

# Proposal of the Physicians' Working Group for Single-Payer National Health Insurance

The Physicians' Working Group for Single-Payer National Health Insurance\*

**T**HE US HEALTH CARE SYSTEM IS rich in resources. Hospitals and sophisticated equipment abound, with even many rural areas boasting well-equipped facilities. Most physicians and nurses are superbly trained, and dedication to patients is the norm. Our research output is prodigious, and we fund health care far more generously than any other nation.

Yet despite medical abundance, health care is too often meager because of the irrationality of the current health care system. More than 41 million Americans have no health insurance, including 33% of all Hispanics, 19% of African Americans and Asians, and 10% of non-Hispanic whites.<sup>1</sup> Many more, perhaps most of us, are underinsured. The world's richest health care system is unable to ensure basics like prenatal care and immunizations, and we trail most of the developed world on such indicators as infant mortality and life expectancy. Even the well-insured may find care compromised when health maintenance organizations (HMOs) deny expensive medications and therapies. Fear of financial ruin often amplifies the misfortune of illness for patients.

For physicians, the gratifications of healing give way to anger and alienation in a system that treats sick people as commodities and physicians as investors' tools. In private practice we waste countless hours on billing and bu-

The United States spends more than twice as much on health care as the average of other developed nations, all of which boast universal coverage. Yet more than 41 million Americans have no health insurance. Many more are underinsured. Confronted by the rising costs and capabilities of modern medicine, other nations have chosen national health insurance (NHI). The United States alone treats health care as a commodity distributed according to the ability to pay, rather than as a social service to be distributed according to medical need. In this market-driven system, insurers and providers compete not so much by increasing quality or lowering costs, but by avoiding unprofitable patients and shifting costs back to patients or to other payers. This creates the paradox of a health care system based on avoiding the sick. It generates huge administrative costs that, along with profits, divert resources from clinical care to the demands of business. In addition, burgeoning satellite businesses, such as consulting firms and marketing companies, consume an increasing fraction of the health care dollar. We endorse a fundamental change in US health care—the creation of an NHI program. Such a program, which in essence would be an expanded and improved version of traditional Medicare, would cover every American for all necessary medical care. An NHI program would save at least \$200 billion annually (more than enough to cover all of the uninsured) by eliminating the high overhead and profits of the private, investor-owned insurance industry and reducing spending for marketing and other satellite services. Physicians and hospitals would be freed from the concomitant burdens and expenses of paperwork created by having to deal with multiple insurers with different rules, often designed to avoid payment. National health insurance would make it possible to set and enforce overall spending limits for the health care system, slowing cost growth over the long run. An NHI program is the only affordable option for universal, comprehensive coverage.

JAMA. 2003;290:798-805

www.jama.com

reaucracy. For the uninsured, we avoid procedures, consultations, and costly medications. In HMOs we walk a tight-

rope between thrift and penuriousness, under the surveillance of bureaucrats who prod us to abdicate allegiance

**\*Authors:** The writing committee for the Physicians' Working Group for Single-Payer National Health Insurance included Steffie Woolhandler, MD, MPH (Department of Medicine, Cambridge Hospital/Harvard Medical School, Cambridge, Mass), David U. Himmelstein, MD (Department of Medicine, Cambridge Hospital/Harvard Medical School, Cambridge, Mass), Marcia Angell, MD (Department of Social Medicine, Harvard Medical School, Boston, Mass),

and Quentin D. Young, MD (Physicians for a National Health Program, Chicago, Ill).

**This article** has been endorsed by 7784 additional physicians and medical students (names available at <http://www.pnhp.org/signers/>).

**Corresponding Author and Reprints:** David U. Himmelstein, MD, Cambridge Hospital/Harvard Medical School, 1493 Cambridge St, Cambridge, MA 02139 (e-mail: Dhimmelstein@challiance.org).

**For editorial comment see p 818.**

to patients and to avoid the sickest who may be unprofitable. In academia, we watch as the scholarly traditions of openness and collaboration give way to secrecy and assertions of private ownership of vital ideas—the search for knowledge displaced by a search for intellectual property.

For 9 decades, opponents have blocked proposals for national health insurance (NHI), touting private sector solutions. Reforms over the past quarter century have emphasized market mechanisms, endorsed the central role of private insurers, and nourished investor ownership of care. But promises of greater efficiency, cost control, and responsiveness to consumers are unfulfilled; meanwhile, the ranks of the uninsured have swelled. Health maintenance organizations, launched as health care's bright hope, have raised Medicare costs by billions<sup>2</sup> and fallen substantially in public esteem. Investor-owned hospital chains, born of the promise of efficiency, have been wracked by scandal, their costs high and their quality low.<sup>3-12</sup> Drug firms, which have secured the highest profits and lowest taxes of any industry, price drugs out of reach of many who need them most.

