Physicians' Working Group on Single-Payer National Health Insurance

Proposal for Health Care Reform
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“Health care is an essential safeguard of human life and dignity, and there is an obligation for society to ensure that every person be able to realize this right”

- Joseph Cardinal Bernardin

Summary/Abstract

The United States spends more than twice as much on health care as the average of other developed nations, all of which boast universal coverage. Yet over 42 million Americans have no health insurance whatsoever, and most others are underinsured, in the sense that they lack adequate coverage for all contingencies (e.g., long-term care and prescription drug costs).

Why is the U. S. so different? The short answer is that we alone treat health care as a commodity distributed according to the ability to pay, rather than as a social service to be distributed according to medical need. In our market-driven system, investor-owned firms compete not so much by increasing quality or lowering costs, but by avoiding unprofitable patients and shifting costs back to patients or to other payers. This creates the paradox of a health care system based on avoiding the sick. It generates huge administrative costs, which, along with profits, divert resources from clinical care to the demands of business. In addition, burgeoning satellite businesses, such as consulting firms and marketing companies, consume an increasing fraction of the health care dollar.

We endorse a fundamental change in America's health care – the creation of a comprehensive National Health Insurance (NHI) Program. Such a program – which in essence would be an expanded and improved version of Medicare – would cover every American for all necessary medical care. Most hospitals and clinics would remain privately owned and operated, receiving a budget from the NHI to cover all operating costs. Investor-owned facilities would be converted to not-for-profit status, and their former owners compensated for past investments. Physicians could continue to practice on a fee-for-service basis, or receive salaries from group practices, hospitals or clinics.

A National Health Insurance Program would save at least $150 billion annually by eliminating the high overhead and profits of the private, investor-owned insurance industry and reducing spending for marketing and other satellite services. Doctors and hospitals would be freed from the concomitant burdens and expenses of paperwork created by having to deal with multiple insurers with different rules – often rules designed to avoid payment. During the transition to an NHI, the savings on administration and profits would

fully offset the costs of expanded and improved coverage. NHI would make it possible to set and enforce overall spending limits for the health care system, slowing cost growth over the long run.

A National Health Insurance Program is the only affordable option for universal, comprehensive coverage. Under the current system, expanding access to health care inevitably means increasing costs, and reducing costs inevitably means limiting access. But an NHI could both expand access and reduce costs. It would squeeze out bureaucratic waste and eliminate the perverse incentives that threaten the quality of care and the ethical foundations of medicine.

Introduction

"Health care is an essential safeguard of human life and dignity, and there is an obligation for society to ensure that every person be able to realize this right."

Cardinal Joseph Bernardin

U.S. health care is rich in resources. Hospitals and sophisticated equipment abound; even many rural areas boast well-equipped facilities. Most physicians and nurses are superbly trained; dedication to patients the norm. Our research output is prodigious. And we fund health care far more generously than any other nation.

Yet despite medical abundance, care is too often meager because of the irrationality of the present health care system. Over 42 million Americans have no health insurance whatsoever, including 33% of Hispanics, 21% of African-Americans and Asians, and 11% of non-Hispanic Whites. Many more - perhaps most of us - are underinsured. The world's richest health care system is unable to assure such basics as prenatal care and immunizations, and we trail most of the developed world on such indicators as infant mortality and life expectancy. Even the well-insured may find care compromised when HMOs deny them expensive medications and therapies. For patients, fear of financial ruin often amplifies the misfortune of illness.

For physicians, the gratifications of healing give way to anger and alienation in a system that treats sick people as commodities and doctors as investors' tools. In private practice we waste countless hours on billing and bureaucracy. For the uninsured, we avoid procedures, consultations, and costly medications. In HMOs we walk a tightrope between thrift and penuriousness, under the surveillance of bureaucrats who prod us to abdicate allegiance to patients, and to avoid the sickest, who may be unprofitable. In academia, we watch as the scholarly traditions of openness and collaboration give way to secrecy and assertions of private ownership of vital ideas; the search for knowledge displaced by a search for intellectual property.

