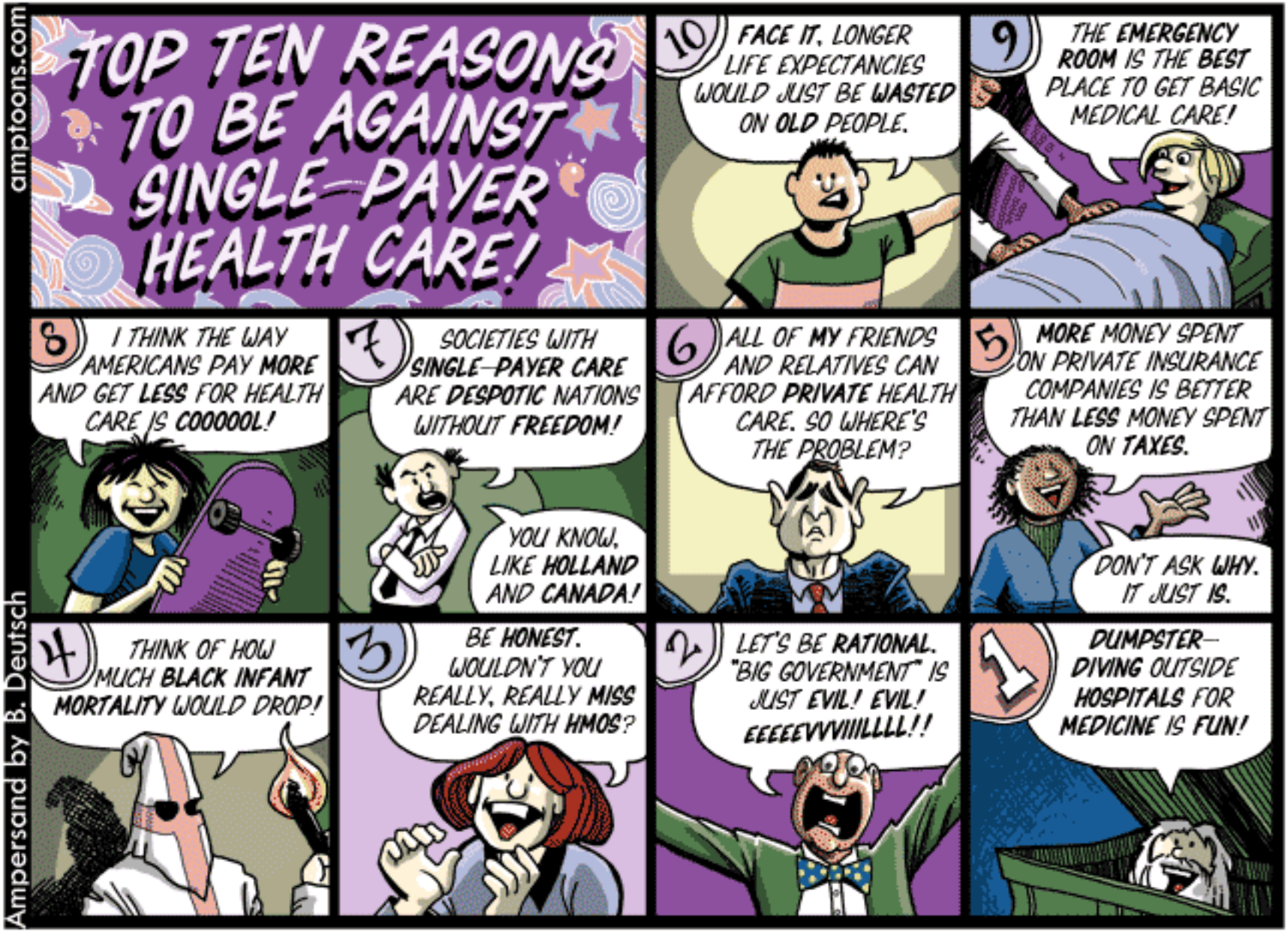

amptoons.com
TOP TEN REASONS TO BE AGAINST SINGLE-PAYER HEALTH CARE!
10 FACE IT, LONGER LIFE EXPECTANCIES WOULD JUST BE WASTED ON OLD PEOPLE.
9 THE EMERGENCY ROOM IS THE BEST PLACE TO GET BASIC MEDICAL CARE!
8 I THINK THE WAY AMERICANS PAY MORE AND GET LESS FOR HEALTH CARE IS COOOOOL!
7 SOCIETIES WITH SINGLE-PAYER CARE ARE DESPOTIC NATIONS WITHOUT FREEDOM!
YOU KNOW, LIKE HOLLAND AND CANADA!
6 ALL OF MY FRIENDS AND RELATIVES CAN AFFORD PRIVATE HEALTH CARE. SO WHERE'S THE PROBLEM?
5 MORE MONEY SPENT ON PRIVATE INSURANCE COMPANIES IS BETTER THAN LESS MONEY SPENT ON TAXES.
DON'T ASK WHY. IT JUST IS.
