UNIVERSAL HEALTH CARE FOR THE USA

June 2017

Summary
A proposed single payer state based privately/publicly insured medical care system

Executive Summary
A brief proposal to bring a single payer medical care system for the USA. A state based single payer system where the primary insurers are private corporations with public payment for seniors and the very poor. With a charity component for undocumented residents. There would also be a cost recovery component for those responsible causing injury to others.

The Problem

It appears everyone in the US who reads or watches the news is very aware of the problems of high cost, costs growing faster than wages, affordability, costly administration, and lack of portability to name some of the biggest issues

RESEARCH
Before the reader goes into political rhetoric about socialized medicine. they may want to examine the Definitions Appendix later in this document. This is not a proposal for socialized medicine which is a non starter in the USA. Nor does it propose a government run single payer system.

In coming up with a proposal many things have to be considered including (in no particular order) costs, patients, vested interests, insurers (and their shareholders), physicians and other medical services providers, support workers, poor and unemployed people, undocumented residents

THE PLAN

Simply put, the plan is to set up a single payer organization in every state (DC and territory) that all insurers that do not provide full service health care participate[1]. Private and Public.

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[1] Excluded organizations would be ones that are both insurers and providers. This includes the VA and organizations like Kaiser-Permanente. To those who have never heard of Kaiser-Permanante, it is an organization that originated n California and has spread into a few some states. This writer has found this was the only sort of US provider that is affordable to middle class workers that exceeds Canadian medical care in quality

The Single Payer Organization (SPO) should be exempt under anti-trust law as they would be a cooperative organization owned by the insurers which would NOT be required to merge and would still be free to compete with each other.

Organizations that both sell medical service plans and provide what are considered all essential medical services would be exempt if they wish. Organizations like the VA, Kaiser Permanente, UPMC, etc.

COST BENEFIT

The idea is to eliminate the large number of billing and administrative staffing the writer has observed in essentially every medical practice in the US except for places like Kaiser Permanente. Typically the USA spends over $1,000 a year per patient on administrative costs, over 3 times what is spent per person in Canada. Over $700 a year more as far back as 1999. See the links section. This accounts for a very large amount of money.

It also has been estimated that doctors use about $60,000 per year of actual physician time interacting with insurance carriers.

As well the insurance companies spend about 16% of revenue on administrative costs while the public insurers in Canada spend under 2%.

Under this plan, medical practices will save a lot of money, cutting their costs and doctors will be able to see more patients per day. As well insurers will be able to reduce their costs quite a bit. Not to 2% but still a good number

The Single Payer Organization (SPO) will have instead to pay some of these costs as they will still not have the luxury of administering just one plan like the Canadian SPOs do but it would be expected that the system would quickly boil itself down to perhaps 20 different plans to assure sufficient choice for the public.

As well the SPO in each state will negotiate with providers in their state to get the lowest practical rates for insured services.

State SPOs would also be allowed to merge to obtain economies of scale that smaller states would not be able to obtain on their own. These need not be contiguous states. For example Rhode Island and Wyoming could merge their plans. However hostile takeovers and buyouts are prohibited. The private insurers themselves will still be able to exploit all the benefits of capitalism they wish.

This sort of plan would eliminate the need for insurers to deal with doctors and patients themselves except for sales and marketing. Each would keep their current network of agents. The private insurers could then become more of a financial services business. Simpler and possibly more profitable.

As for the call centers and the rest needed the SPO would merge those of the all the insurers moving workers from the small ones to the larger ones to improve exomomies of scale. With current technology these do not need to be located all in one location.

OWNERSHIP and CONTROL

The SPO in each state would be a non-profit corporation owned by shareholders. These shareholders would include the insurers, both private and public in proportion to their annual expenditures through the SPO in each state. This includes all private carriers, medicare, medicaid, charities balanced every few years. Anticipated expenditures at first and actual ones after a while.

The composition of the board of directors would be set by the state legislature but it could look something like this:

10 seats for private insurers divided by each insurers market share in the state
1 seat for a representative from Medicare
1 seat for a representative for Medicaid
1 seat for the state Medical association to represent doctors
1 seat for a representative of the state association of hospital owners
1 seat for a representative of a patient's rights organization
1 seat for a representative for the poor
1 seat for a representative for the pharmaceutical industry
1 seat representing the labor organizations representing medical workers
1 seat representing the state department of finance
1 seat would be a health care actuary appointed by the state governor.

These board members would elect a chairman from themselves. The state legislature would also determine terms of office, remuneration and other conditions for the board of directors.

BENEFITS

It is expected that this will be a multi-tiered system with different levels of coverage from very basic, up to unlimited everything.