For seven decades, opponents have blocked proposals for national health insurance, touting private sector solutions. Their reforms over the past quarter century have emphasized market mechanisms, endorsed

the central role of private insurers, and nourished investor-ownership of care. But vows of greater efficiency, cost control, and consumer responsiveness are unfulfilled; meanwhile the ranks of the uninsured have swelled. HMOs, launched as health care's bright hope, have raised Medicare costs by billions, and fallen to the basement of public esteem. Investor-owned hospital chains, born of the promise of efficiency, have been wracked by scandal; their costs high, their quality low. And drug firms, which have secured the highest profits and lowest taxes of any industry, price drugs out of reach of those who need them most.

Many in today's political climate propose pushing on with the marketization of health care. They would shift more public money to private insurers; funnel Medicare through private managed care; and further fray the threadbare safety net of Medicaid, public hospitals and community clinics. These steps would fortify investors' control of care, squander additional billions on useless paperwork, and raise barriers to care still higher.

It is time to change fundamentally the trajectory of America's health care - to develop a comprehensive National Health Insurance (NHI) program for the United States.

Four principles shape our vision of reform.

1- Access to comprehensive health care is a human right. It is the responsibility of society, through its government, to assure this right. Coverage should not be tied to employment. Private insurance firms' past record disqualifies them from a central role in managing health care.

2- The right to choose and change one's physician is fundamental to patient autonomy. Patients should be free to seek care from any licensed health care professional.

3- Pursuit of œrporate profit and personal fortune have no place in caregiving and they create enormous waste. The U.S. already spends enough to provide comprehensive health care to all Americans with no increase in total costs. However, the vast health care resources now squandered on bureaucracy (mostly due to efforts to divert costs to other payers or onto patients themselves), profits, marketing, and useless or even harmful medical interventions must be shifted to needed care.

4- In a democracy, the public should set overall health policies. Personal medical decisions must be made by patients with their caregivers, not by corporate or government bureaucrats.

We envision a national health insurance program (NHI) that builds upon the strengths of the current Medicare system. Coverage would be extended to all age groups, and expanded to include prescription medications and long term care. Payment mechanisms would be structured to improve efficiency and assure prompt reimbursement, while reducing bureaucracy and cost shifting. Health planning would be enhanced to improve the availability of resources and minimize wasteful duplication. Finally, investor-owned facilities would be phased out. In each section we present a key feature of the proposal followed by the rationale for our approach.

Coverage

A single public plan would cover every American for all medically-necessary services including: acute, rehabilitative, long term and home care, mental health, dental services, occupational health care, prescription drugs and supplies, and preventive and public health measures. Boards of expert and community representatives would assess which services are unnecessary or ineffective, and exclude them from coverage. As in the Medicare program, private insurance duplicating the public coverage would be proscribed. Patient co-payments and deductibles would also be eliminated.

Abolishing financial barriers to care is the *sine qua non* of reform. Only a single comprehensive program, covering rich and poor alike, can end disparities based on race, ethnicity, social class and region that compromise the health care of the American people. A single payer program is also key to minimizing the complexity and expense of billing and administration.

Private insurance that duplicates the NHI coverage would undermine the public system in several ways. (1) The market for private coverage would disappear if the public coverage were fully adequate. Hence, private insurers would continually lobby for underfunding of the public system. (2) If the wealthy could turn to private coverage, their support for adequate funding of NHI would also wane. Why pay taxes

for coverage they don't use? (3) Private coverage would encourage doctors and hospitals to provide two classes of care. (4) A fractured payment system, preserving the chaos of multiple claims data bases, would subvert quality improvement efforts, e.g. the monitoring of surgical death rates and other patterns of care. (5) Eliminating multiple payers is essential to cost containment. Public administration of insurance funds would save tens of billions of dollars each year. Our private health insurers and HMOs now consume 13.6 percent of premiums for overhead[i], while both the Medicare program and Canadian NHI have overhead costs below 3 percent. Our multiplicity of insurers forces U.S. hospitals to spend more than twice as much as Canadian hospitals on billing and administration, and U.S. physicians to spend about 10 percent of their gross incomes on excess billing costs[ii]. Only a true single payer system would realize large administrative savings. Perpetuating multiple payers - even two - would force hospitals to maintain expensive cost accounting systems to attribute costs and charges to individual patients and payers. In the U.K., market-based reforms that fractured hospital payment have swollen administrative costs[iii iv].

Co-payments and deductibles endanger the health of the sick poor, decrease use of vital inpatient medical services as much as unnecessary ones, discourage preventive care, and are unwieldy and expensive to administer[v]. Canada has few such charges, yet health costs are lower than in the U.S. and have risen more slowly.

