The Promise of Medicare-for-All

By Nancy Spannaus

This article is part 3 in a series on the American System in health care. The context for the analysis here will become clearer upon your reading those articles as well.

July 29, 2017—With the deserved defeat of the Republican offensive against health care, a serious debate on Medicare-for-all, also known as Single Payer, should proceed.

Little known to the public, Rep. John Conyers (D-MI) has been introducing legislation under the concept of Medicare-for-all since 2003, and he believes the time for action on his plan has finally come. Conyers has support from more than half the Democratic Caucus in the House of Representatives (including some conservative Blue Dog Democrats), as well as significant institutional support from the American Nurses Association, the Conference of Mayors, and the League of Women Voters, to name a few. Sen. Bernie Sanders has said that he will be re-introducing parallel legislation to Conyers' H.R. 676 into the U.S. Senate in the immediate future.

Conyers has a political profile as a civil rights fighter. He was first elected during the LBJ era, and has championed legislation to defend labor and the poor, and attack Wall Street. He considers medical care a matter of right for all citizens, and has crafted a bill which tackles the current inequities in the system. His 30-page H.R. 676 contrasts sharply with both Obamacare and the various Republican replacements now under discussion, in its simplicity, commitment to universality of care, and lack of special deals for the insurance and drug companies.

Rep. John Conyers (D-MI), prime sponsors of H.R. 676, Medicare-for-All

Conyers' bill gets two General Welfare principles absolutely right: 1) the government is responsible for ensuring the health of the population (universal medical care); and 2) health care must not be driven by a quest for private profit.In this article we precis the components of the bill, and provide some brief commentary. The full bill can and should be read in light of our analysis here. So far it's the best thing out there.

A Healthy Economy

But first, we have to turn our attention to a more fundamental question. There is no way that an adequate health care system can function in an unhealthy economy. So the first order of business is to create that healthy economy.

Imagine an economy where 19% of the workforce is producing all the food, housing, transportation, power, and other physical goods. The rest of the workforce is "servicing" these productive workers—some in necessary services like education and health care, but the vast majority in entertainment, gambling, selling and buying, and speculating on what the dwindling productive sector is doing. In other words, overhead is the vast bulk of the economy. That's the U.S. economy today. No wonder there's low productivity, underemployment, collapsing infrastructure, and inadequate living standards. Millions of families cannot afford necessary health care,

because they are scrambling to survive, and the economy as a whole has generated a massive debt overload. The situation is so bad that numerous economists are projecting a new crash, worse than 2007-8, by the end of the year, which would further pauperize the population.

What is a healthy economy? It's one where, as a rule of thumb, 50% of the population is involved in productive activity or necessary overhead. Basic physical infrastructure (transportation, water, power) and social-cultural infrastructure (research, health facilities, education, the arts) are being expanded and improved. Breakthroughs in science and technology are improving physical productivity, permitting increasingly better standards of living, education, and culture. Poverty is being eliminated, and future generations live better than the last.

None of those conditions can be met if, as today, the nation's financial system is controlled by Wall Street parasites, who in turn control an increasing amount of the nation's economic activity. Wall Street is literally getting away with murder for the sake of a quick profit, and that must be stopped. That means returning to an American System approach, where the priority is producing continuous scientific and technological progress in service of the General Welfare.

A nuclear power plant under construction (dreamstime)

Step Number One must be the re-imposition of FDR's Glass-Steagall, which will cut off the speculators from public

support. Step Number Two must be a return to a credit system (national banking), whereby low-interest, long-term credit can be provided to employ millions in rebuilding the nation's crucial infrastructure—from transportation, to energy, to hospitals and clinics. The United States has a shameful deficit of health care facilities, and personnel—not to mention basic health research,—a deficit which would become even more obvious under conditions of universal access to care. Such access would be a cruel hoax without addressing the physical shortfalls mentioned here.

Of course, even under current breakdown conditions, the government has a responsibility to provide universal medical care (the general welfare). But to make that a reality, the financial nut must be cracked from the top.

Now, to the Conyers bill.

Expanded and Improved Medicare for All

The explicit purpose of H.R. 676, officially titled as above, is stated succinctly: "to provide for comprehensive health insurance coverage for all United States residents, improved health care delivery, and for other purposes." It has five sections or titles: 1) eligibility and benefits; 2) finances; 3) administration; 4) additional provisions; and 5) effective date.

