Business Leaders Transforming Healthcare

FAQ

1. Will Single Payer cost my company more? Will there be a tax increase associated with Single Payer?

Under Single Payer, employers will pay less because they will no longer provide commercial health insurance for their employees. Insurance costs will be replaced by a payroll deduction, similar to Social Security and Medicare. The payroll taxes will be significantly lower than what employers are paying now to insure their employees.

Here's the math: The average wage for an American worker is $49,000. The average cost for employer-based commercial insurance is $19,000 per year for family coverage and $6,500 per year for single coverage. Therefore, the average cost of a health benefit is in excess of 15% of employee compensation. Further, insurance premiums do not include what employees additionally pay out-of-pocket for care. Those costs include rising deductibles and co-pays. The insurance premiums that employers pay also do not include the HR expense to administer health plans or the rising cost of other insurances that have a health care component, such as Workman's comp; the state, local and school taxes that have a high cost of health care; or the overall drag health care has on disposable income that deteriorates demand for our products.

For many employers, the cost of a health care benefit is over 20% of payroll.

What about Single Payer? Under one plan under consideration, employers would pay 7.75% of payroll as a payroll deduction, and employees would pay 3.25%. Deductibles, which are payments by users of the system prior to insurance payments kicking in, are eliminated, but all users of the system will pay a modest co-pay on use such as:

$10 per generic prescription.
$20 per brand name prescription.
$20 per doctor or other professional service visit.
$50 for hospital facility fee (outpatient).
$50 for a semi-private room in a hospital per night.
$200 for a private room in a hospital per night.

The current Medicare tax and Affordable Care Act (ACA) surcharge tax would stay in place. However, under this scenario, taxes on revenue not associated with compensation for work performed would not be required.

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2. Why will Single Payer financed health care cost less — particularly when it is coupled with the concept of universal coverage for all Americans, which will add cost?

The U.S. health care system is grossly inefficient. Much of this inefficiency comes from the way the system is financed, particularly from the unnecessary complexity associated with commercial health insurance.

For every dollar employers pay to insurance companies in premiums, fewer than 80 cents go to doctors, hospitals and other providers of care. The remaining cents on the dollar go to the financing side of health care, costing hospitals and physicians to interface with the complex insurance industry. The collective waste adds up to 30% of insurance premium dollars, or $300 billion-400 billion annually.

Traditional Medicare, on the other hand, is much more efficient. For every dollar collected, via payroll taxes, over 95 cents goes to providers with less hassle and administrative cost. In addition, Medicare does a better job in general of negotiating reimbursement rates from providers for equivalent care. Medicare's Advantage Plans, those Medicare supplements administered by commercial insurance companies, are less efficient. They add more than double the administrative cost of traditional Medicare.

Economists estimate that the cost of providing health coverage to the currently uninsured will be $77 billion annually. This is significantly less than the monies we will save from reducing inefficiency through Single Payer.

Countries throughout the industrialized world have recognized this phenomenon and have adopted Single Payer, with some variation, as a "best practice" in health care system structure. Simply put, Single Payer is publically financed, privately delivered health care. It can be delivered efficiently for all Americans, and we can save billions in cost.

3. Why are drug costs in the U.S. so high? How do we continue to stimulate innovation in life-saving medications when prices become lower?

Americans pay twice as much for medications than the rest of the industrialized world. The typical American family of four spends $4,200 a year on average for drugs. Why do Americans pay more? Because our government allows monopoly pricing through the patent system, there is no regulation or negotiation, we do not mass our purchasing power and bargain effectively, and we allow TV advertising and massive sales and marketing activity by the pharmaceutical industry.

The solution is not complicated. We need to empanel the nation's most renown doctors and biomedical scientists to establish an evidence-based formulary of drugs at the national level. Pricing would be negotiated by Medicare for its programs, and those prices will become the standard for the rest of the country. Similar to the rest of the industrialized world, the Veterans

Administration negotiates price effectively. The projected system-wide savings of this plan is $150 billion a year.

Lowering the price in the U.S. to international levels will not deter innovation. There is little correlation between current U.S. price levels and innovation. The great majority of cost for basic biomedical research is paid by the U.S. taxpayer through grants from the National Institutes of Health and from philanthropy and academia. The pharmaceutical industry spends 50% more on sales and marketing expenses than it does on R&D. Most of its R&D is devoted to non-innovative, competing ("me too") drugs and for expensive FDA trials after a particularly innovative drug is discovered.

4. Why has the business community been silent? Why should the business community organize to reform the U.S. health care system?

Health care is our nation's biggest expense. It takes 28% of the annual federal budget, a sum significantly higher than national defense (16%). Health care is a volatile expense for state and local government and schools. It is the single factor that keeps economists awake at night as annual increases in health care costs dramatically surpass general inflation.

The health care sector in the U.S. is well-organized and well-financed. It uses its size — almost one-fifth of the economy — and its substantial profitability to advance its commercial interests. It lobbies Congress and state legislatures and spreads its influence and financial support throughout American society. The sector leads all other industry sectors, by far, in lobbying expense and activity, and it also uses popularly recognized business voices, like the U.S. Chamber of Commerce and the Business Roundtable, to carry its water to the detriment of the overall business community. It supports candidates, public institutions and academia in ways that advance its overall power and influence. Even state- and local-level business groups formed to negotiate insurance plans that are supposed to operate at arms-length in negotiating health plans for the business community receive financial support from the industry. There must be a counterbalance to the health care sector's power and influence.