Instead of the confused and often unjust dictates of insurance companies, a greatly expanded program of clinical effectiveness research would guide decisions on covered services and drugs, as well as on capital allocation.

Payment for Hospital Services

The NHI would pay each hospital a monthly lump sum to cover all operating expenses - that is, a global budget. The hospital and the NHI would negotiate the amount of this payment annually, based on past expenditures, previous financial and clinical performance, projected changes in levels of services, wages and input costs, and proposed new and innovative programs. Hospitals would not bill for services covered by the NHI. Hospitals could not use any of their operating budget for expansion, profit, excessive executives' incomes, marketing, or major capital purchases or leases. Major capital

expenditures would come from the NHI fund, but would be appropriated separately based upon community needs. Investor-owned hospitals would be converted to not-for-profit status, and their owners compensated for past investment.

Global budgeting would simplify hospital administration and virtually eliminate billing, freeing up substantial resources for enhanced clinical care. Prohibiting the use of operating funds for major capital purchases or profit would eliminate the main financial incentive for both excessive interventions (under fee-for-service payment) and skimping on care (under capitated or DRG systems), since neither inflating revenues nor limiting care could result in institutional gain. Separate and explicit appropriation of capital funds would facilitate rational health care planning. These methods of hospital payment would shift the focus of hospital administration away from lucrative services that enhance the "bottom line" and toward providing optimal clinical services in accord with patients' needs.

Payment for Physicians and Outpatient Care

The NHI would include three payment options for physicians and other practitioners: fee-for-service; salaried positions in institutions receiving global budgets; and salaried positions within group practices or HMOs receiving capitation payments. Investor-owned HMOs and group practices would be converted to not-for-profit status. Only institutions that actually deliver care could receive NHI payments, excluding most current HMOs and some practice management firms that contract for services but don't own or operate any clinical facilities.

1- Fee-for-service: The NHI and representatives of the fee-for-service practitioners (perhaps state medical societies) would negotiate a simplified, binding fee schedule. Physicians would submit bills to the NHI on a simple form, or via computer, and would receive extra payment for any bill not paid within 30 days. Physician payment would cover only the work of physicians and their support staff, and would exclude reimbursement for costly office-based capital expenditures for such items as

MRI scanners. Physicians accepting payment from the NHI could bill patients directly only for uncovered services (e.g. for cosmetic surgery).

2- Salaries within institutions receiving global budgets: Institutions such as hospitals, health centers, group practices, migrant clinics, and home care agencies could elect to be paid a global budget for the delivery of care as well as for education and prevention programs. The negotiation process and regulations regarding capital payment and profits would be similar to those for inpatient hospital services. Physicians employed in such institutions would be salaried.

3- Salaries within capitated groups: HMOs, group practices, and other institutions could elect to be paid capitation premiums to cover all outpatient, physician, and medical home care. Regulation of payment for capital and profits would be similar to that for hospitals. The capitation premium would not cover inpatient services (except physician care) which would be included in hospital global budgets. Selective enrollment policies would be prohibited and patients would be permitted to disenroll with appropriate notice. HMOs would pay physicians a salary, and financial incentives based on the utilization or expense of care would be prohibited.

The proposed pluralistic approach to delivery would avoid unnecessary disruption of current practice arrangements. All three proposed options would uncouple capital purchases and institutional profits from physician payment and other operating costs, a feature essential for minimizing entrepreneurial incentives, containing costs and facilitating health planning.

The fee-for-service option would greatly reduce physicians' office overhead by simplifying billing. Canada, and several European nations have developed successful mechanisms for reconciling the inflationary potential of fee-for-service practice with cost containment. These include: limiting the supply of physicians; monitoring for extreme practice patterns; setting overall limits on regional spending for physicians' services (thus relying on the profession to "police" itself); and even capping individual physicians' reimbursement. These regulatory options are not difficult (and have not required extensive bureaucracy) when all payment comes from a single source. Similar measures might be needed in the U.S. There might also be a

concomitant cap on spending for the regulatory apparatus - eg. expenditures for program administration and reimbursement bureaucracy might be restricted to three percent of total costs.