Many in today's political climate propose pushing on with the marketization of health care. They would shift more public money to private insurers; funnel Medicare through private managed care; and further fray the threadbare safety net of Medicaid, public hospitals, and community clinics. These steps would fortify investors' control of care, squander additional billions of dollars on useless paperwork, and raise barriers to care still higher. Instead, we propose a fundamental change in US health care—a comprehensive NHI program.

Four principles shape this vision of reform:

1. Access to comprehensive health care is a human right. It is the responsibility of society, through its government, to ensure this right. Coverage should not be tied to employment.

2. The right to choose and change one's physician is fundamental to pa-

tient autonomy. Patients should be free to seek care from any licensed health care professional.

3. Pursuit of corporate profit and personal fortune have no place in caregiving. They create enormous waste and too often warp clinical decision making.

4. In a democracy, the public should set health policies and budgets. Personal medical decisions must be made by patients with their caregivers, not by corporate or government bureaucrats.

We envision an NHI program that builds on the strengths and rectifies the deficiencies of the current Medicare system. Coverage would be extended to all age groups and expanded to include prescription medications and long-term care. Payment mechanisms would be structured to improve efficiency and ensure prompt, fair reimbursement, while reducing bureaucracy and cost shifting. Health planning would be enhanced to improve the availability of resources and minimize wasteful duplication. Finally, investor-owned facilities would be phased out. These reforms would shift resources from bureaucracy to the bedside, allowing universal coverage without increasing the total costs of health care.

Key features of the proposal [in italics] followed by the rationale for our approach are presented below.

### ELIGIBILITY AND COVERAGE

*A single public plan would cover every American for all medically necessary services, including long-term care, mental health and dental services, and prescription drugs and supplies. Unnecessary or ineffective services, as determined by boards of experts and community representatives, would be excluded from coverage. As in the Medicare program, private insurance duplicating the public coverage would be proscribed. Patient co-payments and deductibles would also be eliminated.*

Abolishing financial barriers to health care is the sine qua non of reform. Only a single comprehensive program, covering rich and poor alike, can end disparities based on race, ethnicity, so-

cial class, and geographic region that compromise the health care of the American people. A single-payer program is also key to minimizing the complexity and expense of billing and administration.

Private insurance that duplicates the NHI coverage would undermine the public system in several ways. First, the market for private coverage would disappear if the public coverage were fully adequate. Hence, private insurers would continually lobby for underfunding of the public system. Second, if the wealthy could turn to private coverage, their support for adequate funding of NHI would also wane. Why pay taxes for coverage they don't use? Third, private coverage would encourage physicians and hospitals to provide 2 classes of care. Fourth, a fractured payment system, preserving the chaos of multiple claims databases, would subvert quality improvement efforts, eg, the monitoring of surgical death rates and other patterns of care. Fifth, eliminating multiple payers is essential to cost containment. Public administration of insurance funds would save tens of billions of dollars each year.

Private health insurers and HMOs now consume 12% of premiums for overhead,<sup>13</sup> while both the Medicare program and Canadian NHI have overhead costs below 3.2%.<sup>14</sup>

Our multiplicity of insurers forces US hospitals to spend more than twice as much as Canadian hospitals on billing and administration; forces US physicians to spend vast amounts on billing; and nourishes a panoply of business consultants, coding software vendors, and other satellite businesses.<sup>14,15</sup> Only a true single-payer system would realize large administrative savings. Perpetuating multiple payers would force hospitals to maintain expensive cost-accounting systems to attribute costs and charges to individual patients and payers. In the United Kingdom, market-based reforms that fractured hospital payment have swollen administrative costs.<sup>16,17</sup>

Co-payments and deductibles discourage preventive care, decrease the

use of essential care, are expensive to administer, and especially endanger the most vulnerable patients—the poor and those with chronic illnesses.<sup>18</sup> Many nations with NHI have effectively contained costs without resorting to such charges.

Coverage decisions would doubtless be difficult and sometimes hotly contested. Even the fairest and best-informed board would confront costly choices where evidence was sparse and passions abundant. Yet we are encouraged by Medicare's generally open and reasoned approach. Moreover, in both Medicare and NHI, the inclusion of the affluent in the same program with others creates a powerful lobby for maintaining adequate coverage. For these reasons, we believe NHI provides a framework for replacing the confused and often unjust dictates of insurance companies with rational, evidence-based decision making.

## HOSPITAL PAYMENT

The NHI program would pay each hospital a monthly lump sum to cover all operating expenses. The hospital and the regional NHI office would negotiate the amount of this payment annually based on past budgets, clinical performance, projected changes in demand for services and input costs, and proposed new programs. Hospitals would not bill for services covered by NHI.

Hospitals could not use any of their operating budgets for expansion, profit, excessive executives' incomes, marketing, or major capital purchases or leases. Major capital expenditures would come from the NHI fund and would be appropriated separately based on community needs. Investor-owned hospitals would be converted to not-for-profit status and their owners compensated for past investment.

