FAQ: Business Leaders Transforming Healthcare

Question 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 they 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 which employers pay also do not include the HR expense to administer health plans or the rising cost of other insurances that have a healthcare component, such as Workman's comp, the state, local, and school taxes that have a high cost of healthcare, or the overall drag healthcare has on disposable income which deteriorates demand for our products.

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

What about Single Payer? Employers will pay 7% of payroll as a payroll deduction, and employees will pay 3% of payroll. There also will be a tax of 6% on non-compensation income, such as dividends and capital gains, that will raise the additional funds needed, but in no event will rates on non-compensation income exceed, for anyone, the tax rates on wage-related income.

Question 2: Why will Single Payer financed healthcare cost less (particularly when it is coupled with the concept of universal coverage for all Americans, which will add cost)?

The U.S. healthcare 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. That waste, 20% of premium revenue on the financing side of healthcare, when wasted administrative costs hospitals and physicians pay to interface with the complex insurance industry, estimated at 10% of revenues, are added (its myriad of plans, the pre-approvals, and payment challenges), it means that 30% of insurance premium dollars are wasted or $300-400 billion annually.

Traditional Medicare, on the other hand, is much more efficient. For every dollar collected, via payroll taxes, over 95 cents goes out to provider with less hassle and administrative cost to those providers. In addition, Medicare, in general, does a better job of negotiating reimbursement rates

from providers for equivalent care. Medicare's Advantage Plans, those Medicare supplement administered by commercial insurance companies, are less efficient. They add more than double the administrative overhead 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 system structure. Simply put, Single Payer is publically financed, privately delivered healthcare. It can be delivered efficiently for all Americans, and we can still save billions in cost.

Question 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?

American's 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 pharma.

The solution is not complicated. We need to empanel the nation's most re-known doctors and bio medical 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 US to international levels will not deter innovation. There is little correlation between current US price levels and innovation. The great majority of cost for basic biomedical research is paid by the US taxpayer through grants from the National Institutes of Health and from philanthropy and academia. The Pharma 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.

Question 4: Why has the business community been silent? Why should the business community organize to reform the U.S. healthcare system?

Healthcare is our nation's biggest expense. It takes 28% of the annual federal budget, a sum significantly higher than national defense (16%). Healthcare 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 healthcare costs dramatically surpass general inflation.

The Healthcare sector in the US is well-organized and well-financed. It uses its size (almost 1/5 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 US 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 Healthcare sector's power and influence.

Left alone, the healthcare sector literally eats the rest of the U.S. economy alive. A RAND study found that in the decade leading up to 2009, 79% of household income growth was absorbed by healthcare, leaving only 21% available for other purposes. The inefficiency of the healthcare sector is seen as a significant drag of US productivity and competitiveness. Why locate a car assembly plant in the US when you can save $5 an hour on health costs for auto workers in Canada and more than that in Mexico? Restructuring the way healthcare 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 healthcare component, has immense potential power in Washington. Why doesn't it assert that power to reform the healthcare system? A 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 healthcare sector appears to be "In complexity, there is much profit." No other country has the massive insurers, the 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 not only makes the system appear to be incomprehensible, it also provides opportunity for profiteering. Our system must be simplified and streamlined for maximum efficiency. The national debate on healthcare needs to be reframed. The healthcare 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 healthcare 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 together the government and the provider side to efficiently run a simplified system.

The US healthcare 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 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.

Question 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 4 hours a week, now required to interface with insurance companies become available to see patients.

Question 6: Rationing, is it a special problem with Single Payer?

The reality is that the US is the most rationed country when it comes to healthcare. 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 then prescribed, which is self-rationing and not in the interest of good health.

Question 7: Is Single Payer a government takeover of healthcare?

No. The government becomes the escrow agent to more efficiently finance the healthcare 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 healthcare 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.

Question 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.

Question 9: What about job loss in the insurance industry, at Pharmacy Benefit Managers, and in the reduction of administrative jobs inside doctor's offices, hospitals, and other provider of care organizations?

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.

Question 10: Why is universal coverage needed?

With Obamacare, older, working Americans are paying 3 times the insurance rates as younger workers. Under recent attempts to replace the ACA, that figure would increase to 5 times, and young people would drop out of the system and only retain insurance when they get ill. The economics for reasonable insurance rates will not work unless the pool is universal and balanced. Everyone has to be in, the healthy as well as the folks more likely to require care.

Question 12: How effective is tort reform to control cost?

Legal action accounts for about 2 percent of healthcare costs. States with tort caps have not experienced significant insurance cost reduction for physicians. Defensive medicine, including excessive use of tests, maybe 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 who motivate doctors to utilize 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 healthcare costs.

To view Big Pharma: Market Failure follow the appropriate links below.

TRAILER
https://vimeo.com/209128846
password: trailer

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https://vimeo.com/205715022
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