Global budgets for institutional providers would eliminate billing, while providing a predictable and stable financial support. Such funding could also stimulate the development of community prevention (eg. school-based smoking prevention programs) whose costs are difficult to attribute (and bill) to individual patients.

Continuity of care would no longer be disrupted as patients' insurance coverage changes due to retirement or job change. Incentives for capitated providers to skimp on care would be minimized since unused operating funds could not be diverted to profits or capital investments.

Long Term Care

The NHI would cover disabled Americans of all ages for all necessary home and nursing home care. Anyone unable to perform activities of daily living (ADLs or IADLs[1]) would be eligible for services. A local public agency in each community would determine eligibility and coordinate care. Each agency would receive a single budgetary allotment to cover the full array of long term care services in its district. The agency would contract with long term care providers for the full range of needed services, eliminating the perverse incentives in the current system that often pays for expensive institutional care but not the home-based services that most patients would prefer.

NHI would pay long term care facilities and home care agencies a global (lump sum) budget to cover all operating expenses. For-profit nursing homes and home care agencies would be transformed to not-for-profit status. Doctors, nurses, therapists, and other individual long term care providers would be paid on either a fee-for-service or salaried basis.

Since most disabled and elderly people would prefer to remain in their homes, the program would encourage home and community based services. The 7 million unpaid care-givers such as family and friends who currently provide 70% of all long term care would be assisted through training, respite

[1] *Activities of daily living (ADLs) include: bathing, dressing, going to the toilet, getting outside, walking, transferring from bed to chair, or eating. Instrumental activities of daily living (IADLs) include: cooking, cleaning, shopping, taking medications, doing laundry, making phone calls, and managing money.*

services, and in some cases financial support. Nurses and social workers, as well as an expanded cadre of trained geriatric physicians, would assume leadership of the system.

Only a handful of Americans have private coverage for long term care. For the rest, only virtual bankruptcy brings entitlement to public coverage under Medicaid. Universal coverage must be combined with local flexibility to match services to needs, overall budgetary limits, and simplified regulations that minimize bureaucracy and assure that payments benefit patients, not executives or investors.

Our proposal borrows features from successful programs in some Canadian provinces and in Germany. The German program, in particular, demonstrates the fiscal and human advantages of encouraging rather than displacing family caregivers - offering them recompense, training and other supports.

Capital Allocation, Health Planning, and Profit

Funds for the construction or renovation of health facilities, and for major equipment purchases would be appropriated from the NHI budget. Regional health planning boards of both experts and community representatives would allocate these capital funds. Major capital projects funded from private donations would require approval by the health planning board if they entailed an increase in future operating expenses.

The NHI would pay owners of for-profit hospitals, nursing homes and clinics a reasonable fixed rate of return on existing equity. Since most new capital investment would be funded by the NHI, it would not be included in calculating return on equity. For-profit HMOs would receive similar compensation for their clinical facilities and for computers and other administrative facilities needed to manage NHI. They would not be reimbursed for loss of business opportunities or for administrative capacity not used by the NHI.

Current capital spending greatly affects future operating costs, as well as the distribution of resources. Effective health planning requires that funds go to high quality, efficient programs in areas of greatest need. Under the existing reimbursement system which combines operating and capital payments,

prosperous hospitals can expand and modernize while impoverished ones cannot, regardless of community health needs or quality of care. NHI would replace this implicit mechanism for distributing capital with an explicit one, facilitating allocation based on need and quality. Insulating these crucial decisions from distortion by special interests will require rigorous technology evaluation and needs assessment, as well as active involvement of providers and patients.

The consistently poor performance of investor-owned facilities precludes their participation in NHI. Investor-ownership has been shown to compromise quality of care in hospitals[vi vii viii], nursing homes[ix], dialysis facilities[x], and HMOs[xi]; for-profit hospitals are particularly costly[xii xiii xiv xv xvi xvii xviii xix]. A wide array of investor-owned firms have defrauded Medicare and been implicated in other illegal activities. For-profit providers would be phased out and compensated for past investments in clinical facilities.

Prescription Drugs and Supplies

NHI would pay for all medically necessary prescription drugs and medical supplies, based on a national formulary. An expert panel would establish and regularly update the formulary. The NHI would negotiate drug and equipment prices with manufacturers, based on their costs (excluding marketing or lobbying). Where therapeutically equivalent drugs are available, the formulary would specify use of the lowest cost medication, with exceptions available in case of medical necessity. Suppliers would bill the NHI directly (for the negotiated wholesale price plus a reasonable dispensing fee) for any item in the formulary that is prescribed by a licensed practitioner.

