

DRAFT COPY

ROADMAP FOR UNIVERSAL HEALTHCARE

Three Steps toward Medicare for All

America's healthcare system is broken, and the American people expect the Federal government to fix it. Even in a nation dominated by concerns about Iraq, healthcare remains at or near the top of domestic policy concerns for most Americans, even among those who do have insurance. And the 49 million Americans who lack health insurance are only one illness or injury away from bankruptcy and ruin. Republicans offer only token measures designed to strengthen their allies in the HMO and pharmaceutical industries, while Democratic candidates offer plans for universal healthcare which are laudable in their goals, but sport pricetags that legislators and the public are not yet ready to swallow.

Our healthcare landscape is a patchwork of private plans, Medicare, Medicaid, SCHIP, the VA system, patients who self-pay, and the uninsured who either do without healthcare or show up at the local emergency room in the last stages of a medical crisis. While legislators and pundits debate the merits of a universal national health plan, they often overlook the fact that a national health plan exists, and is in many ways the best run of any of the segments of our healthcare landscape: Medicare.

The Medicare program, originally intended to ultimately cover all Americans, was derailed by Vietnam War funding to become a program exclusively for the elderly and disabled. Although Medicare's benefit structure is not perfect, it is in many ways far preferable to any of the other players in the healthcare coverage field. Medicare is very popular with its beneficiaries, and is far more efficient than private plans. Medicare's administrative costs total 2.6% in contrast to the 20-30% spent on administration, marketing and profit by typical private plans. This has led to frantic maneuvers by Republicans to prevent Medicare from ever competing against private plans on a level playing field. If Medicare were allowed to compete fairly, it would emerge as the de facto national health insurance plan that it was always meant to be, and a consensus would build for inclusion of all Americans in Medicare. We offer three specific, concrete steps toward this goal, with attractive prices and additional political and social benefits as we move toward universal coverage under Medicare. Each step is not only economically and politically feasible, but also increases the inevitability of the next step:

Step 1: Access to Medicare enrollment, at cost, for all adult Americans, and to SCHIP for all American children.

Step 2: Subsidized Medicare premiums for young adults, 55-64 year olds and the working poor, funded by a Medicare tax on unearned income.

Step 3: Federally-funded Medicare (SCHIP for children) for all Americans, funded by an increase in the Medicare tax on employers.

The first step is particularly attractive because it can be taken at essentially no cost to the Federal government, while building a consensus for the steps that follow, and undermining the counter-arguments of the Republicans and the insurance industry:

Step 1 is to offer a Medicare purchase option to all adult Americans, regardless of health status or prior insurance, at actuarially adjusted rates. This would level the playing field by allowing Medicare to compete directly with private HMO and PPO plans for the first time in history. Medicare enrollment, at cost, would be available not only for individuals but also for employer-sponsored groups. This would be expected to drive private insurance premiums down, as they are forced to compete with the much more efficient Medicare system. Republicans and the insurance industry would find it difficult to mount persuasive arguments against a plan that increases “patient choice” and “market competition,” at no cost to the Federal government.

Similarly, all American children would be offered enrollment in the State Children’s Health Insurance Program (SCHIP) at cost, regardless of pre-existing condition. For a modest investment of \$10 to \$20 billion per year, this could be coupled with a subsidy to provide SCHIP at no cost for all families below 300% of the federal poverty line.

Medicare copayments and deductibles would be the same as for current Medicare beneficiaries. The new beneficiaries would be able to purchase supplementary “MediGap” policies if they so choose, just as current beneficiaries do. Enrollees could choose either the traditional Medicare plan or a Medicare HMO or PPO, but the GOP’s preferential subsidies for HMO’s, PPO’s, and private fee-for-service plans would be eliminated. Premiums would be actuarially adjusted only for age, not for health status.

Because there might initially be high enrollment among individuals with significant health problems, which could lead to high utilization and hence higher premiums, it might be necessary to exclude coverage for pre-existing conditions, e.g. for the first 6-12 months after an individual enrolls, or to subsidize adverse selection among individuals by charging slightly higher premiums for employer groups – premiums that would still be less expensive than private insurance plans. Eventually, when the risk pool grows large and diverse enough, with many healthy individuals participating, adverse selection will disappear.

As more Americans in all age groups acquire a positive experience with Medicare, and join the millions of seniors who are satisfied with their Medicare benefits, a constituency would build for creating a true universal national health insurance plan based on Medicare. This would help increase the political support for further Medicare expansion, and counter the inevitable “Harry and Louise” attacks.

