



SINGLE PAYER NEW YORK

Single Payer New York was founded in September 2008 by organizations and individuals from all around New York State who seek a change to a single payer health care system.

For more information and/or how to get involved with SinglePayerNY, please contact us by calling (518) 279-3749, or visiting our website at www.singlepayernewyork.org.

THE PRESCRIPTION FOR OUR SICK HEALTH SYSTEM: ONE NATION-ONE PLAN

Rx

SINGLE-PAYER NATIONAL HEALTH INSURANCE

“THE U.S. NATIONAL HEALTH CARE ACT” (HR 676)

The Problem: A Failed Private Insurance System that Puts Profits Ahead of Patients

The United States has the highest health spending in the world, estimated at \$2.5 trillion dollars for 2009; yet 45.7 million Americans were uninsured in 2007 (the most recent year for which data is available) including 8.1 million children (Census Bureau). An estimated 25 million non-elderly adults (14 percent) were underinsured in 2007, a 60 percent increase since 2003. The Institute of Medicine estimated that 18,000 Americans died in 2000 due to lack of health insurance. Illness and medical bills contribute to half of all U.S. bankruptcies. Prescription drug costs are the highest in the world. Even though other industrialized democracies spend less on health care, their citizens are guaranteed coverage for life, live longer, and have superior access to care.

The Solution: Non-Profit National Health Insurance

Americans spend more money for less coverage and care because we are the only industrialized country to allow for-profit insurance companies to be middlemen in our health system. In their drive to enroll healthy (and profitable) patients and screen out the sick, private insurers waste vast sums on billing, marketing, underwriting, utilization review and other activities that enhance profits but divert resources from care and hassle patients and physicians. The paperwork they inflict on doctors and hospitals wastes hundreds of billions more each year.

Replacing private insurance companies with a single-payer public program – “Expanded and Improved Medicare for All” – would save more than \$350 billion per year, enough new money to provide guaranteed comprehensive health benefits for all. (New England Journal of Medicine, 2003)

Beware of Phony Universal Coverage: Many say they support “universal health care” but usually this means just increasing the number of private insurance company customers. Real universal coverage means eliminating the administrative burdens, overhead and wasteful profits of private health insurance and establishing a national health care program instead.

Contact your Congressional Representatives at 1-866-338-1015

Printing funded by PEF/encon, Division 169, AFT/SEIU Local 4053

Congressman John Conyers is the Main Sponsor of HR 676,
which has 74 co-sponsors as of March 31, 2009.

This Frequently Asked Questions is from <http://www.johnconyers.com/HR676faq>

What is H.R. 676?

H.R. 676, also called the United States National Health Insurance Act, is a bill to create a single-payer, *publicly-financed, privately-delivered* universal health care program that would cover all Americans without charging co-pays or deductibles. It guarantees access to the highest quality and most affordable health care services regardless of employment, ability to pay or pre-existing health conditions.

What is "single-payer"?

The term single-payer describes the kind of financing system that H.R. 676 uses. It means that one entity--in this case, established by the government--handles all billing and payment for health care services. Right now, there are thousands upon thousands of "payers"-- HMOs, PPOs, bill collection agencies, etc. The sheer volume of paperwork required by our current system means that administrative waste accounts for roughly 31% of the money spent on health care [*]. The single-payer system would eliminate the wasteful paperwork and administrative costs, redirecting more of our health care dollars to providing care.

Medicare is perhaps the best known single-payer system. Essentially, H.R. 676 would improve Medicare and expand it, so that it covers all Americans, regardless of their income.

Who will be eligible for health care coverage under H.R. 676?

All Americans will be eligible for health care coverage. Every person who enrolls in the program will receive a United States National Health Insurance Card and individual ID number, and that is all anyone will need to receive care.

What health care services are covered?

The program established by H.R. 676 will cover all medically-necessary services without charging co-pays or deductibles. The services covered will include: primary care; inpatient, outpatient and emergency hospital care; prescription drugs; durable medical equipment; hearing, dental and vision care; chiropractic treatment; mental health services; and long-term care.

What about "catastrophic" care? Will I ever reach a limit for coverage?

No. There are no limits on coverage. Just as you will never pay a co-pay or a deductible under the universal national health care program, you will never reach a ceiling on your coverage.

Will I be able to choose my doctor?

Yes. Patients will have their choice of physicians, providers, hospitals and clinics. The financing will be public, but the providers will all remain private.

[*] www.pnhp.org/single_payer_resources/administrative_waste_consumes_31_percent_of_health_spending.php

No co-pays or deductibles-- what's the catch? Will I actually pay less for health care?

There is no catch. Both families and employers will pay significantly less for health care.