NHI could simultaneously address two pressing needs: (1) providing all Americans with full coverage for necessary drugs and supplies; and (2) containing drug costs. As a monopsony purchaser, the NHI could exert substantial pressure on pharmaceutical companies to lower prices. Similar programs in the U.S. and in other nations (e.g. Australia) have resulted in substantial savings.

Additional reforms are urgently needed to: improve prescribing practices; minimize medication errors; upgrade monitoring of drug safety; curtail pharmaceutical marketing; assure that the fruits of publicly

funded drug research are not appropriated for private profit; and ameliorate financial pressures that skew drug development.

Funding

NHI would disburse virtually all payments for health services. Total expenditures would be set at approximately the same proportion of the Gross National Product as in the year preceding the establishment of NHI.

Funds for the NHI could be raised through a variety of mechanisms. In the long run, funding based on an income or other progressive tax is the fairest and most efficient solution, since tax-based funding is the least cumbersome and least expensive mechanism for collecting money.

It is critical that the vast majority of funds flow through the NHI. Such single source (monopsony) payment has been the cornerstone of cost containment and health planning in Canada and other nations with universal coverage. Government expenditures, including payments for public employees' private health coverage and tax subsidies to private insurance, already account for nearly two-thirds of total health spending in the U.S. This figure would rise modestly under NHI, to perhaps 85% of health costs, and the public money now routed through private insurers would instead be used to fund public coverage. The mechanism for raising the additional funds for NHI is a matter of tax policy, largely separate from the organization of health care *per se*. Federal funding would attenuate inequalities among the states in financial and medical resources.

Discussion

The Patient's View - NHI would establish a right to comprehensive health care. Each person would receive an NHI card entitling him or her to care without co-payments or deductibles. The card could be used at any fee-for-service practitioner and at any institution receiving a global budget. HMO members could receive non-emergency care only through their HMO, though they could readily transfer to the non-HMO option.

Thus patients would have a free choice of providers and delivery systems, and the financial threat of illness would be eliminated. Taxes would increase, but would be more than offset by the elimination of insurance premiums and out-of-pocket costs.

The Practitioner's View - Physicians would have a free choice of practice settings. Treatment would no longer be constrained by the patient's insurance status, nor by bureaucratic dictum.

Fee-for-service practitioners would be paid promptly. The entrepreneurial aspects of medicine - the problems as well as the possibilities - would be limited. Physicians could concentrate on medicine; every patient would be fully insured, but physicians could increase their incomes only by working harder. Billing would involve imprinting the patient's NHI card onto a slip, checking a box indicating the complexity of the encounter, and sending the slip (or electronic equivalent) to the physician payment board. This simplification of billing would save each practitioner thousands of dollars annually in office expense.

Bureaucratic interference in clinical decision making would sharply diminish. Costs would be contained by controlling overall spending and limiting entrepreneurial incentives, obviating the need for the kind of detailed administrative oversight characteristic of current practice.

Salaried practitioners would be insulated from the financial consequences of clinical decisions. Since savings on patient care could no longer be used for institutional expansion or profits, pressure to skimp on care would be minimized.

The Effect on Other Health Workers - Nurses and other personnel would enjoy a more humane and efficient clinical milieu. The burdens of paperwork associated with billing would be lightened. The jobs

of many administrative and insurance employees would disappear, necessitating a major effort at job placement and retraining. Many of these displaced workers might be deployed in expanded programs of public health, health promotion and education, home care, and as support personnel to free up nurses for clinical tasks.

The Effect on Hospitals - Hospitals' revenues would become stable and predictable. More than half of the current hospital bureaucracy would be eliminated, and the remaining administrators could focus on facilitating clinical care and planning for future health needs.

The capital budget requests of hospitals would be weighed against other priorities for health care investment. Hospitals would neither grow because they were profitable nor fail because of unpaid bills - though regional health planning would undoubtedly mandate that some expand and others close or be put to other uses. Responsiveness to community needs, quality of care, efficiency and innovation would replace financial performance as the "bottom line." Proprietary hospitals would be converted to not-for-profit status.