Left alone, the health care sector literally eats the rest of the U.S. economy alive. A 2010 RAND study found that in the decade leading up to 2009, 79% of household income growth was absorbed by health care, leaving only 21% available for other purposes. The inefficiency of the health care sector is seen as a significant drag of U.S. productivity and competitiveness. Why locate a car assembly plant in the U.S. when you can save $5 an hour on health costs for auto workers in Canada and more than that in Mexico? Restructuring the way health care is financed in the U.S. following the "best practice" of other modern industrialized societies can level that playing field.

The business sector, separate from its health care component, has immense potential power in Washington. Why doesn't it assert that power to reform the health care system? Our national organization, Business Leaders Transforming Healthcare, with state affiliates can be an effective

voice in Washington and elsewhere when it gains substantial business leader membership and support.

The operating business mantra of the health care sector appears to be, “In complexity, there is much profit.” No other country has the massive insurers, the Pharmacy Benefit Manager (PBM) middlemen, the incomprehensible consumer manuals and brochures, the myriad of plans and the challenging informational and administrative interface between financing and delivery sides. All this noise and confusion makes the system appear to be incomprehensible and provides opportunity for profiteering. Our system must be simplified and streamlined for maximum efficiency. The national debate on health care needs to be reframed. The health care is taxable with solutions tested in hand.

No other modern industrialized country tolerates U.S. inefficiency in health, its high cost or its poor outcomes (ranked 37th by the World Health Organization). In other countries, citizens get a health care card to use, not 100-page manuals with lots of fine print. In those countries, government is the escrow agent, it takes in tax dollars and pays them out to providers with little administrative “noise” or supposed rationing or “death panels.” Doctors work on the government and the provider side to efficiently run a simplified system.

The U.S. health care system needs the lessons and discipline that its business community can provide:

LEANING the process.
REDUCING unnecessary profit centers.
BEST PRACTICES gathered from around the world.
EVIDENCE-BASED research and decision making.
SCALING best local practices to the national level.
ZERO TOLERANCE for fraud.
ERROR PROOFING to ensure quality.

Single Payer enables the best business practices to be applied as a singular system, not prone to the complexities that are inevitable in a multi-payer system.

5. What are the waiting times in a Single Payer system?

There is no automatic correlation between Single Payer and wait times. Taiwan and Germany have no wait times. Canada has wait time for some elective surgery, not in health-threatening circumstances. The U.S. has wait times in dermatology. Wait times must be addressed in every system. If the U.S. were to adopt Single Payer, research shows doctors would have an additional four hours a week to see patients that is now being used to interface with insurance companies.

6. Rationing. Is it a special problem with Single Payer?

The reality is that the U.S. is the most rationed country when it comes to health care. Americans without insurance are 40% more likely to die than their insured age group counterparts. Insured Americans are also not immune to rationing. High deductible insurance plans, under Obamacare and commercial insurance, deter many Americans from accessing the care they need. The median employee income is $30,000 in the U.S., which means approximately 50% of American workers make less than $30,000 a year. They don't have the funds to use higher deductible insurance plans. They don't have the funds for high co-pays to buy the prescriptions, and when they do buy them, they are more likely to take less than the amount prescribed, which is self-rationing and not in the interest of good health.

7. Is Single Payer a government takeover of health care?

No. The government becomes the escrow agent to more efficiently finance the health care system. It takes in taxes, and it pays out to private providers of care. In Canada, most doctors are private. In the U.S., most doctors have been collectivized into large regional health care networks because they want to relieve themselves of administrative burdens related to insurance companies, and doctors are deeply troubled by the daily intrusion of insurance companies into their clinical work. In general, doctor morale in the U.S. has declined. Doctor attitudinal studies report feelings of dissatisfaction in an increasingly commercialized environment. Single Payer has the opportunity to free-up doctors, returning them to their historic independence.

8. How does Single Payer impact labor negotiations?

It takes one of the most contentious issues off the table. Both labor and management should welcome this change.

9. What about job loss in the insurance industry, for Pharmacy Benefit Managers and in the reduction of administrative jobs inside physician offices, hospitals and other providers?

It is a serious problem — one that is addressed through relocation benefits and retraining grants available in Single Payer legislation. However, with universal coverage, there will be additional services and employment required at the provider level, as higher levels of utilization are anticipated.

10. Why is universal coverage needed?

With the ACA, older, working Americans are paying three times the insurance rates as younger workers. Under recent attempts to replace the ACA, that figure would increase to five times, and young people would drop out of the system and only retain insurance when they are ill. The economics for reasonable insurance rates will not work unless the pool is universal and balanced. Everyone has to be in: those who are healthy and those more likely to require care.

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11. How effective is tort reform to control cost?

Legal action accounts for about 2% of health care costs. States with tort caps have not experienced significant insurance cost reduction for physicians. Defensive medicine, including excessive use of tests, may be a factor in cost, but it appears from the data that over-testing and over-treatment is encouraged more by the commercialization of larger regional health networks that motivate doctors to use expensive equipment and ever-expanding facilities. Reduction of frivolous lawsuits and more efficient dispute resolution are worthy goals, but are not at the heart of what drives our health care costs.

12. What can I do about all of this?

Visit www.BLTH.org to learn more about our business organization, Business Leaders Transforming Healthcare, and how we are advocating for Single Payer, the ability for Medicare to negotiate drug pricing and overall transparency in our health care system. We encourage you to watch our film "Fix It - Healthcare at the Tipping Point" at https://fixithealthcare.com/ and the trailer for our upcoming film "Big Pharma…Market Failure" at https://vimeo.com/209128846.