The opening statement of Title I is worth quoting in full:

> *a) In general—All individuals residing in the United States (including any territory of the United States) are covered under the Medicare For All Program entitling them to a universal, best quality standard of care. Each such individual shall receive a card with a unique number in the mail. An individual's Social Security number shall not be used for purposes of registration under this section.*
>
> *(b) Registration.—Individuals and families shall receive a*

Medicare For All Program Card in the mail, after filling out a Medicare For All Program application form at a health care provider. Such application form shall be no more than 2 pages long.

(c) Presumption.—Individuals who present themselves for covered services from a participating provider shall be presumed to be eligible for benefits under this Act, but shall complete an application for benefits in order to receive a Medicare for All Program Card and have payment made for such benefits.

Title I then details the categories of "universal" care, which include all "medically necessary" services, including long-term care. The section concludes by stating: "No deductibles, copayments, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits."

Comment: This section represents a major breakthrough in the American health care system. No longer will there be categories of eligibility for care, requiring haggling over meeting financial or physical requirements. No longer will there be means testing, or specific categories of "cheap" care for the poor, such as today's Medicaid. The same standard of care will be provided to all, including those in long-term care facilities.

Providers

The second section of Title I deals with providers, and declares that "no institution may be a participating provider unless it is a public or not-for-profit institution. Private physicians, private clinics, and private health care providers shall continue to operate as private entities, but are prohibited from being investor owned." Authorized providers include Health Maintenance Organizations which "deliver care in their own facilities and employ clinicians on a salaried basis," but not those who contract out services.

A nursing home patient receiving care (dreamstime)

Funds are provided in the bill to aid providers in converting from for-profit to non-profit status over a 15-year period. Those providers will remain privately owned and operated, as they participate in the system.

Comment: This provision attempts to deal with the fact that the American health care system has become increasingly taken over by for-profit entities. Approximately 1000 of the 4800 community hospitals in the United States are owned by for-profit entities, with the largest being Hospital Corporation of America (173 hospitals) and Community Health Systems (154 hospitals). These and non-profit hospitals are also increasingly purchasing physician practices.

Insurance companies—clearly for-profit operations and not even regulated as the public utilities they are—are also purchasing hospitals and physician practices. In fact, one could appropriately characterize the current system—and that proposed by the Republicans—as run by the insurance industry.

One consequence of this financialization is that hospitals cluster in wealthy areas, and advertise for more patients, while—due to lack of Federal support—they are shut down in rural areas. Thus people in these communities can find themselves having to travel over a hundred miles to reach a hospital. There is a similar shortage of doctors in rural communities, according to the National Rural Health

Association.

Financing

Title II of the bill deals with finances, an area clearly bound to raise enormous controversy. LBJ followed FDR’s model of financing by providing the lion’s share of funds for Medicare through dedicated funds raised through a small (2.9% divided equally between employer and employee) payroll tax. His assumption, like FDR’s, was that as long as workers were paying into a dedicated fund, it would be impossible for Congress to take the benefit away.

Conyers’ bill would incorporate this Medicare Trust fund into a new Trust Fund, which would be augmented by a slight increase in the payroll tax, and some additional small taxes on the wealthy. The bill also envisions significant savings in the new system through reducing paperwork, negotiation for rational bulk drug purchases, and promised improved access to preventive health care.

How will paper work be reduced? In general, as outlined in the bill, the government will pay institutional providers (hospitals, nursing homes, etc.) according to a “global budget,” i.e. a lump sum monthly which has been determined through negotiation based on “past expenditures, projected changes in levels of services, ages and input costs, a provider’s maximum capacity to provide care, and proposed new and innovative programs.”

This same policy will apply to long-term care facilities—an overall global allotment to cover costs. Specifically, the bill expresses a bias for non-institutional care (i.e. in the home).

Payments to physicians can be paid by fee for service, according to “a simplified fee schedule that is fair and optimal with representatives of physicians and other clinicians, after close consultation with the National Board

of Universal Quality and Access and regional and State directors.” They can also be paid as salaried employees of an institution, or within group practices or non-profit health insurance organizations “receiving capitation payments.” One restriction noted for eligible HMOs is that “financial incentives between such organizations and physicians based on utilization are prohibited.”