Global budgeting would simplify hospital administration by virtually eliminating billing, thus freeing up resources for enhanced clinical care. Prohibiting the transfer of operating funds to capital projects or shareholders would eliminate the main financial incentive for both excessive interven-

tions (under fee-for-service payment) and skimping on care (under capitated or diagnosis related group systems), since neither inflating revenues nor limiting care could result in institutional gain. Separate and explicit appropriation of capital funds would facilitate rational health care planning. These methods of hospital payment would shift the focus of hospital administration away from lucrative services that enhance the bottom line and toward providing optimal clinical services according to patients' needs.

## PAYMENT FOR PHYSICIANS AND OUTPATIENT CARE

Physicians and other practitioners could choose from 3 payment options: fee-for-service, salaried practice in institutions receiving global budgets, and salaried practice in group practices or HMOs receiving capitation payments. Investor-owned HMOs and group practices would be converted to not-for-profit status. Only institutions that actually deliver care could receive NHI payments, excluding most current HMOs and some practice management firms that contract for services but don't own or operate clinical facilities.

(1) *Fee-for-service:* The NHI and organizations representing fee-for-service practitioners (eg, medical associations) would negotiate a simple, binding fee schedule. As in Canada, physicians would submit bills on a simple form or via computer and would receive interest for bills not paid within 30 days. Physicians accepting payment from the NHI program could not bill patients for covered services, but they could bill for excluded procedures such as cosmetic surgery.

(2) *Salaries within institutions receiving global budgets:* Hospitals, group practices, clinics, home care agencies, and the like could elect to be paid a global budget, which could include funding for items such as education, community prevention programs, and patient care. Regulations regarding capital payment would be similar to those for inpatient hospital services, as would the budget setting process.

(3) *Salaries within capitated groups:* Group practices and nonprofit HMOs

could opt to receive capitation payments to cover all physicians and other outpatient care. Regulation of payment for capital would be similar to that for hospitals. The capitation payment would not cover most inpatient services, which would be included in hospital global budgets. However, a capitated group could elect to provide and be compensated for physician services to inpatients. Enrollment would be open to any patient, and efforts to selectively enroll those at low risk would be prohibited. Patients could disenroll with appropriate notice. Health maintenance organizations would pay physicians a salary, and bonuses based on the utilization or expense of care would be prohibited.

The proposed pluralistic approach to health care delivery would avoid unnecessary disruption of current practice arrangements. All 3 proposed options would eliminate profiteering and uncouple capital from operating costs, features essential to cost containment and health planning.

The fee-for-service option would greatly reduce physicians' office overhead by simplifying billing. Canada and several European nations have developed successful mechanisms for controlling the inflationary potential of fee-for-service practice.<sup>19</sup> These include limiting the supply of physicians, monitoring for extreme practice patterns, and setting overall limits on regional spending for physicians' services (thus requiring the profession to monitor itself). Because of the administrative advantages of single-source funding, these regulatory options have been implemented without extensive bureaucracy. Similar cost-constraint mechanisms might be needed in the United States. We also recommend capping expenditures for the regulatory and reimbursement apparatus; the Canadian experience suggests that 2% to 3% of total costs should suffice.<sup>14</sup>

Global budgets would allow institutions to virtually eliminate billing, while assuring them a predictable revenue stream. Such funding could also stimulate the development of community prevention programs whose costs cannot

be attributed (or billed) to individual patients.

### LONG-TERM CARE

The NHI program would cover disabled Americans of all ages for all necessary home and nursing home care. Persons unable to perform activities of daily living would be eligible for services. A local public agency in each community would determine eligibility and coordinate care. Each agency would receive a single budgetary allotment to cover the full array of long-term care services in its district. The agency would contract with long-term care providers for the full range of needed services, eliminating the perverse incentives in the current system that often pays for expensive institutional care but not the home-based services that most patients would prefer.

The NHI program would pay long-term care facilities and home care agencies a lump sum budget to cover all operating expenses. For-profit nursing homes and home care agencies would be converted to not-for-profit status. Physicians, nurses, therapists, and other individual long-term care providers would be paid on either a fee-for-service or salaried basis.

Since most disabled and elderly people would prefer to remain in their homes, the program would encourage home- and community-based services. The 7 million unpaid caregivers, the family and friends who currently provide 70% of all long-term care,<sup>20</sup> would be assisted through training, respite services, and in some cases, financial support. Nurses, social workers, and an expanded cadre of trained geriatric physicians would assume leadership of the system.

Few Americans have private coverage for long-term care. For the rest, only virtual bankruptcy brings entitlement to public coverage under Medicaid. Universal coverage must be combined with local flexibility to match services to needs.

Our proposal borrows features from successful long-term care programs in some Canadian provinces<sup>21</sup> and in Germany. The German program, in particular, demonstrates the fiscal and hu-

man advantages of encouraging rather than displacing family caregivers, offering them recompense, training, and other supports.<sup>22</sup>

### CAPITAL SPENDING, HEALTH PLANNING, AND PROFIT

The NHI budget would fund the construction of health facilities and the purchase of expensive equipment. Regional health planning boards would allocate these capital funds. These boards would also oversee capital projects funded from private donations when they entailed any increase in future publicly supported operating costs.