4 THINK OF HOW MUCH BLACK INFANT MORTALITY WOULD DROP!
3 BE HONEST. WOULDN'T YOU REALLY, REALLY MISS DEALING WITH HMOS?
2 LET'S BE RATIONAL. "BIG GOVERNMENT" IS JUST EVIL! EVIL! EEEEEVVVIIILLLL!!
1 DUMPSTER-DIVING OUTSIDE HOSPITALS FOR MEDICINE IS FUN!
Ampersand by B. Deutsch

Medicare fo All How do we pay for it?

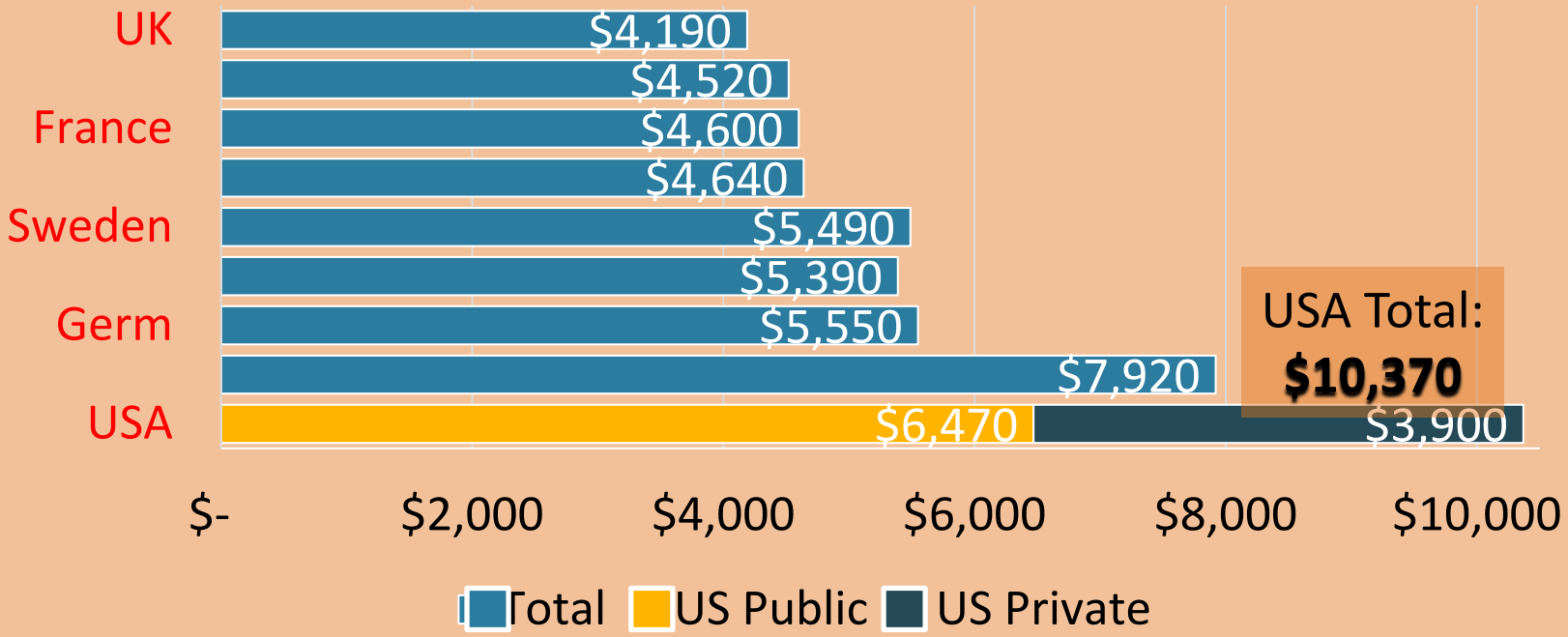
- Vince Markovchick MD
- Professor Emeritus of Emergency Medicine
- University of Colorado School of Medicine
- Past President Americam Board of Emergency Medicine
- Former Director of Emergency Medicine, Denver Health
-
- Freedom from Religion Foundation
- June 1, 2019

