

Nurses' guide to single-payer reform

Chapter 58: An overview of the state's health care reform plan

Select passages from Richard Kirsch's "If Wishes Were Horses: The False Promise of the Massachusetts Health Plan"

Revealing history

"The campaign that led to enactment of the Massachusetts legislation was designed by Health Care For All (HCFA), a highly respected and effective, 20-year old health care advocacy organization.

"The focus of the campaign was on expanding coverage—rather than controlling cost. The strategy was to build strong grassroots and public support and to forge an alliance with major non-profit insurers who would be favored in a reformed system and with hospitals and doctors who would get higher Medicaid reimbursement.

"The cudgel that would force [legislative] action was placing an initiative to enact the legislation on the Massachusetts ballot in November 2006. HCFA built a strong coalition of consumer, community and faith based organizations to back the initiative effort. The HCFA initiative proposal included subsidies for the cost of health coverage for low to-middle income families and a requirement that employers pay a percentage of payroll to cover their employees.

"As the petition effort sped forward, the speaker of the Massachusetts House of Representatives introduced a bill that was very similar to the HCFA proposal. Governor Romney countered with his own proposal, based on a requirement that individuals must purchase coverage, which did not include any employer contribution.

"The majority leader of the state Senate agreed with the Romney approach of not requiring employers to pay for coverage [and] the final legislative agreement placed the cost of paying for coverage for the uninsured entirely on families and taxpayers. (The legislation *does* include a small assessment of up to \$295 on businesses that do not provide coverage, but these funds are not used to pay for health coverage; they are to compensate hospitals and health centers for the cost of providing services to uninsured patients.)"

Expanding coverage

"As of July 1, 2007 all individuals will be required to have health coverage if the State—through a new authority called the Commonwealth Health Insurance Connector—says that affordable insurance is available for those individuals. The legislation does not specify what is affordable. The mandate will be enforced through the Massachusetts income tax system, with penalties that escalate over time for those who are not insured.

"The Commonwealth Care Health Insurance Program will offer subsidized individual coverage, with no premiums for those who earn below 100 percent of FPL [Federal Poverty Level], and an income-based sliding scale for premium payments for those who earn up to 300 percent of FPL. The coverage will be provided through the same handful of plans that now cover people in Medicaid managed care. The coverage will include all currently mandated health benefits. The plans will not include a deductible but the level of other cost sharing is not specified.

"[But] there is no way to know what the state will deem affordable and whether the public funds allocated for this program will be sufficient to make the coverage affordable.

"If the state funding is sufficient to make the coverage affordable, the Commonwealth Health Plan, coupled with SCHIP and Medic-

individual burden."

Insurance reforms and mandates

"Some 215,000 uninsured in Massachusetts (39 percent of the uninsured) earn more than 300 percent of FPL. These individuals would be required to purchase coverage if the State decides that affordable coverage is

Chapter 58: what the experts say

"This week's proposals merely repeat one from 20 years ago when Governor Dukakis was celebrating passage of his universal healthcare bill. That plan imploded within two years, and Massachusetts' new health reform legislation looks set to repeat that disaster."

—Steffie Woolhandler and David Himmelstein, professors of medicine at Harvard University

"This mandate throws financially-struggling individuals into battle with insurance agents, insurers and caregivers,"

—Alan Sager and Deborah Socolar, directors of the Health Reform Program, Boston University School of Public Health

"The bill will worsen the complex and costly administrative system that wastes funds needed to pay for actual health services,"

—Alice Rothchild, MD and board president of the Alliance to Defend Health Care

"This bill is going to exacerbate the crisis in Massachusetts health care. It will move more people into individual health plans, the costliest and most wasteful insurance plans on the planet, without taking any steps to contain the costs that neither the State, nor its employers or its residents can afford. Only a plan that consolidates health care finance and streamlines delivery, such as the single-payer model adopted successfully in much of the rest of the world, can provide quality, sustainable health care for all."

—Sandy Eaton, RN and chair of Mass-Care

aid, will provide the framework for covering most of the uninsured who earn under 300 percent of FPL. This may be a shaky solution in the long run since it will depend on continued very high levels of public funding.

"If adequate public funding is not maintained, given the rapid increase in health care inflation, individuals will be required to pay a higher percentage of income for coverage. Individuals who cannot in reality afford coverage that the State nevertheless deems affordable will face tax penalties and no coverage.

"The existence of the program may also be an incentive for more low-wage businesses to drop coverage, adding to the public and

available.

"While the legislation includes some insurance reforms meant to reduce costs in the individual market, there is no reason to think that the premiums will be less than now available in the group market. The legislation merges the individual and small group market, which will lower the cost of individual policies while raising the cost of small business policies."

The impact on employer coverage

"Under the legislation, employers with more than 10 workers who do not make a 'fair and reasonable' contribution toward employee health insurance will be required

to contribute a fee of up to \$295. The fee is not used to fund the purchase of insurance coverage; it is designated to fund the 'free care pool,' a fund that compensates hospitals and community health centers for serving the uninsured. The fee may be reduced if the free care pool does not need all the funds.