The NHI program would compensate owners of investor-owned hospitals, HMOs, nursing homes, and clinics for the loss of their clinical facilities, as well as any computers and administrative facilities needed to manage NHI. They would not be reimbursed for loss of business opportunities or for administrative capacity not used by NHI.

Capital spending drives operating costs and determines the geographic distribution of resources. Capital funds must go to excellent and efficient projects in areas of greatest need. When operating and capital payments are combined, as they are currently, prosperous hospitals can expand and modernize while impoverished ones cannot, regardless of need or quality. National health insurance would replace implicit mechanisms of capital allocation with explicit ones. Insulating these crucial decisions from lobbying and other distorting influences would be difficult and require rigorous evaluation, needs assessment, and active participation by providers and the public. The consistently poor performance of investor-owned facilities precludes their participation in NHI.

Investor ownership has been shown to compromise quality of care in hospitals,<sup>3-5</sup> nursing homes,<sup>23</sup> dialysis facilities,<sup>24</sup> and HMOs<sup>25</sup>; for-profit hospitals are particularly costly.<sup>6-12</sup> A wide array of investor-owned firms have defrauded Medicare and been implicated in other illegal activities.<sup>26</sup> Investor-owned providers would be converted to nonprofit status. The NHI

program would issue long-term bonds to amortize the one-time costs of compensating investors for the appraised value of their facilities. These conversion costs would be offset by reductions in payments for capital that are currently folded into Medicare and other reimbursements.

### MEDICATIONS AND SUPPLIES

The NHI program would pay for all medically necessary prescription drugs and medical supplies, based on a national formulary. An expert panel would establish and regularly update the formulary. The NHI program would negotiate drug and equipment prices with manufacturers based on their costs, excluding marketing or lobbying. Where therapeutically equivalent drugs are available, the formulary would specify use of the lowest-cost medication, with exceptions available in specific cases. Outpatient suppliers would bill the NHI program directly for the negotiated wholesale price, plus a reasonable dispensing fee, for any item in the formulary that is prescribed by a licensed practitioner.

National health insurance could simultaneously address 2 pressing needs: providing all Americans with full drug coverage and containing drug costs. As a single purchaser with a disproportionate influence on the market, the NHI program could exert substantial pressure on pharmaceutical companies to lower prices. Similar programs in the United States and other nations have resulted in substantial drug price reductions.<sup>27-29</sup>

Additional reforms are needed to improve prescribing practices, minimize medication errors, upgrade monitoring of drug safety, curtail pharmaceutical marketing, ensure that the fruits of publicly funded drug research are not appropriated for private profit, and stimulate real innovation while ameliorating current incentives to develop “me-too” drugs that add little to the therapeutic armamentarium.<sup>30</sup>

### FUNDING

The NHI program would pay for virtually all medically necessary health ser-

vices, with total expenditures set at approximately the same proportion of the gross domestic product as in the year preceding the establishment of NHI.

While it is critical that the vast majority of funds flow out to providers from a single payer in each region, the mix of taxes used to raise these funds is a matter of tax policy, largely separate from the organization of health care *per se*.

Single-source payment is the sine qua non of administrative simplification and the cornerstone of cost containment and health planning. Government expenditures, including payments for public employees' private health coverage and tax subsidies to private insurance, already account for about 60% of total health spending in the United States.<sup>31</sup> This would increase under NHI, to perhaps 80% of health costs with the remainder used for such items as non-prescription drugs, cosmetic surgery, and other excluded services. The public money now routed through private insurers would be used to fund public coverage. The additional funds could be raised in a number of ways, including earmarked income taxes, payroll taxes, or required employer contributions. During a transition period, it seems reasonable to require that employers transfer money earmarked for health benefits under existing labor pacts to the NHI program. In the long run, we believe that funding based on income or other progressive taxes is fairest. Federal funding would attenuate inequalities among the states in financial and medical resources. The increase in government funding would be offset by reductions in premiums and out-of-pocket costs. The total costs of the NHI program would be no greater (and eventually less) than those of the current fragmented system.

## COMMENT

Under an NHI program, the financial threat of illness to patients would be eliminated, as would current restrictions on choice of physicians and hospitals. Taxes would increase, but except for the very wealthy, would be fully offset by the elimination of insurance

premiums and out-of-pocket costs. Most important, NHI would establish a right to health care.

Clinical decisions would be driven by science and compassion, not the patient's insurance status or bureaucratic dictum. National health insurance would offer physicians a choice of payment options and practice settings. Nurses and other personnel would also benefit from the reduction in paperwork and a more humane clinical milieu.

National health insurance would curtail the entrepreneurial aspects of medicine, including both the problems and the possibilities. All patients would be insured, with a uniform fee schedule. Physicians who work harder would make more. Billing would be simplified, saving each practitioner thousands of dollars annually in office expense. Based on experience in Canada, NHI would have little impact on physicians' average incomes, although differences among specialties might be attenuated.