The National Board of Universal Quality and Access is a new entity set up by the bill. It is comprised of 15 members appointed by the President, including health care professionals, representatives of institutional providers, healthcare advocates, labor union representatives, and citizen patient advocates. It is to meet twice a year and advise the Secretary of Health and Human Services and the Director of the Medicare program on all matters to do with standards of care.

Mountains of paperwork like this is to be eliminated. (dreamstime)

The bill explicitly authorizes the now-prohibited practice of negotiating prices for covered pharmaceuticals, medical supplies, and medically necessary assistive equipment on an annual basis. Not surprisingly, it will encourage generics. As for setting the fees to be paid, the bill explicitly declares they should be set according to a national standard relative to the physicians’ expertise and value, not vary by region or past fee schedules.

Comment: What is refreshing here is the lack of the *ad nauseam* admonitions of Obamacare propagandists like Ezekiel Emanuel to eliminate "unnecessary" treatments that they consider the cause of pushing up the cost of health care. Apparently gone are the incentives for reducing care, and penalties for "over-utilization" of emergencies rooms and other facilities. The brief reference to how eligible HMOs are not permitted to provide incentives linked to utilization points to the practice which horrified the nation back in the 1990s, when the grisly consequences of doctors seeking to get better pay by denying certain treatments made the headlines. (http://www.newsweek.com/beware-your-hmo-184306) If this is to be outlawed for eligible HMOs, presumably it will be for other medical institutions as well.

As far as standards are concerned, it would appear that the new National Board of Quality would replace the U.S. Preventive Services Taskforce and Med-Pac—both notorious for ruling against vital testing and services—but this is not explicitly stated.

Of great importance is the determination to stop giving drug companies a free pass on prices (instituting negotiation), and to apparently equalize physician pay throughout the system. The second is particularly important since Medicaid physicians are now paid an average of 50-60% of what Medicare physicians get paid for a procedure—and Medicare physicians get (allegedly) 80% of what private practices pay. This system is clearly related to the fact that Medicaid's costs are shared between the Federal government and the states (with the Feds paying an average of 57% of the cost), and the states set the Medicaid reimbursement rate.

Of course, the devil is in the details. Under Obamacare and the Republican bills, the emphasis is put on saving money. And while the Republicans would do it by removing the safety net altogether, and letting people sink or swim, Obamacare does it by deliberately squeezing hospitals and other providers to cut

back on costs. And while this was done in the name of prioritizing preventive care, I can testify to the fact that previously standard preventive procedures—such as cholesterol testing and other blood tests—have been eliminated under Obamacare for Medicare patients, i.e. no longer paid for by Medicare, unless they can be specifically justified.

This is not to mention the fact that Obamacare mandates keeping the growth of healthcare costs down to some arbitrarily determined rate. If that rate is exceeded, the "nonpartisan" Independent Payment Advisory Board set up by Obamacare is mandated to decide on cuts in care and send them to Congress, which has to deal with them with an up-or-down vote.

The Conyers bill would also appear to take effective aim at another counterproductive consequence of Obamacare, a new mountain of paperwork, mostly aimed at reducing care. An authoritative study published by the New England Journal of Medicine in 2003 by advocates of the Single Payer Plan found that overall administrative costs in the U.S. health care system were ranging at 31% (of which insurance costs per se were 12-15%). http://www.pnhp.org/publications/nejmadmin.pdf These costs have likely gone up—but would be drastically cut by a Single Payer plan.

Although it's not in the bill, the Conyers plan anticipates that the enactment of Medicare-for-All would actually reduce the spending for healthcare in the U.S. economy. Co-sponsor Rep. Ro Khanna of California told Fox News July 22 that he expected that the plan would actually reduce health care spending over the next 10 years from $49 trillion to $32 trillion. Even when factoring in increased spending on drastically needed medical facilities with Federal aid (Hill-Burton), the saving is still significant.

Conclusion

The time is overripe for a return to the American System approach to our nation's economy as a whole, to take back our economy in the interest of the General Welfare of all our citizens. The fight for Medicare-for-All is a crucial part of that fight, which must lead with taking back our financial system; restoring Glass-Steagall and national banking are the pivots on which that process depends.