of health or income status. Since everyone would be covered, greater cost sharing is achieved. Medicare works in this way; the young subsidize the care of the elderly through taxes. National health insurance essentially expands Medicare coverage to all Americans regardless of age, vastly reducing the role that private health insurance companies play in the system. Because a single payer collects all health care funds and also pays providers, tremendous administrative savings are achieved. According to a study done in 1991 by the General Accounting Office, the administrative savings achieved through converting to a single payer system are enough to cover the costs of providing coverage to the uninsured. The study, *Canadian Health Insurance: Lessons for the United States*, found that simply replacing the current multi-payer system with a single payer system, like Medicare, would yield \$70 billion in savings. Another study, published in the *New England Journal of Medicine* in 2003, found that if the U.S. health care system was as efficient as the Medicare system, it would generate \$286 billion annually. An update of the study in 2007 estimated the annual savings at \$300 to \$350 billion. Most single payer proposals are financed by payroll and progressive income taxes that replace the current piecemeal financing and would result in most citizens paying less than they do now for insurance.

Maintains High Quality Health Services

National health insurance via a single payer is a system of health care financing; it does not dramatically change the health care delivery system. It is instrumental in improving the delivery of care by increasing access to proven treatments which are currently out of reach for those who are uninsured or underinsured. Maintaining health coverage that is comprehensive and consistent improves the likelihood of having a long-term primary care physician. Having a primary care physician is important for detecting conditions early, reducing the cost of treatment and improving outcomes. Universal coverage will free emergency rooms of uninsured patients

seeking primary care, allowing them to return to their roles as crisis care providers. Getting health care spending under control will allow more public resources to be devoted to research and development of new treatments and procedures. The reduction in multiple payers will reduce paperwork and the likelihood of costly and life-threatening errors.

Contains Costs

Medicare currently operates with a 3 percent administrative cost, which is much more efficient than any private insurer, where administrative costs range from 15 to 30%. Because of our multitudes of inefficient private insurance companies, administration accounts for 25 to 30 percent of health care costs in the U.S. (Campbell, et al.) Under a single payer system administrative costs would be similar to Medicare, because there will be no costs for underwriting, risk adjustment, advertising, extravagant executive salaries and shareholder profits. Monies allocated for health care would be spent primarily on health care services, not red tape and profit. The government would negotiate fees for provider services and operating budgets for hospitals annually. The government would also negotiate the price of prescription drugs. Some single payer plans would employ private insurers to administer the national insurance plan, but their administrative costs would be capped, similar to the current practice of private insurers serving as third party administrators for self-funded plans or Medicare and Medicaid programs. Single payer would also eliminate cost-shifting; the practice employed by providers to cover some of the costs of providing uncompensated care by shifting those costs to people with insurance.

Provides Comprehensive Coverage

Under a national health insurance system, all Americans would have comprehensive health coverage. Coverage would include all medically necessary services, including primary care, inpatient and outpatient care, emergency care, prescription drugs, durable medical equipment, long-term care, mental health services, dentistry, eye care, chiropractic care, and substance abuse treatment. Patients would have a choice in physicians, providers, hospitals, clinics and practices. This coverage can be achieved without increasing current spending on health care, since more people will be contributing through the tax base, costs will be contained through fee schedules and budgeting and administrative costs will be greatly reduced.

Unlinks coverage from employment

All citizens would be covered under a national health insurance plan. Citizens would be free to change jobs, take time off to raise children or retire early, without having to worry about losing health care benefits. Employers, large and small, would still contribute to the health care plan, but in most cases their burden would be reduced and future cost increases controlled.

The Need for Single Payer National Health Insurance

Converting our current health system to a universal, single payer system of national health insurance is not a matter of figuring out how to pay for it. We currently spend \$1.9 trillion a year on health care. (CHCWG) In October 1998, the Economic Policy Institute stated, "The impediment to fundamental reform in health care financing is not economic, but political. Political will, not economic expertise, is what will bring about this important advance." (Rasell) A survey involving medical students, residents, fellows, academic faculty, residency program directors and deans of medical schools showed overwhelming support for a universal coverage, single-payer system over a fee for service or managed care market based system. Fifty seven percent of the participants favored single-payer. When the physicians in training were removed, 69 percent favored a single-payer health system. (Mueller)

A study released in April 2008 by Indiana University physician and researcher Aaron Carroll, M.D. found strong and growing support among physicians, across specialties, for a national health insurance system. Carroll's study noted that 59% of physicians are in favor of national health insurance, up from 49% just five years ago.

Americans, like people over the world, see access to quality health care as an important quality of life issue. A recent survey commissioned by the Pew research group found that 65% of Americans (including 59% of social conservatives and 75% of conservative Democrats) favored a government financed health insurance plan for all, even if it meant that taxes would increase.