National health insurance would contain costs by enforcing overall budgets and eliminating profit incentives and not by detailed administrative oversight of utilization. Since hospitals and HMOs could not transfer monies for patient care to shareholders or divert them to institutional expansion, pressure to skimp on care would be minimized.

National health insurance would eliminate many administrative and insurance worker positions, necessitating a major effort at job placement and retraining. Many of these displaced workers might be deployed as support personnel to free up nurses for clinical tasks; others might be retrained to staff expanded programs in public health, home care, and the like.

Clinical departments would see only modest changes, eg, the elimination of billing-related work. However, hospitals' and nursing homes' administrative departments would shrink, and their financial incentives would change. Responsiveness to community needs, quality of care, and efficiency would replace financial performance as the bottom line.

Operating revenues would become stable and predictable; capital requests would be weighed against other priorities for health care investment. Facilities would not grow or shrink based on their financial performance, although rational health planning would mandate that some expand and others close. Investor-owned providers would be converted to not-for-profit status.

The insurance/HMO industry's role would be virtually eliminated. Most of the funds to expand care under NHI would come from eliminating insurance company overhead and profits, as well as the administrative expense they impose on health professionals and hospitals.

Private employers now fund 19% of health spending.<sup>31</sup> Even if new NHI taxes on employers fully replaced this spending, firms would achieve savings on their employee benefits departments, which currently cost billions of dollars to administer. Hence, for the average business, reform would likely yield at least modest short-term savings. Over the longer term, enhanced cost containment under NHI would spare firms from rapid and erratic health care cost growth. Many firms would undoubtedly choose to continue current wellness programs and workplace safety initiatives.

Covering the uninsured would save thousands of lives annually.<sup>32</sup> Upgrading coverage for those who are currently insured (eg, by adding full prescription drug benefits) would yield additional health benefits.

Independent estimates by several government agencies and private sector experts indicate that NHI would not increase total health care costs.<sup>33-37</sup> Savings on administration and billing, which would drop from the current 30% of total health spending to perhaps 15%, would approximately offset the costs of expanded services. Over the long run, improvements in health planning and cost containment made possible by single-source payment would slow health care cost escalation.

This article presents a framework for the urgently needed reform of our health

care payment system. We do not pretend to address the full range of health care problems or even to provide the detailed transition plan that will be needed to minimize dislocations during reform of the financing system. The need for quality improvement would remain urgent. National health insurance would not, in itself, encourage healthy lifestyles or upgrade environmental and public health services. Non-financial barriers to care—racial, linguistic, and geographic—would persist. Many issues in medical education would remain, including medical students' debt burden that skews specialty choices and discourages low-income applicants, the underrepresentation of minorities, and the appropriate role for commercial firms in supporting research and education. Some patients would still seek unnecessary services, and some physicians would still yield to financial temptation to provide them. The malpractice crisis would be partially ameliorated—the 25% of jury awards designated as compensation for future medical costs would be eliminated. However, our society would probably remain litigious, and legal and insurance fees would still consume about three fifths of malpractice premiums.<sup>38</sup> The aging of our population and the development of costly new technologies would present a continuing challenge to affordability.

Finally, while we propose a central role for government in financing care, we hold no illusions about government's shortcomings. Many of us disagree with government policies and priorities and are concerned by the influence of powerful special interests. Yet only a public NHI program can streamline our system and garner the savings needed to make universal coverage affordable. Ultimately, we prefer the democratic process, however flawed, to the boardroom decision making of private insurance firms.

## ALTERNATIVES TO NHI

The mounting crisis in health care has called forth a variety of incremental reform proposals discussed below. All

share one critical liability: because they would retain the role of private insurers, they would perpetuate administrative waste, making universal coverage unaffordable. Most would augment bureaucracy. Proponents' assertions that private insurers would achieve large savings through computerized bill processing are not credible; most claims processing is already automated.

### "Defined Contribution Schemes" and Other Mechanisms to Increase Patients' Price Sensitivity

These plans cap employers' premium contributions at a fixed amount, pressuring employees to choose lower-cost insurance options. Many cite the Federal Employees Health Benefit Program as a model for such reform, even though premiums in this program are rising faster than in Medicare or for private employers.<sup>39</sup> Hence, such programs are more likely to shift costs from firms to employees than to slow overall cost growth. Moreover, defined contribution schemes ensure a multi-tiered insurance system, with lower-income workers forced into skimpy plans, and the uninsured remaining uncovered.