2017 Total Healthcare Spending

- $3.5 Trillion
- 18% of GDP
- $10,348 per capita

CMS.gov

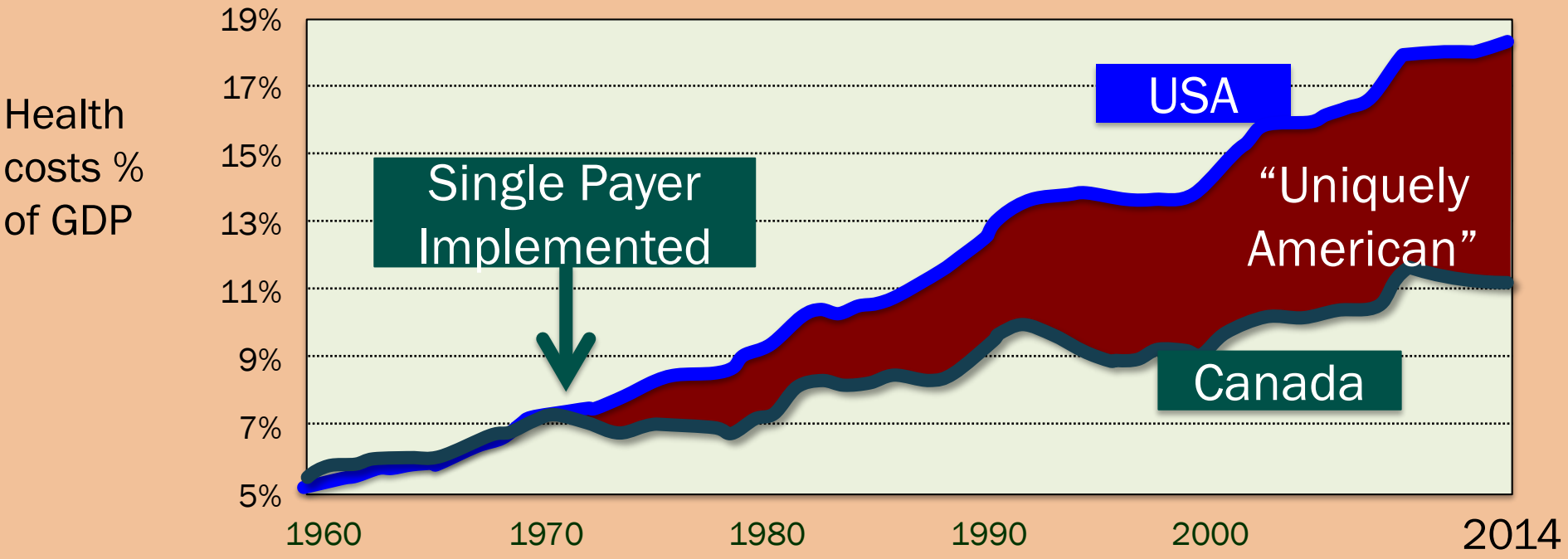
US *Public* Spending per Capita for Health Exceeds *Total* Spending in Other Nations



Note: "Public" includes benefit costs for gvt employees and tax subsidies for private insurance