The Effect on the Insurance/HMO Industry - The insurance/HMO industry would have virtually no role in health care financing, since public insurance administration is more efficient, and single source payment is the key to both equal access and cost control. Indeed, most of the extra funds needed to finance the expansion of care would come from eliminating insurance company overhead and profits, and abolishing the billing apparatus necessary to apportion costs among the various plans.

The Effect on Corporate America - Firms now providing generous employee health benefits would probably realize savings because their tax contribution to NHI would likely be less than current health insurance costs. Since most firms competing on international markets would save money, the competitiveness of U.S. products would be enhanced. Tax-based NHI funding might, however increase costs for companies not now providing health benefits.

Health Benefits and Financial Costs - Ample evidence indicates that removing financial barriers encourages timely care and improves health[xx].

Independent estimates by several government agencies and private sector experts indicate that NHI could cover all of the uninsured and eliminate co-payments and deductibles for the insured, without increasing total health care costs[xxi xxii xxiii xxiv xxv]. Savings on administration and billing (which would drop from the current 25% of total health spending to under 15%) would approximately offset the costs of expanded services. However, the expansion of long term care (under any system) would increase costs. Experience in Canada suggests that the increased demand for acute care would be modest (after an initial surge)[xxvi xxvii], and improvements in health planning and cost containment made possible by single source payment would slow health care cost escalation. Vigilance would be needed to stem the regrowth of costly and intrusive bureaucracy.

Unsolved Problems - This brief proposal leaves many vexing problems unsolved. Careful planning will be needed to ease dislocations during the implementation of the program. The encouragement of prevention and healthy life styles, and improvements in occupational and environmental health will not automatically follow from the institution of NHI. Similarly, the abolition of racial, linguistic, geographic and other non-financial barriers to access will require continuing efforts. The need for quality improvement will remain urgent. High medical school tuitions that discourage low income applicants, the underrepresentation of minorities, the role of foreign medical graduates, and other problems in medical education will remain. Some patients will still seek inappropriate care, and some physicians will still succumb to the temptation to increase their incomes by encouraging unneeded services. Assuring adequate research funding, engendering collegiality and excellence in academia, and minimizing the commercial skew of current research priorities will remain challenging. Though NHI will not eliminate these problems, it will establish a framework for addressing many of them.

Alternatives To NHI

President Bush and others have proposed a variety of health reforms aimed at slowing cost growth, shoring up Medicare, expanding coverage, and improving efficiency. These proposals share several common themes.

1- "Defined contribution schemes" and other mechanisms to increase patients' price sensitivity. Some prominent economists and corporate leaders favor limiting employers' premium contributions to a fixed amount, pressuring employees to choose lower-cost insurance options. Many cite the Federal Employees Health Benefit Program (FEHBP) as a model for such reform.

Unfortunately, costs in the FEHBP have risen as rapidly as in Medicare or for private employers, providing little evidence that the defined contribution approach contains costs. Moreover, this approach assures a multi-tiered insurance system, with lower-income workers forced into skimpier plans. In the long run, such programs are more likely to shift costs from firms to employees than to slow overall cost growth.

2- Tax subsidies and vouchers for coverage for the uninsured. President Bush, as well as some Democrats, would offer tax credits to low income families who purchase private coverage.

The $2000 per family subsidy ($1000 per single person) that the President has proposed falls far short of the cost of adequate insurance; in Massachusetts, HMO family premiums average about $6000 annually. Hence, few of the uninsured could afford adequate coverage even with the subsidy. This problem would increase over time; premiums would surely rise more rapidly than subsidies. Most of the tax credits would subsidize premium payments for people who already have coverage, since employers would be tempted to drop insurance for employees eligible for subsidies. As a result, large outlays for tax subsidies would buy little new coverage; $13 billion annually would cover only 4 million (less than 10%) of the uninsured[xxviii].

Moreover, tax credits would amplify administrative inefficiency. If the IRS paid the year's subsidy when tax returns were filed (i.e. the following April), it would come too late to provide the cash flow that low income families need to purchase coverage. Paying the credit with each paycheck would create an administrative nightmare; it would require ongoing monitoring of household income, qualification for the subsidy, etc.

In addition, the new coverage would be purchased from private insurers whose average overhead/profits consumes 13.6% of premiums - six times that of Medicare. Not surprisingly, the health insurance industry supports the tax credit approach; additional tax dollars would end up in their coffers, with little public oversight.