A single payer national health insurance program would function and operate quite differently from the current system. Instead of thousands of different insurance companies with hundreds of different plans, all Americans would participate in the same program and get the same benefits. Insurance coverage would no longer be linked to employment. The program would be federally funded and administered at the state or regional level by a public entity, or an insurance company that would bid for the work on contract. Premiums, co-pays and deductibles and other out-of-pocket costs to consumers would be eliminated. Instead, individuals and businesses would contribute via the tax system, with payments structured in a progressive fashion, requiring those with higher incomes and higher payrolls to pay a higher percentage tax.

Hospital and other institutional billing would end and be replaced by an annual operating budget. Doctors in private practice would be paid on a fee-for-service basis and doctors on hospital and university staffs would be paid a salary. (Baker, et al.)

In order to control health care costs and inflation, the government would negotiate fees for services and goods on a regular basis.

All Americans would receive comprehensive coverage for all medically necessary services, including primary care, inpatient and outpatient care, emergency care, prescription drugs, durable medical equipment, long-term care, mental health services, dentistry, eye care, chiropractic care, and substance abuse treatment. Patients would have a choice in physicians, providers, hospitals, clinics and practices. Americans would all be issued a health insurance card and present it at the time of service. Americans would no longer receive bills from providers or "this is not a bill" forms from the insurance company. Out-of-pocket spending would be eliminated. (Ibid)

By preserving much of the current financing and replacing regressive sources with more progressive sources, the U.S. can fund a national health insurance system with little increase in spending. New funding can be captured through income and payroll taxes. By incorporating a payroll tax on employers, we can preserve the spending of employers that currently provide health coverage, while easing their burden by requiring all employers to pay into the system.

These business taxes would be combined with an individual income tax based on a sliding scale, requiring those at upper incomes to pay a higher rate. With these taxes instead of insurance premiums, funds lost from private sector insurance can be replaced equitably and out-of-pocket spending by patients will be eliminated. (Ibid)

The October 1998 report by the Economic Policy Institute stated that under this system of financing, "[f]or the average, middle-income household, taxes would rise by \$731. In other words, for fully 60% of households, the increase would average less than \$731. For another 20%, the increase would average about \$1,600. Only the 20% of households with the highest

incomes would face a larger tax increase. In exchange for the tax increase, premiums and out-of-pocket spending would be eliminated. Costs would be redistributed from the sick to the healthy, from the low- and middle-income households to those with higher-incomes, and from businesses currently providing health care benefits to those that do not. Just as important, greater efficiency and improved cost containment would become possible, leading to a sizeable savings in the future.” (Rasell)

Under a single payer system, a National Health Advisory Board would be established, consisting of health care professionals and representatives of health advocacy groups. Since the program would be a government financed social program, the public will have more opportunity for oversight, criticism and public participation in planning than the current, disjointed system. This will provide more oversight and accountability than the current system does. This will empower Americans and give them more say in health spending and the direction of health care in America.

Myths about Single Payer

Detractors of single payer reform like to exaggerate problems in Canada and other countries that have national insurance systems in order to frighten the public away from systemic reform.

While queues do exist for some health services in Canada, in the vast majority of cases any significant wait is for an elective procedure. Further, physicians control the queues and manage them according to need. So, anyone waiting in line for a non-elective procedure that needs care immediately can most often get it.

In 1998 a study found that fewer than 14% of Canadians were on waiting lists and fewer than 10% were on lists for more than four months. Data shows that queues in Canada have been decreasing. (Geyman)

In the United States, waiting times even for the privately insured are increasing for check-ups, doctor visits and even hospitalization. Physicians at the University of Southern California Medical Center have testified that some patients may wait up to four days for a bed, with some dying as a result.

Private interests have successfully lobbied their way into countries with single payer systems. Studies have shown that average waiting time for cataract surgery with doctors who work solely in the public sector is 10 weeks. For those doctors who work in the public and private sector, the average waiting time is 26 weeks, with preference given to the privately insured patients. (Ibid) Statistics like these are important to consider when some suggest reform should entail a public system with an opt-out for the wealthy to buy into a private system.

Another common misconception about Canada’s system is that Canadians flock to America for health care, making our system their “safety valve.” In 2002 a study was conducted in three states. The studies found that the number of Canadians seeking care in America is very low for both outpatient and hospital services. In fact many of these people were traveling in America at the time and needed care while here. Most were not making a special trip. (Ibid)

Those opposed to a Canadian style system of health care say that it will lead to rationing. All health care systems ration care to some extent. In the U.S., we ration care according to

income, where you live, or where you work. In single payer systems, health care is occasionally rationed, based on medical necessity. And, given the over-abundance of medical technology that exists in many health care markets, including cities like Indianapolis, it is misguided to assume lines would form for services like MRI imaging or CT scans. In the U.S., expensive high-tech services are sometime over-promoted and over-utilized by wealthy and/or well-insured patients, even though these technologies have not been proven to be a medical benefit or cost effective. (Ibid)

Many people mistake Canada's system for "socialized medicine." However, while Canada's health system is a social service, it is not socialized medicine. In socialized systems, the government owns and operates the health care facilities as well as employs the doctors and other providers, which is the case in Britain and Spain. Canada's health care system is one of national insurance, where the federal government collects monies through taxes and the insurance program is administered by the provinces. Doctors and hospitals are mostly privately owned. Indeed, the Canadian system is no more socialized than our own Medicare program.