OECD 2017; NCHS; AJPH 2016;106:449 – Data are for 2017 or most recent available

Health Costs: USA vs Canada

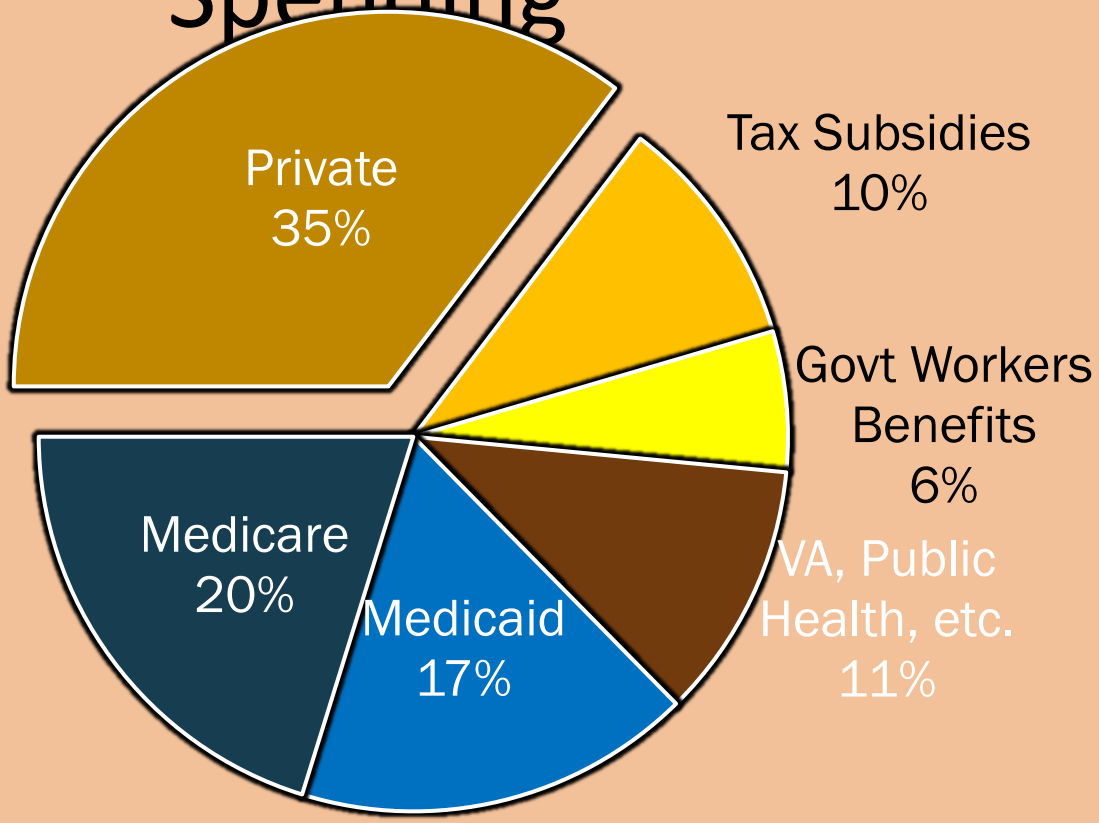


Source: Statistics Canada, Canadian Institute for Health Info, and NCHS/Commerce Dept.

Who paid the 2017 $3.5 Trillion bill?

