Single-Payer Plan for New York Could Lead the Country

See also Morabia, p. 426; Sundwall, p. 449; Woolhandler and Himmelstein, p. 451; Moffit, p. 453; Olden, p. 454; Zimmer, p. 456; Bassett and Graves, p. 457; and Kirkham, p. 458.

After the Las Vegas mass shooting in October, a Nevada official set up a GoFundMe page to help pay the medical bills of survivors. GoFundMe has a medical fundraising category with disease-specific sample pages and staff assistance to "make sure you tell a compelling story." This is unacceptable in the wealthiest country in history.

In one third of American families, someone goes without needed health care. Insurance companies take 15 to 20 cents of each premium dollar for administrative costs, marketing, and profit, as compared with only two to three cents in traditional Medicare. Physicians, hospitals, and other providers spend just under 25% of their revenue on administrative costs. Twenty-eight million Americans remain uninsured and another 30 million are underinsured, with high deductibles or out-of-pocket costs.

Rising premiums, deductibles, copays, and out-of-network charges—imposed without regard to ability to pay—contribute to economic inequality. Insurance companies tell us which health care providers and services they will cover. In the case of labor unions, health benefits are a crushing burden on collective bargaining, crowding out negotiations for wages and other benefits and causing strikes. Almost every problem we face in health care—as patients, providers, employers, and taxpayers—is made worse and more difficult to solve by our reliance on health insurance companies.

Some say the current system offers choice and market competition. But the "competition" is really a race to the bottom. Insurance companies know their customer is usually the employer, whose focus is its bottom line as opposed to workers' welfare. And in the individual market, "shopping" for coverage simply does not work. Unless someone already has an expensive condition or a crystal ball, how does he or she rationally choose a low-premium–high-deductible plan versus the opposite? Rational choice is even harder because the actuarial values claimed for plans are misleadingly high.

No American should have to go without health care or suffer financial hardship to get it. The most practical and affordable way to achieve the goal of health care for all is a universal public improved Medicare for all or single-payer system. Washington may be a long way from enacting such a system, but states can lead the way.

NEW YORK HEALTH ACT

The proposed New York Health Act (A. 4738/S. 4840) would create "New York Health," a single-payer system covering every New Yorker without deductibles, copays, or restricted provider networks. Reducing administrative costs, overhead and profit, and bargaining for prescription drugs and devices would more than offset the increased costs of universal coverage. The bill would bar the sale of insurance in New York that duplicates any New York Health benefit. Providers would be barred from seeking or accepting additional payments for any New York Health service.

With a single-payer system, everyone would be in the same boat. People with wealth and power will make sure that their health plan treats them and their health care providers well. The rest of us will benefit, because we will be in the same plan with them.

According to University of Massachusetts Amherst Professor of Economics Gerald Friedman, New York Health would cut $71 billion from the cost of care in New York, which he projects to be $287 billion in 2019. The savings would finance coverage for uninsured New Yorkers and raise payment rates for Medicaid and Medicare providers to rates comparable to commercial insurance. After these additional investments, New York Health would produce $45 billion in net savings for New Yorkers.[1]

"MEDICINE, NOT BUSINESS"

At a legislative hearing on the New York Health Act, a medical student supporting the bill voiced a common complaint: "I went [to medical school] to learn to practice medicine, not business." Health care providers spend massive amounts of time and money—more than in any industrial democracy—processing insurance company billing statements and arguing with health plans and pharmacy benefit managers, taking time away from patient care.[2] (Pharmacy benefit managers consume prescriber and pharmacist time and are an increasingly costly factor in prescription pricing.) Physician practices in the United States spend four times more money and 10 times more hours interacting with payers than Canadian practices do.[3] The situation is worse for smaller practices and safety net providers.

Under the New York Health Act's drug benefit, the state's Medicaid preferred drug program could negotiate lower prices for 20 million individuals with coverage. The preferred drug program has successfully held down Medicaid drug prices, and its prior authorization process (for nonpreferred drugs) is patient, prescriber, and pharmacist friendly.

The bill would authorize collective negotiations with plans by organizations of providers. Professionals and hospitals should not have to form large systems to have bargaining clout with payers, and this is especially important if there is only one payer.

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VERMONT, COLORADO, AND CALIFORNIA

People often ask what happened to the single-payer proposals in Vermont, Colorado, and California. In Vermont, even as then-governor Peter Shumlin withdrew his proposal, his analysis showed that it would have saved money for most families making under $150 000.[4] But a key problem was that it involved a flat tax rate. As a result, average Vermonters would have had to pay a much higher rate than if a progressively graduated tax had been chosen.

California's Senate passed a single-payer bill without a financing mechanism, leaving it to subsequent legislation. The assembly leadership tabled the bill because it was not ready for prime time. This was not a rejection of the concept, but it led to negative press coverage.

The defeat of the Colorado proposal in a referendum is largely a lesson about the referendum process. Supporters were outspent almost six to one, and the ballot text began with the words (required by state law) "[s]hall state taxes be increased by $25 billion"—calculated to generate voter opposition, especially without any clear explanation of the cost savings the proposal would create in health care and coverage.[5]

The New York Health Act spells out its funding mechanism: a progressively graduated tax on income subject to the Medicare Part A tax, with the employer paying at least 80% of the tax and the tax paid in full by self-employed individuals, and on state taxable nonpayroll income such as capital gains, interest, and dividends. Specific brackets and rates would be set during an implementation period.

LABORATORIES OF DEMOCRACY

The New York bill has passed the Democratic-controlled assembly for three consecutive years. In the Republican-led Senate, the bill's cosponsors are one short of a majority. The 2018 elections could well produce a pro–single-payer Democratic majority. Governor Andrew Cuomo has said the bill is "a very exciting possibility [if it is] not incongruous to what the Federal government would do to us."[6]

Several major health care provider organizations in New York endorse the bill, including the New York State Nurses Association, Local 1199 SEIU, the New York chapters of the Academy of Family Physicians and the American Academy of Pediatrics, the Public Health Association of New York City, and the Community Health Care Association of New York State (representing community health centers).

The Washington health care debate and the increase in health plans with high premiums, high deductibles, and narrow provider networks have boosted support for single-payer systems. The savings generated by a single-payer system are the only way a state can sustain health care for its people in the face of assaults from Washington on Medicaid, Medicare, and the Patient Protection and Affordable Care Act.

The states have always been "the laboratories of democracy," and New York has led on many issues that once seemed out of reach. As support builds with health care providers, organized labor, and the general public, New York Health can evolve from a great idea that will never happen to being achievable. AJPH

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Moffit Responds

See also Morabia, p. 426; Sundwall, p. 449; Woolhandler and Himmelstein, p. 451; Gottfried, p. 452; Olden, p. 454; Zimmer, p. 456; Bassett and Graves, p. 457; and Kirkham, p. 458.

The recently resurrected single payer model is the latest health policy fashion. It is seemingly simple and cost-efficient. In the case of the proposed New York Health Act, as Rep. Richard Gottfried observes, the bill would cover every New Yorker without annoying deductibles, copays, and provider networks. Care would be "free" at the point of service, and savings would emerge from reduced administrative costs, economies of scale, and the "negotiation" ("fixing") of provider prices. As Rep. Gottfried points out, the New York Health Act would rely on a graduated employer-based tax, with employers nominally bearing 80% of the tax. Also, the New York plan would be funded by special taxes on capital gains, interest, and dividends. "Specific brackets and rates," Gottfried tells us, "would be set during an implementation period." Details matter. The recent single payer efforts collapsed for substantive reasons, indicating that the reality is different from the expectations.

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