Step 2 begins to couple increased Medicare availability with increased Federal funding. With a Medicare purchase option already available for all adult Americans, and a growing realization amongst the public and legislators that Medicare insurance is in many ways superior and more cost-effective than private insurance products, government would now begin to subsidize a portion of the premium costs for targeted groups of individuals, for example, the 55-64 age group, who will soon enter traditional Medicare, as well as young adults ages 18-25, who are relatively inexpensive to insure, yet often lack coverage in today’s system. Additionally, coverage could be subsidized for the working poor, who do not qualify for Medicaid but cannot afford private insurance and are not covered by their employers. Revenues for these modest expansions in government funding could be generated by a new Medicare tax on unearned income (currently, only earned income incurs a Medicare tax).

Step 2 should also include some much needed updates for the Medicare program in general, such as coverage for an annual routine exam and preventive care (which will save money in the long run), improved hospital coverage benefits and possibility long term care. However, until universal coverage is achieved, the focus must remain on increasing access to coverage, not on tweaking the Medicare product.

Step 3, the final step, would be to offer Federally-funded Medicare coverage for all adult Americans and SCHIP coverage for all children. Ultimately, it might even be possible to phase out SCHIP (and Medicaid) in favor of Medicare for all ages. Some copays and deductibles would remain, to discourage excessive utilization. The funding for this ambitious expansion would come from an increase in the employer portion of the Medicare tax, perhaps to 9% instead of the current 1.5%, possibly accompanied by an increase in the corporate income tax rate. The overall tax burden to industry would probably be less in this system than their healthcare expenditures in the current private system. Those companies that have been doing the right thing and covering their employees would see a decrease in their net costs, while those who have been refused to cover their workers would finally pay their fair share.

Private HMO and PPO plans could continue to exist, as they do in England for the wealthy who prefer such coverage. However, due to the incremental increase in

publicly funded healthcare through the implementation of these Three Steps to Medicare for All, the private insurance industry would dwindle to a size where it would no longer have the political clout to shape legislation to its liking. Private health insurance companies could also continue to act as fiscal intermediaries for Medicare, as they do under the current system, within the 2.6% budget that Medicare allocates for such expenses.

What would a national “Medicare for All” plan ultimately look like? Every American would be enrolled from birth through the end of life, with all medically necessary care provided by the largest network of providers in the country, with each person being able to choose doctors and hospitals from the largest panel in the country. Government would be the payer, but providers would not be government employers and this plan would not create “socialized medicine.” Many options would continue to exist for receiving care through Medicare, including individual hospitals and doctors’ offices, group practices, large systems such as Kaiser (which could continue to exist as they currently do, but with all funding provided through Medicare), and the continued existence of specialized programs such as the Veterans Administration system, the Indian Health Service, and the military. Patients would continue to have reasonable co-pays and deductibles, and the private system could continue to exist for cosmetic procedures and other non-covered benefits.

Patients would benefit greatly from the absence of claims paperwork, referrals and pre-authorizations, and the ability to choose all of their providers from a huge available network. Providers and hospitals would benefit from having only one entity to deal with from a coverage policy and billing standpoint, and could achieve significant efficiencies in staffing and information technology. The government would benefit from universal enrollment, which would eliminate once and for all the problem of adverse selection, and the costs of emergency-room care for illnesses that could have been prevented in the first place. Most importantly, the American people would benefit by joining the rest of the civilized world in recognizing that healthcare can and should be a right of every citizen in a free society, not a privilege for those who can afford it.

Steps 2 and 3 will require strong leadership from a newly-elected Democratic President. But Congress can take the first step right now, and make universal healthcare not only achievable but inevitable, by enacting Step 1 of this plan. By making a Medicare purchase option available to all Americans, at no cost to the taxpayer, Congress can offer true choice to patients and true competition to the marketplace for the first time. Unlike plans to offer all Americans enrollment in the privately-administered Federal Employees Health Benefits Program, which would further enrich the private insurance industry and hence help fund the Republican Party, a Medicare purchase option will weaken the insurance industry, force insurance companies to lower their premiums, and

bolster the public's realization that Medicare is the most efficient source of high-quality healthcare available in the United States today.

Harry Truman first made universal healthcare a national priority for the Democratic Party nearly 60 years ago. The Medicare program established by our Democratic predecessors, and the Three Steps in this roadmap, can get us there.

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