H.R. 676 - The Conyers Bill

The push for universal health care in America has been a long one. From Roosevelt cutting universal sickness insurance from the New Deal in order to get it passed, to Truman championing the first big push for a universal health care bill, to the Clinton administration's health care failure of the 1990s, the issue will not go away.

Universal health care is important; however universality can be only one part of the goal. Health care that works for all Americans must be:

1. Universal and affordable;
2. Maintain high quality health services;
3. Contain costs;
4. Provide comprehensive coverage; and
5. Unlink coverage from employment.

While Nixon came close to these goals with a National Health Insurance bill in 1974, the Watergate scandal killed all bipartisan progress made on the bill. Clinton's attempt failed to gain any significant support from Republicans. Health care reform is unfortunately mostly a political battle and a lack of political will has killed health reform time and again.

Rep. John Conyers, (D-Michigan), is the lead sponsor of federal legislation to create a single payer system, the National Health Insurance Act (H.R. 676). The bill, which is co-sponsored by 88 members of Congress, would establish national health insurance for all Americans. According to Conyers' website, the bill will create a publicly financed, privately delivered health care program which uses the existing Medicare program as a model and extends coverage to all Americans, guaranteed by law. According to the website, the program would reduce overall annual health care spending by \$50 billion in the first year. (Segal, et al.)

Under this proposal, all employers would pay a modest 3.3% payroll tax on all employees. The cost to an employer for an employee making \$35,000 a year would be \$1,155 a year. According to the website, 95% of all families will pay less for health care coverage than they do today. (Ibid)

The Act establishes eligibility for all persons living in the United States and U.S. territories. Everyone would receive a national health insurance ID card with a unique, identifying number. The program will cover all medically necessary services including primary care, inpatient and outpatient care, emergency care, prescription drugs, durable medical equipment, long term care, mental health services, dentistry, eye care, chiropractic care, and substance abuse treatments. The Act converts the current for profit health care system into a not-for-profit system and strictly forbids insurance companies from duplicating benefits provided by the federal program. Insurance companies may provide coverage for non-medically necessary services such as cosmetic surgery.

The conversion to a not-for-profit system is estimated to take place over 15 years. The United States National Health Insurance (USNHI) program will set annual reimbursement rates for physicians and health care providers and negotiate prescription drug prices. The national office would provide an annual lump sum to existing Medicare regions, which will administer the program and pay physicians a fee-for-service and use global budgets. (Ibid)

The U.S. Congress will establish annual funding outlays through an annual entitlement. The program will operate under the Department of Health and Human Services. All current spending on public health will be retained and administered through regional Medicare offices. The funding proposal consists of employer and employee payroll and income taxes. The program would incorporate a 3.3% payroll tax on employers and maintain the 1.45% employer and employee tax for Medicare. The Act calls for a sliding scale percentage on employee income tax contributions, as well a small tax on stock and bond transfers and closing corporate tax shelters. The Act also calls for a repeal of the 2001 tax cuts. (Ibid)

The Conyers bill is the only proposal in Congress that adequately addresses all the issues facing the U.S. health care system. The bill provides for universal health care coverage, while containing cost and assuring quality health care. The bill also reduces massive overhead cost by eliminating excessive administrative costs. The United States National Health Insurance Act is the only bill which can cover all while providing comprehensive health coverage regardless of income. This bill will provide true equality in health care coverage and reduce health care spending for the vast majority of Americans and most businesses.

Conclusion

Forty seven million Americans are uninsured and just as many are underinsured. (KFF, Jan 2006) Since 2000, premiums have increased at double-digit rates annually. Out-of-pocket spending has increased and the number one reason for personal bankruptcy is medical expenses. The nations ER's are overcrowded with those who have no place else to go for health care. Businesses are seeing their profits shrink every year as premiums rise. The Institute of Medicine estimates at least 18,000 people die every year because they lack insurance coverage. It is painfully obvious that the current health care financing system has failed.

Attempts to reform the system by tinkering around the edges of the current system will not work. Legislation such as the Massachusetts individual mandate law is loaded with subsidies for private insurers, yet includes no direct attempt to control rising premiums. Requiring citizens to purchase health insurance or businesses to offer it without controlling costs cannot work. Instead of helping the uninsured and underinsured, they help to further beef up the profits of the

insurance industry at the expense of millions of Americans.

Consumer directed health plans, like medical savings account, will not reform the system and in fact, enrollees in these kinds of plan are paying more out of pocket and getting less care.

Citizen Action Coalition of Indiana supports a system of national health insurance like the one envisioned in H.R. 676. CAC has determined that solutions aimed at maintaining the current market-based health care system do not address the health care coverage needs for all Americans.

As long as health care coverage is treated as a commodity that can be bought and sold for a profit, America will continue to see high rates of uninsured individuals, rising costs and poor health outcomes. This already has devastating effects on individuals, families, entire communities, businesses and the economy. America needs national health insurance and we need it now.

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