3- Expansion of Medicaid, CHIP and other public programs. Some Democrats favor expanding Medicaid eligibility by raising income limits for families, or by including poor, childless adults. Recently, the National Governors' Association (NGA) proposed that states be allowed to buy stripped-down HMO coverage for Medicaid recipients, and use the savings to expand coverage.

Several problems bedevil these strategies. First, Medicaid already offers second-class coverage. Programs like Medicaid that segregate the poor virtually assure poor care, and are more vulnerable to funding cuts than public programs that also serve affluent constituencies. In most states, Medicaid payment rates are low and many doctors resist caring for Medicaid patients. As a result, access to care for Medicaid enrollees is often little better than for the uninsured[xxix xxx]. Further cuts to benefits, as the NGA suggests, would leave Medicaid recipients with coverage in name only.

Second, even large Medicaid expansions in the past have failed to keep pace with the erosion of private coverage. Between 1987 and 1993, Medicaid enrollment grew from 20.2 million to 31.7 million, yet the number of uninsured rose by 8.7 million[xxxi]. Only the unprecedented economic boom of the late 1990s interrupted this trend. An economic downturn would quickly deplete states' tax revenues, reducing funds for Medicaid at the same time as rising unemployment would deprive many of private coverage.

Turning Medicaid dollars over to private HMOs assures that scarce funds will be diverted to overhead and profit, and places vulnerable patients at risk. In the first Medicaid HMO experiment in California a quarter of a century ago private plans routinely exploited poor patients, an experience repeated in Florida, Tennessee and other states. Past promises (e.g. in Oregon and Tennessee) that savings from Medicaid coverage cuts would lead to universal coverage have proven empty.

Finally, the complexity of enrollment procedures, the need for repeated eligibility determination, and the stigma attached to Medicaid and similar programs for the poor assures that many of those who are eligible will not be enrolled.

While few can argue with proposals to cover more of the poor and near-poor, Medicaid expansion without systemwide reform is a stopgap measure unlikely to stem future increases in the number of uninsured. It does not lead to universal coverage.

4- The Medicare HMO program and Medicare voucher schemes. Under Medicare's HMO program, private HMOs have already enrolled millions of seniors. Medicare has paid these plans a set fee - 95% of the average cost of a Medicare fee-for-service enrollee in the region - for each enrollee. Several states have also pushed Medicaid recipients into privately-run HMOs. Many Republicans and a few Democrats hope to expand Medicare's use of private insurers by offering seniors a voucher to purchase private coverage in lieu of traditional Medicare.

These strategies assume that private plans are more efficient than Medicare; that seniors can make informed choices among health plan options; and that private insurers' risk avoidance can be thwarted. All three assumptions are ill-founded.

Medicare is more efficient than commercial insurers; costs per beneficiary have risen more slowly and overhead is far lower.

An AARP survey of seniors found that few had adequate knowledge to make informed choices among plans[xxxii].

Despite regulations prohibiting risk selection in the current Medicare HMO program, plans have successfully recruited healthier than average seniors. Hence HMOs have collected high premiums for patients who would have cost Medicare little had they remained in fee-for-service Medicare. Moreover, HMOs have dumped more than a million seniors in counties where profits are low, while continuing to enroll Medicare patients in profitable areas. As a result, HMOs have increased Medicare costs by $2 billion to $3 billion each year, and disrupted the continuity of care for many patients.

A voucher (so-called "premium support") program for Medicare would also push low income seniors into skimpy plans - similar to the "defined contribution" approach to employee coverage discussed above. Moreover, Congress is unlikely to increase the value of the voucher to keep pace with the rising costs of private plans. Over time, seniors' out-of-pocket costs for coverage would likely rise.

Conclusion

Health care reform is again near the top of the political agenda. Health care costs have turned sharply upward. The number of Americans without insurance or with inadequate coverage rose even in the boom years of the 1990s. Medicare and Medicaid are threatened by ill-conceived reform schemes. And middle class voters are fed up with the abuses of managed care.

Incremental changes cannot solve these problems; further reliance on market-based strategies will exacerbate them. What needs to be changed is the system itself.

National Health Insurance is an essential safeguard for our patients; its advocacy is an ethical responsibility of our profession.

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