The list of essential benefits that must be covered by all plans would be set by the federal legislative branch, house and senate. Likely these would be most of the benefits mandated by Medicaid likely excepting long term nursing home care.

Individual states may add others they seem necessary. Beyond this, the benefits and coverage offered will be up to the private insurers to determine in order to attract business. It is expected that these levels will vary from state to state.

To reduce confusion and costs the state legislatures may determine a number of different plans with different coverage, deductibles, etc. 20 Standardized plans are suggested. These would then be offered by carriers(insurers) at various price points and co-pays and

they would compete in the market by price and whatever added features they may want to offer. These would include basic medicare and Medicare advantage plans.

The writer can visualize the ads:

THIS WEEK ONLY SIGN UP FOR PLAN 12 AND ONLY PAY FOR PLAN 8 INCLUDING FREE VIAGARA
(for the first 6 months)

Plans offered would include:

- current benefits offered by Medicaid
- coverage offered by Medicare
- a basic plan for the uninsured
- a good plan for children
- a charity supported plan for the undocumented
- whatever private insurers feel fit to offer under the guidelines set by each state.

For example, the top plans might offer service at concierge or boutique clinics with a more comfortable sort of experience.

The state legislatures would also set the maximum allowed premium as a multiple of the lowest cost plan for a 25 year old healthy person. Likely 5 times with similar deductibles.

Medicare members would pay their current premiums for the various parts with no change.

COSTS

Each SPO would negotiate provider rates as they see fit according to the needs of each state and its people. It is expected that more deluxe plans would offer higher payments to providers for high levels of service, shorter wait times, etc. One possible method to use would be a multiple of medicare or Medicaid rates for different service levels.

Copays would vary as well in plans as would annual out of pocket expense caps as determined in each state.

The most deluxe plan would be pegged at a multiple of the cost of the most basic plan like Medicaid. As well for a given plan, the oldest patients would be charged a fixed multiple, say 5 times the rate, of the lowest cost age group. Until they moved onto medicare.

CHILDREN

As children are the future of the nation. The USA pays dearly to educate its children but many, due to bad luck in their choice of parents, many do not have proper medical care. Children are the future workers, taxpayers and defenders of the country. No child should lack in pre-natal and post birth medical care until they reach their majority.

It is proposed that all children of preschool age in the USA would be covered by medicaid if their parents did not have other coverage. This includes pre-natal care during pregnancy. This may be through planned parenthood, faith based charities, etc. Plus, all other children up to the age of majority in their state who are attending school, whether public, private or home based would be covered on Medicaid regardless of status in the USA unless their parents have their own coverage.

Where parents have coverage of their own the rule for children to stay on parents coverage up to age 26 will stand.

This may sound like a give away to the undocumented children who are in the USA. That is correct. But really, these children who are law abiding are not going to be sent back to their parent's country. Not after the billions of dollars the US spends to educate them. To throw away these US educated kids and deport them when they are old enough to become taxpayers is a placing politics ahead of what is best for the economy. Plans are proposed to accept them as US residents after military or civic service and we want them to be healthy and strong for their duties.

UNINSURED PEOPLE

There are some people this plan will not reach. The working poor is the main group as well as those who for one reason or another make the choice to not purchase medical insurance.

WORKING POOR

For the working poor, those people who make too much to qualify for Medicaid but make insufficient income to buy even the lowest cost medical plan. Or their employers simply do not offer any medical coverage at all.

These people would be offered the ability to buy Medicaid coverage for the same per capita rate (plus a small overhead fee) as the federal government and state pay in that state for those covered by Medicaid. This would cost them 10% of their gross income for each adult in their immediate family. Where their income is to low to cover their entire cost, the state and federal government will share the cost of a subsidy. If their income rose someday to the point that a subsidy is no longer needed, they would be advised they need to choose one of the private insurers in the SPO for their state.

This would also include older people who lose their employer based insurance but are not old enough for medicare.

VOLUNTARILY UNINSURED

There are some people who deliberately choose to be uninsured and pay for services as needed. Or are unable to obtain insurance for other reasons. These people would be billed at double the medicare or Medicaid rate for services used. The choice is up to each state.

The markup in cost is because medicare buys in bulk and a 100% markup is for the cost of administering individual billing.

UNDOCUMENTED PEOPLE

One possibility would be that they are treated similarly to the voluntarily uninsured except in the case of serious illness or injury, after being stabilized, they would have the option or either being treated at the county hospital or a charity hospital and released, in debt or to be returned to their country of origin for treatment there. In the case of the first option, it is hoped that charities would be founded to assist these people.

In the second case, the INS would be responsible to see about the transfer to a foreign medical facility.