Currently, the average family of four covered by an employer-provided health care plan spends roughly \$4,225 on health care each year, including premiums, services, prescription drugs and supplies. This figure does not include the annual Medicare payroll tax, currently at 1.45%. Under the plan created by H.R. 676, a family of four making the median income of \$56,200 would pay about \$2,700 in payroll tax for all health care costs. No deductibles, no co-pays, no worrying about catastrophic coverage.

Employers who provide health insurance currently pay, on average, 74% of employee health premiums. For a family of four, the average employer share is \$8,510 per year. Under H.R. 676, the employer pays a 4.75% payroll tax, not a premium to health insurance companies. For an employee making the median family income of \$56,200 annually, the employer would pay roughly \$2,700.

Estimates taken from: Employer Health Benefits 2006 Annual Survey, Kaiser Family Foundation and Health Research and Educational Trust; Consumer Expenditure Survey, U.S. Department of Labor, Bureau of Labor Statistics; and Study by the Center for Economic Research and Policy.

How will the transition to the new system work?

The full conversion to a non-profit, single-payer universal health care program will not take place overnight once the bill is passed. The total transition time will be roughly a 15-year period. Important elements of the transition will include:

- Private health insurance companies will be prohibited from selling coverage that duplicates any benefits included in the universal national health care program. The private companies will, however, still be able to sell coverage for services that are not deemed medically necessary, such as many cosmetic surgery procedures.
- Private insurance company workers who are displaced as a result of the transition will be the first to be hired and retained by the new single-payer entity. Any of the displaced workers who are not rehired will receive two years of unemployment benefits and job reemployment training.

How will the universal program be paid for?

First, switching to a single-payer system will lead to billions of dollars saved in reduced administrative costs. Those savings will be passed on through the system and allow coverage for all Americans. Additional savings in the overall cost of health care will come from annual reimbursement rate negotiations with physicians and negotiated prices for prescription drugs, medical supplies and equipment.

Second, a "Medicare For All Trust Fund" will be created to ensure a dedicated source of funding in addition to annual appropriations. Sources of funding will include:

- Maintain current federal and state funding for existing health care programs
- Closing corporate tax loopholes
- Repealing the Bush tax cuts for the highest income earners
- Establish employer/employee payroll tax of 4.75% (includes present 1.45% Medicare tax)
- Establish a 5% health tax on the top 5% of income earners; a 10% tax on top 1% of wage earners
- One quarter of one percent stock transaction tax

Ten Problems with the Private Health Insurance System

1. **Profit before health care.** Private health insurance companies make more money when they prevent consumers from receiving care. To them health care is just another product for sale.
2. **High Administrative Costs.** Around 25 cents of each health care dollar paid to private health insurance goes to its profits and administrative costs. Premiums are raised regardless of patients' ability to pay.
3. **Creation of paperwork and confusion.** Consumers and doctors can't figure out what is covered. Physicians on average have to hire 2.5 staff people to fill out insurance forms and try to figure out what medical services are covered by the various insurance programs.
4. **Excessive Role in Health Policy.** The private health insurance industry, whose primary accountability is to corporate shareholders, has too much power over the health care system. They dictate how our health care resources are spent, what medical services are available, and how healthcare providers and hospitals are financed.
5. **Undercuts social responsibility.** Private insurers carve up the risk pool and impose high premiums that exclude many individuals forcing the taxpayer to assume the cost of coverage for the uninsured and underinsured.
6. **Restricts choice.** Private health insurance unduly restricts what doctors and other medical providers we can use. In addition, private health insurances frequently deny prescribed medical treatment recommended by your healthcare provider.
7. **Lack of portability.** Private health insurance is primarily financed through employers. Workers become "locked" into their job, since they often can't carry their policy to their next job, and may be denied coverage at their new job due to "pre-existing conditions." Changing jobs or employment status often requires people to change their health providers.
8. **Excludes the sick.** Private insurance companies make more money by covering those who are healthy and likely to remain so. They invariably exclude pre-existing medical conditions.
9. **Coverage is often inadequate.** Being insured does not guarantee access to health care nor coverage for services received. Most people with insurance don't know the scope of their coverage. They may not learn these limitations until the insurance company rejects coverage when they seek medical treatment.
10. **High costs for workers and employers.** The annual premium that a health insurer charges an employer for a health plan covering a family of four exceeded \$12,000 in 2008; individual coverage averaged \$4,704. As costs rise, employers pass on more of the costs to their employees. Health insurance expenses are the fastest growing cost component for employers and are becoming the largest expense for employees as well.

Only a Single Payer System such as HR 676 – Expanded and Improved Medicare for All – can solve all these problems!

Further information available at: www.americanpatientsunited.org ; www.healthcare-now.org ; www.johnconyers.com/healthcare ; www.pnhp.org and www.unionsforsinglepayerhr676.org