### Tax Subsidies and Vouchers for Coverage for the Uninsured

These proposals would offer tax credits to low-income families who purchase private coverage. While promises of new government funding to expand coverage are attractive, the proposed subsidies (eg, \$3000 per family under President Bush's proposal) fall far short of the cost of adequate insurance, requiring low-income families to pay thousands of dollars out of their own pockets. Hence, few of the uninsured would actually purchase coverage, even with the subsidy. Instead, most of the tax credits would subsidize premiums for low-income people who already have coverage. As a result, large outlays for tax subsidies would buy little new coverage. For instance, outlays of \$13 billion annually would cover only 4 million of the uninsured.<sup>40</sup>

### Expansion of Medicaid, State Children's Health Insurance Program (SCHIP), and Other Public Programs

Some proposals would expand Medicaid eligibility. Others would allow states to buy stripped-down HMO coverage for Medicaid recipients, with the savings ostensibly used to enroll more beneficiaries. Several problems bedevil these strategies. First, Medicaid already offers second-class coverage. Such programs that segregate the poor virtually ensure poor care and are more vulnerable to funding cuts than public programs that also serve affluent constituencies. In most states, Medicaid payment rates are so low that many physicians resist caring for Medicaid patients. As a result, access to care for Medicaid enrollees is often little better than for the uninsured.<sup>41,42</sup> Further cuts to benefits, as envisioned in some Medicaid HMO schemes, would leave Medicaid recipients with coverage in name only. Moreover, the disempowered Medicaid population is particularly vulnerable to exploitation by profit-seeking HMOs, as evidenced by past scandals in California, Florida, Tennessee, and other states.<sup>43-45</sup> Promises (eg, in Oregon<sup>46,47</sup> and Tennessee<sup>48</sup>) that savings from Medicaid coverage cuts would lead to universal coverage have proven empty.

Second, even large Medicaid expansions in the past have failed to keep pace with the erosion of private coverage.<sup>49</sup> Moreover, Medicaid funding is most endangered when it is most needed; any economic downturn depletes states' tax revenues, reducing funds for Medicaid just as rising unemployment rates deprive many of private coverage.

While few can argue with proposals to cover more of the poor and near-poor, Medicaid expansion without systemwide reform is a stopgap measure unlikely to stem future increases in the number of uninsured. It does not lead to universal coverage.

### Employer Mandates

This approach would require most employers to offer private coverage for

their workers, with employees paying part of the premiums. The proposed mandates are usually coupled with a plan to expand Medicaid-like public programs. Some versions would offer employers the option of paying into a public program rather than providing the coverage themselves. Such programs can only add coverage by adding cost, leaving premiums unaffordable to many. In states where such plans have been passed, they have achieved neither universal coverage nor cost control.<sup>1,50-53</sup> Hawaii's program has left many uncovered because of loopholes in the law, and costs in that state have continued to spiral upward. A 1988 Massachusetts employer mandate law was passed but later abandoned when costs soared.<sup>51</sup>

### The Medicare HMO Program and Medicare Voucher Schemes

Under Medicare's HMO program, private HMOs have already enrolled millions of senior citizens. Prominent proposals would expand Medicare's use of private insurers by offering seniors a voucher to purchase private coverage in lieu of traditional Medicare. These strategies assume that private plans are more efficient than Medicare, that seniors can make informed choices among health plan options, and that private insurers' risk avoidance can be thwarted. All 3 assumptions are ill-founded. Traditional Medicare is more efficient than commercial insurers; costs per beneficiary have risen more slowly and overhead is far lower.

An American Association of Retired Persons survey of seniors found that few had adequate knowledge to make informed choices among plans.<sup>54</sup> Despite regulations prohibiting risk selection in the current Medicare HMO program, plans have successfully recruited healthier than average seniors. Hence HMOs have collected high premiums for patients who would have cost Medicare little had they remained in fee-for-service Medicare. Moreover, HMOs have evicted millions of seniors in counties where profits are low, while continuing to enroll Medicare patients in prof-

itable areas.<sup>55</sup> As a result, HMOs have increased Medicare costs by \$2 billion to \$3 billion each year<sup>2</sup> and disrupted the continuity of care for many patients.

A voucher program for Medicare would also push low-income seniors into skimpy plans similar to the defined contribution approach to employee coverage discussed above. Moreover, Congress is unlikely to increase the value of the voucher to keep pace with the rising costs of private plans. Over time, seniors' out-of-pocket costs for coverage would likely rise.

### CONCLUSION

Health care reform is again near the top of the political agenda. Health care costs have turned sharply upward. The number of Americans without insurance or with inadequate coverage rose even in the boom years of the 1990s. Medicare and Medicaid are threatened by ill-conceived reform schemes, and middle-class voters are very concerned about the abuses of managed care. Other wealthy countries manage to provide universal health care at half the cost we pay. Their problems stem mainly from inadequate funding, not the structure of their systems. In contrast, the problems in the United States are systemic. Incremental changes cannot solve them; further reliance on market-based strategies will exacerbate them. What needs to be changed is the system itself.

**Author Contributions:** *Article concept and design:* Woolhandler, Himmelstein, Angell, Young.

*Acquisition of data:* Woolhandler, Himmelstein, Young. *Analysis and interpretation of data:* Woolhandler, Himmelstein, Angell.

*Drafting of the manuscript:* Woolhandler, Himmelstein, Angell, Young.