ENROLLMENT

The concept of mandatory enrolment is a sticking point for most people. But without very high participation rates, the whole concept of lowering the cost of medical insurance breaks down. To encourage people to enroll before they have a condition needing care, the plan to charge a higher premium for the first year to those with an interruption in coverage is likely the easiest way to encourage as many people to enrol as possible. Possibly a waiting period as well for serious levels of treatment if a person with interrupted coverage applies.

SOURCE OF FUNDS

Funds for services paid by the SPO for privately insured patients would come from private insurers. Medicare patient funding would be from the medicare program. It is expected that Medicaid patient funds may become a block grant from the federal government which would be topped up from state general revenue

County hospitals which currently treat uninsured people would receive funding from their respective counties.

To assist raising funds for covering costs, several cost recovery plans would also take effect where those who cause injury would pay the associated costs. These will be covered in a cost recovery section.

Each insurer would transfer the payment side of their policy holders to the SPO but keep their premium collection side of their operations separate. If for no other reason than to avoid anti-trust laws. However the publicly owned operations would, if it was felt beneficial, organize their premium collection operations into the framework of the SPO as well as their payments system.

PATIENT EXPERIENCE

In this plan every legal resident and citizen would be issued a care card. Encoded in this card will be data required to allow a provider to connect with an SPO server to determine exactly what benefits are covered and the priority level of that patient for non-life threatening services. Of course life threatening emergencies are always priority 1. Copay information would be there as well.

All of this will be in a standardized format where each item of data is in the same place on the provider's screen and all the billing codes would be the same in that state for all carriers. As well, if the patient is an out of state visitor, their data would also appear in the places on the screen the same as for an instate patient. This will help reduce billing costs and errors in service.

Otherwise, the patient will have the same service they currently expect.

COST RECOVERY

Part of the principles that certain parties teach is the one that we are responsible for our own actions and that we should pay for we get. In that spirit the following are suggested as a way to obtain additional health care funds

Criminal Acts

In the case of any person, except determined to be in self defence by a court of law, who commits a violent act to another are responsible for the entire cost of medical treatment of those they injure. Whether it be by gunshot, knife or any means. In order to not make it cheaper to kill the victim, if the victim dies at the hands of the perpetrator, they would be responsible for the cost to society for their victim no longer being available.

For example, for the death of a younger person the perpetrator is responsible for the all government costs, at all levels, for the education of that victim, government paid medical costs and all else, less the taxes the victim had paid to date to the federal and state government. The perpetrator is also responsible for any outstanding student loans.

Because our young people are the future and some perp who guns down one of these young people has robbed the people of the benefit of that education that society has invested in so dearly.

For a person where their cost of becoming an adult has been recovered, the perpetrator is responsible for all lost future taxed the victim would have pain excluding FICA taxes if they lived to the average age of the victim. To not collect these taxes would be to rob society of the future taxes the victim would have paid.

These debts can be declared to be non-dischargeable in bankruptcy.

It is realized that few perpetrators would have such assets but for those who do, the amounts recovered may still be better than the amounts collected now.

The same as above would be in the case of an at fault motor vehicle accident. Except that people can purchase insurance to cover such eventualities. It is suggested that the minimum insurance that can be purchased be raised. Some states have liability amounts that have not been raised for decades. Some as low as $35,000 of coverage. $500,000 should be closer to the required monimum.

Links

Administrative costs

http://medicaleconomics.modernmedicine.com/medical-economics/news/administrative-costs-are-killing-us-healthcare

http://www.nejm.org/doi/full/10.1056/NEJMsa022033

http://gopractice.kareo.com/article/your-practice-administrative-costs-what's-your-cost-getting-paid-part-i

DEFINITIONS

Socialized Medicine

Where a single organization, usually government operated, provides both the medical care and they take care of the payments.

A typical example of socialized medicine in the USA is The Veterans Administration where the providing organization and the payer are both the US government. The VA, while a lot of money is spent on it, the service is perceived by many as very bad with long wait times.

Under this definition, private organizations may also be a form of socialized medicine. Kaiser Permanente, which operates mainly in California, has all the appearance of socialized medicine. where the provider and the insurer are the same organization. In the case of the UK and most others, this is the government. Doctors are usually work for the government owned provider on a salary. Kaiser is essentially the same except they are owned by a non-profit foundation. They have over 10 million members. The writer is a former Kaiser Permanente member until moving out of the coverage area. www.kp.org

UPMC in the West Pennsylvania area centered on Pittsburgh is another such organization that offers medical care as well as operating its own insurance plans. With about 3.2 million members. http://www.upmc.com/about/facts/pages/default.aspx

Kaiser and UPMC offer some of the lowest cost full service medical plans in the areas they serve.

Socialized Insurance
This is where the medical providers are independent of the insurance system. One group of organizations and individuals which may be publicly or privately owned provide services while a separate organization pays for these services. Raising the money to do this through premiums and other means.