"In addition, there is a 'free rider' surcharge on employers who do not provide insurance, if one of their workers uses the free care pool more than three times or its employees as a group use the pool more than five times a year. The free rider surcharge creates serious anti-worker incentives for these employers and their workers including: encouraging the firing of an uninsured employee who uses the free care pool; putting a premium on hiring younger healthier workers; avoiding hiring workers with a health problem; discouraging uninsured workers from seeking needed care; and leading uninsured workers to pay out of pocket for care rather than apply for coverage from the free care pool. Scary stuff.

"It is impossible to say what the impact of this legislation will be on employer-based coverage. But I believe that the legislation has the potential to seriously erode such coverage. By establishing a public consensus that individuals are primarily responsible for health coverage, dropping coverage becomes more acceptable. The public would be now providing subsidies for moderate-to-middle income adults and make it easy for employers to pay into the subsidized pool. An employer who pays its \$295 a year can be said to have done its civic duty.

"Of course, if something appears to be too good to be true, it is. The Massachusetts claim to achieve universal coverage is a false promise, never likely to be enacted. When Massachusetts did not require employers to contribute to health coverage, it placed the obligation for paying for coverage entirely on taxpayers and consumers. The resulting political backlash is very likely to lead to the individual mandate never actually becoming a requirement."

Massachusetts as a model

"The debate over reform in Massachusetts must be seen in the context of the broader debate about the direction of health care reform in the nation.

"The Right sees health care as a consumer good like any other consumer good and that health care markets work like other markets is pure fantasy, at odds with everything we know about how health care is actually consumed. But health care markets are exactly the opposite of the basic economic theory of consumer demand. That theory is based on consumers, who have complete information, creating demand based on their preferences.

"In health care, it is not consumers who have the most information and who drive demand. We spend hundreds of thousands of dollars educating doctors and other practitioners so that they can make informed decisions about what the proper supply of health care should be to treat disease. We give the suppliers of health care the legal authority to determine demand: prescribe



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tests and medications and undertake medical procedures. While good practitioners listen to their patients, they use their training and experience *and* listening to determine the best course of care—that’s their job. We don’t want consumers to be practicing medicine, particularly when they are using cost as their prime method of determining treatment.

“The other part of the economic theory that’s absurd when it comes to health care is the idea of consumers acting from their preferences. Would you prefer cancer to heart disease? If you have cancer would you prefer chemotherapy to radiation? People end up in the health care system quite against their wishes, particularly when it comes to the serious illnesses that are responsible for most health care spending.”

Expanding coverage/controlling cost

“To all this I can hear the advocates of Massachusetts health saying, you miss the point. Our goal was to expand coverage, not control cost. Their argument might well go

something like this: ‘Our first obligation is to right the fundamental injustice in our health care system: leaving 550,000 people in Massachusetts (and 45 million people in the nation) uninsured. The systemic problem of high health care costs can not be an excuse to deny coverage to the uninsured. Uninsured people don’t have the luxury of worrying about theories of health economics or larger debates about the direction of the nation. They need health coverage and our obligation is to do everything we can to help them get it.’

“From my point of view, this is the strongest argument for defending what was accomplished in the Massachusetts legislation. It’s certainly the most candid. But I would question it’s validity on two grounds. The first is that, as we have pointed out, a good part of what was supposedly accomplished in Massachusetts is a chimera, with almost no likelihood of actually providing coverage, because it does not make health care affordable or control costs. The second reason is that we

have ample evidence that failing to tackle the larger structural problems will result in only short term gains.

“The advantages of single-payer are clear and go well beyond the elimination of excess administrative costs that is too often the prime rallying point of single-payer advocates. National health insurance provides the basic structure for universal coverage: everyone is automatically covered in one large pool. It provides the tools for systemic affordability: setting prices; controlling supply; limiting out of pocket costs; directing funds towards high quality care. But these goals, all of which stem from the concept that health care is a public good rather than a private commodity, can be achieved in various measures with systemic changes that don’t require a single-payer system.

“As students of health care systems in other nations know, there are numerous ways to assure affordable, universal coverage other than through a single-payer, national health insurance system. What all these systems have in common is that health

care is a public good, not a private commodity. Donald W. Light has studied health care systems in developed nations and identified ten benchmarks that foster a “justice-based” health care system (Fostering a Justice-based Health Care System, *Contemporary Sociology*, 1999; 29; 62-74.) These benchmarks include: universal participation regardless of health condition, risks and ability to pay; minimizing non-financial barriers; comprehensive and uniform services; equitable financing through community-rated contributions and ability to pay; value through clinical and financial efficiency; public accountability and choice of providers.

“There are no shortcuts. Wishing won’t make it so. Winning real health care reform requires a clear vision, a persistent, strategic energy and a belief in the miracle of change.”

Richard Kirsch is executive director of Citizen Action of New York and the Public Policy and Education Fund of New York. This is a publication of the Public Policy and Education Fund of New York; April, 2006. ■