*Critical revision of the manuscript for important intellectual content:* Woolhandler, Himmelstein, Angell, Young.

*Administrative, technical, or material support:* Woolhandler, Himmelstein, Young.

*Study supervision:* Woolhandler, Himmelstein, Young.

### REFERENCES

1. US Census Bureau. Health insurance coverage: 2001. Available at: <http://www.census.gov/prod/2002pubs/p60-22.pdf>. Accessed July 14, 2003.
2. Risk selection and risk adjustment in Medicare. In: *Annual Report to Congress*. Washington, DC: Physician Payment Review Commission; 1996. Chapter 15.
3. Hartz AJ, Krakauer H, Kuhn EM, et al. Hospital characteristics and mortality. *N Engl J Med*. 1989;321:1720-1725.
4. Kovner C, Gergen P. Nurse staffing levels and ad-

verse events following surgery in US hospitals. *Image J Nurs Sch*. 1998;30:315-321.

5. Taylor DH, Whellan DJ, Sloan FA. Effects of admission to a teaching hospital on the costs and quality of care for Medicare beneficiaries. *N Engl J Med*. 1999;340:293-299.

6. Pattison RV, Katz HM. Investor-owned and not-for-profit hospitals: a comparison based on California data. *N Engl J Med*. 1983;309:347-353.

7. Watt JM, Derzon RA, Ren SC, Schramm CJ, Hahn JS, Pillari GD. The comparative economic performance of investor-owned chain and not-for-profit hospitals. *N Engl J Med*. 1986;314:89-96.

8. Gray BH, McInerney WJ. For-profit enterprise in health care: the Institute of Medicine Study. *N Engl J Med*. 1986;314:1523-1528.

9. Gray BH, ed. *For-profit Enterprise in Health Care*. Washington, DC: National Academy Press; 1986.

10. Woolhandler S, Himmelstein DU. Costs of care and administration at for-profit and other hospitals in the United States. *N Engl J Med*. 1997;336:769-774.

11. Chan L, Koepsell TD, Deyo PA, et al. The effect of Medicare's payment system for rehabilitation hospitals on length of stay, charges and total payments. *N Engl J Med*. 1997;337:978-985.

12. Silverman EM, Skinner JS, Fisher ES. The association between for-profit hospital ownership and increased Medicare spending. *N Engl J Med*. 1999;341:420-426.

13. Centers for Medicare and Medicaid Services. Table 3: National Health Expenditures by Source of Funds and Type of Expenditure: Selected Calendar Years 1996-2001. Available at: <http://cms.hhs.gov/statistics/nhe/historical/t3.asp>. Accessibility verified July 10, 2003.

14. Woolhandler S, Campbell T, Himmelstein DU. Health care administration costs in the US and Canada. *N Engl J Med*. In press.

15. Woolhandler S, Himmelstein DU. The deteriorating administrative efficiency of US health care. *N Engl J Med*. 1991;324:1253-1258.

16. Robinson R, Le Grand J. *Evaluating the NHS Reforms*. New Brunswick, NJ: Rutgers University; 1994.

17. Dickinson CJ. De-engineering in the NHS. *BMJ*. 1996;312:1617.

18. Rasell ME. Cost sharing in health insurance—a re-examination. *N Engl J Med*. 1995;332:1164-1168.

19. Barer ML, Lomas J, Sanmartin C. Re-minding our Ps and Qs: medical cost controls in Canada. *Health Aff (Millwood)*. 1996;15:216-234.

20. Liu K, Manton KG, Liu BM. Home care expenses for the disabled elderly. *Health Care Financ Rev*. 1985;7:51-57.

21. Kane RL. Lessons in long-term care: the benefits of a northern exposure. *Health Econ*. 1992;1:105-114.

22. Geraedts M, Heller GV, Harrington CA. Germany's long-term-care insurance: putting a social insurance model into practice. *Milbank Q*. 2000;78:375-401.

23. Harrington C, Woolhandler S, Mullan J, Carrillo H, Himmelstein DU. Does investor-ownership of nursing homes compromise the quality of care? *Am J Public Health*. 2001;91:1452-1455.

24. Garg PP, Frick KD, Diener-West M, Powe NR. Effect of ownership status of dialysis facilities on patients' survival and referral for transplantation. *N Engl J Med*. 1999;341:1653-1660.

25. Himmelstein DU, Woolhandler S, Hellander I, Wolfe SM. Quality of care in investor-owned vs not-for-profit health maintenance organizations. *JAMA*. 1999;282:159-163.

26. Himmelstein D, Woolhandler S, Hellander I. *Bleeding the Patient: The Consequences of Corporate Health Care*. Monroe, Me: Common Courage Press; 2001.