Canada has such a system where each province and territory has a medical services plan. Called MSP in British Columbia. These organizations in some provinces collect funds from member premiums. Besides premiums, where charged, they receive funding from the provincial and federal governments.

Providers consist of hospitals that are mainly owned by educational institutions, municipalities, charities or religions organizations. Medical practices, laboratories, non-hospital imaging centres and medical supply operations are privately owned, often by corporations. As well, services for things not covered by MSP such as cosmetic surgery are privately operated.

This is often known as SINGLE PAYER INSURANCE.

It surprised the writer when they heard the amount of rhetoric against this system in spite of the US Medicare system for seniors is a Single Payer/Socialized Insurance system. Watching Tea Party rallies and the shouts of "Guvmint hands off Medicare" it seemed odd considering that medicare is a government run single payer system. Though not one as efficient as it could be.

Mixed Systems
Other countries such as many in Europe have a mixture of socialized medicine, socialized insurance and private insurance.

CONSIDERATIONS
In looking for solutions to the US medical care system, there are many things to be considered that people from outside the USA are often not aware of. As a Canadian who lived for 10 years in the USA (having US medical insurance including from Kaiser-Permanente) and where I have family in the USA, I have seen both sides of this issue.

About the Writer

The writer was fortunate having an employer that was able to offer a reasonable choice of plans and paid 80% of my premiums. When I moved to the Los Angeles area in 2001 and had to choose medical insurance I could not believe the confusion and the incredible amount of waste all the duplicate administration involved.

Where in Canada I just signed up for payroll deduction and got a plan better than the best my US employer offered. A plan with zero deductible, zero co-pay, no pre-existing condition exclusion, a plan where my rates would never change with age and much more. The only bad thing in Canada is that prescribed drugs are not included until you reach a certain threshold.

And what was this "groups" thing. What the heck was this having to go to just one hospital and I had to select a primary care physician from a relatively small group? What was this not being able to go to the nearest doctor taking new patients? Yet my American friends consider this to be normal. To go to an in network ER yet get a bill anyway as the physician was not in my network. In Canada, every single hospital in the country was in my network. And every doctor. If one hospital and doctor in my area was too busy I could go some place else.

In Newport Beach my kid had to see a neurologist and there was exactly one in my HMO group. What did they mean a 4 month wait? My kid was not able to walk and needed to be seen NOW! I was told it would take 2-3 months to maybe see an out of network neurologist.

Once I got fed up waiting months to see an endocrinologist for them. One that knew anything about anything but diabetes. Finally I just paid $600 to get her in to see the endocrinologist to the stars in Westwood. And he solved one of the major problems they was having for months.

In the end we got such a runaround so much that finally thy had to go back to Canada for the surgery needed to be cured of their immediate problems. But the messing around cost them the ability to have children.

Everyone was so nice but the system was cut up into so many discrete little boxes and no body talks to one another that her uncommon condition (for their age) just fell through the gaps. The insurance companies spend tens of thousands of dollars on them but the lack of coordination and duplication of tests gave us an ineffectual result but at great cost to the system.

Observing things when got various services I could see huge amounts of waste, especially in administration. Maybe it is good for the employment numbers of mid skilled administrative workers. It was not until I was insured with a combination insurer and care network in 2008 did I see any real effort to keep costs in check by improving

care and getting people out the door faster. This was with Kaiser Permanente in California.

Generally if one has a gall bladder attack pain relief is given for several times until finally the gall bladder is removed. As a Kaiser Permanente member, my daughter took me into their Sand Canyon ER in Irvine at 1 AM Sunday. I never sat in the waiting room. I was on a gurney being examined within 15 minutes getting into the door. I was impressed.

I was given pain relief and a sedative to be able to sleep. At 7AM I had an ultrasound and gall stones confirmed. At around 10 ish, Dr. Cole came in to introduce himself and to brief me on the surgery. I was taken in before 1PM and woke up just after 3 PM. At 5 I was taken to a ward. At 7 I was offered a light meal and was told if I did not throw it up I could go home to recover at home. The meal stayed down fine and I was home in time to see Family Guy at 9. Maybe they let me out sooner as my daughter was an Emergency Medical Technician. What I saw was a system that kept their cost down by instead of me making 5 ER visits before doing surgery. Where the insurer did as little as they could hoping I could be strung along to the next year where I would be a different insurer's problem. Because my employer changed carriers a lot.

Instead Kaiser kept costs down by doing the inevitable immediately, not after a lot of other care before then. My only regret was that I did not sign with them when I first came to California. Kaiser was the only medical care that I would rate superior to Canadian health care. At least at popular price points.