27. US General Accounting Office. *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain*. Washington, DC: US Gen-

- eral Accounting Office; June 11, 1997. Document GAO-/HEHS-97-60.
28. US General Accounting Office. *Prescription Drugs: Companies Typically Charge More in the United States Than in Canada*. Washington, DC: US General Accounting Office; September 30, 1992. Document HRD-92-110.
29. Schneeweiss S, Walker AM, Glynn RJ, Maclure M, Dormuth C, Soumerai SB. Outcomes of reference pricing for angiotensin-converting-enzyme inhibitors. *N Engl J Med*. 2002;346:822-829.
30. Relman AS, Angell M. America's other drug problem. *The New Republic*. December 16, 2002:27-41.
31. Woolhandler S, Himmelstein DU. Paying for national health insurance—and not getting it: taxes pay for a larger share of U.S. health care than most Americans think they do. *Health Aff (Millwood)*. 2002;21:88-98.
32. Institute of Medicine. *Care Without Coverage: Too Little, Too Late*. Washington, DC: Institute of Medicine; 2002.
33. US Government Accounting Office. *Canadian Health Insurance: Lessons for the United States*. Washington, DC: US Government Accounting Office; 1991. Document GAO/HRD-91-90.
34. Congressional Budget Office. *Single-payer and All-payer Health Insurance Systems Using Medicare's Payment Rates*. Washington, DC: Congressional Budget Office; April 1993.
35. Sheils JF, Haught RA. *Analysis of the Costs and Impact of Universal Health Care Models for the State of Maryland: The Single-payer and Multi-payer Models*. Fairfax, Va: The Lewin Group; 2000.
36. Brand R, Ford D, Sager A, Socolar D. *Universal Comprehensive Coverage: A Report to the Massachusetts Medical Society*. Waltham: The Massachusetts Medical Society; 1998.
37. Grumbach K, Bodenheimer T, Woolhandler S, Himmelstein DU. Liberal benefits conservative spending: the Physicians for a National Health Program proposal. *JAMA*. 1991;265:2549-2554.
38. Weiler PC. Fixing the tail: the place of malpractice in health care reform. *Rutgers Law Rev*. 1995;47:1157-1192.
39. Merlis M. *The Federal Employees Health Benefits Program: Program Design, Recent Performance and Implications for Medicare Reform*. Menlo Park, Calif: The Henry J. Kaiser Foundation; May 2003. Available at: <http://www.kff.org/content/2003/6081v1.pdf>. Accessed July 15, 2003.
40. Gruber J, Levitt L. Tax subsidies for health insurance: costs and benefits. *Health Aff (Millwood)*. 2000;19:72-85.
41. Ayanian JZ, Kohler BA, Abe T, Epstein AM. The relation between health insurance coverage and clinical outcomes among women with breast cancer. *N Engl J Med*. 1993;329:326-331.
42. The Medicaid Access Study Group. Access of Medicaid recipients to outpatient care. *N Engl J Med*. 1994;330:1426-1430.
43. Galblum T, Trieger S. Demonstrations of alternative delivery systems under Medicare and Medicaid. *Health Care Financ Rev*. 1982;3:1-12.
44. Schulte F, Bergal J. Profits from pain: Medicaid HMO system failing. *Fort Lauderdale Sun Sentinel*. December 11, 1994:1.
45. Gottlieb M. A free-for-all in swapping Medicaid for managed care. *New York Times*. October 2, 1995: A1, A14.
46. Bodenheimer T. The Oregon Health Plan—lessons for the nation: first of two parts. *N Engl J Med*. 1997;337:651-655.
47. Bodenheimer T. The Oregon Health Plan—lessons for the nation: second of two parts. *N Engl J Med*. 1997;337:720-723.
48. Mirvis DM, Chang CF, Hall CJ, Zaar GT, Applegate WB. TennCare—health system reform for Tennessee. *JAMA*. 1995;274:1235-1241.
49. US Census Bureau. Historical Health Insurance Table HI-1. Available at: [www.census.gov/hhes/hlthins/historic/hihist1.html](http://www.census.gov/hhes/hlthins/historic/hihist1.html). Accessibility verified July 10, 2003.
50. Glaser W. Employer mandates: a failed American invention [letter]. *Health Aff (Millwood)*. 1994;13:229-331.
51. Iglehart JK. Health policy report: health care reform: the states. *N Engl J Med*. 1994;330:75-79.
52. Dick AW. State report: will employer mandates really work? another look at Hawaii. *Health Aff (Millwood)*. 1994;13:343-349.
53. Martin A, Whittle L, Levit K. Trends in State Health Care Expenditures and Funding: 1980-1998. Available at: <http://cms.hhs.gov/statistics/nhe/state-trends/>. Accessed July 14, 2003.
54. Hibbard JH, Jewett JJ, Engelmann S, Tusler M. Can Medicare beneficiaries make informed choices? *Health Aff (Millwood)*. 1998;17:181-193.
55. Charatan F. Health maintenance organisations drop Medicare beneficiaries. *BMJ*. 2001;323:772.

Thoughts give birth to a creative force that is neither elemental nor sidereal. . . . Thoughts create a new heaven, a new firmament, a new source of energy, from which new arts flow.

—Philippus Aureolus Paracelsus (c 1493-1541)