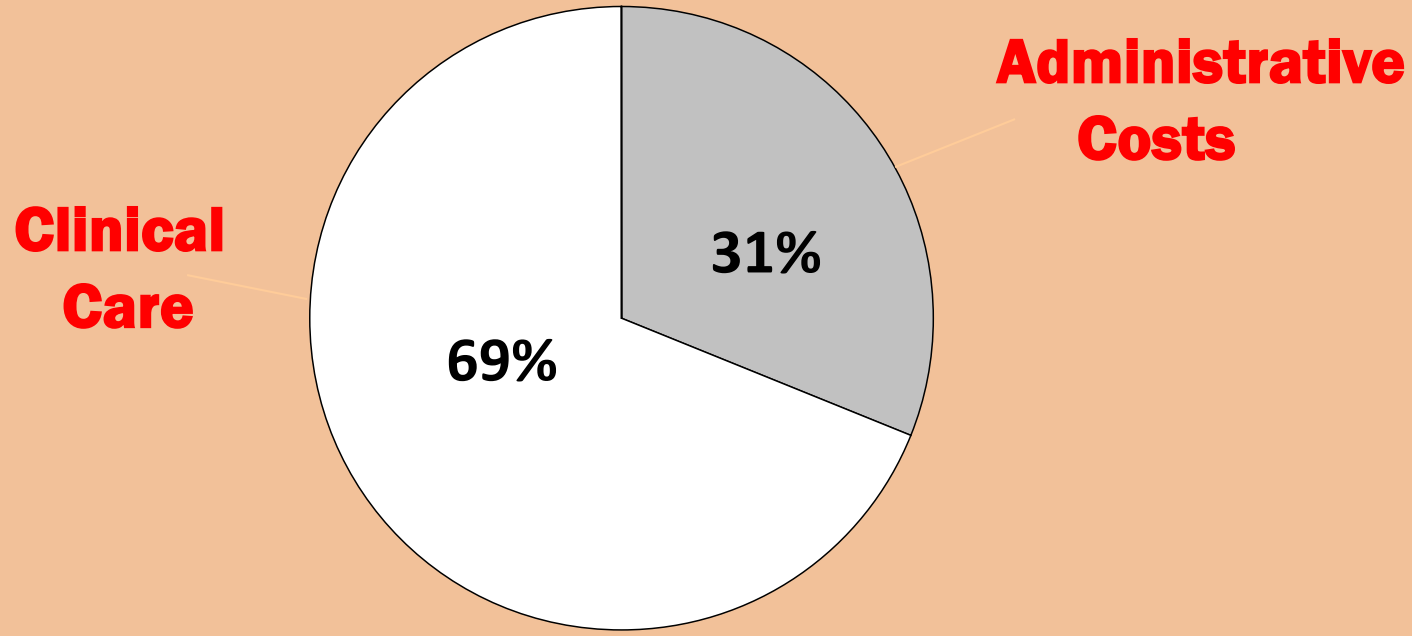
- 65% FUNDED BY TAXPAYERS
- Medicare $672 Billion
- Medicaid $566 Billion
- Private insurance and other subsidies $685 Billion
- VA System $186 Billion
- Other health programs $336 Billion
- US Military,Public health,NIH,Correctional care
- cms,cbo,va.gov

Taxes Fund 2/3 of Health Spending



Himmelstein and Woolhandler
Analysis of NCHS data

One-Third of Health Spending is Consumed by Administration



Source: Woolhandler, et al, New England Journal of Medicine, August 2003 & Int. Jrnl. Of Hlth. Services, 2004

What is the root cause of our healthcare dilemma?

- **The EXHORBITANTLY HIGH COST OF U. S. HEALTHCARE**
- Why do we pay 1.5 to 3 times more for healthcare than all other developed nations and still have…
- 30 million uninsured
- Millions more underinsured
- Relatively poor outcome measures
- Bankruptcy caused by medical debt

Why are costs so high?

- Private medical insurance premiums, copays, and deductibles
- PHARMA charges
- Hospital charges
- Provider fees
- Ancillary charges
- Absurd level of WASTE, FRAUD, and ABUSE

Health Care Waste

Current state of US Healthcare Marketplace

- We are the only developed nation that does not provide comprehensive health care to all its citizens
- 30 million Americans remain uninsured
- Many are underinsured - lack comprehensive coverage eg. long-term care & drug costs
- 45,000 die a year from lack of coverage
- Markets are good for many things, but they are not a good way to fund and access health care

Healthcare costs compared to incomes?

- According to the Milliman Medical Index in 2018 a family of 4:
- Total expenditure was $28,166
- 57% paid by the employer
- 43% paid by the employee

- 2017 U. S. median household income was $61,372 ($69,117 Co.)
- **Can the average family afford these costs?**
- **Are these costs sustainable?**
- **Can the average worker afford the full cost of health insurance?**

Future of Our Healthcare Marketplace

Current marketplace is **UNSUSTAINABLE**

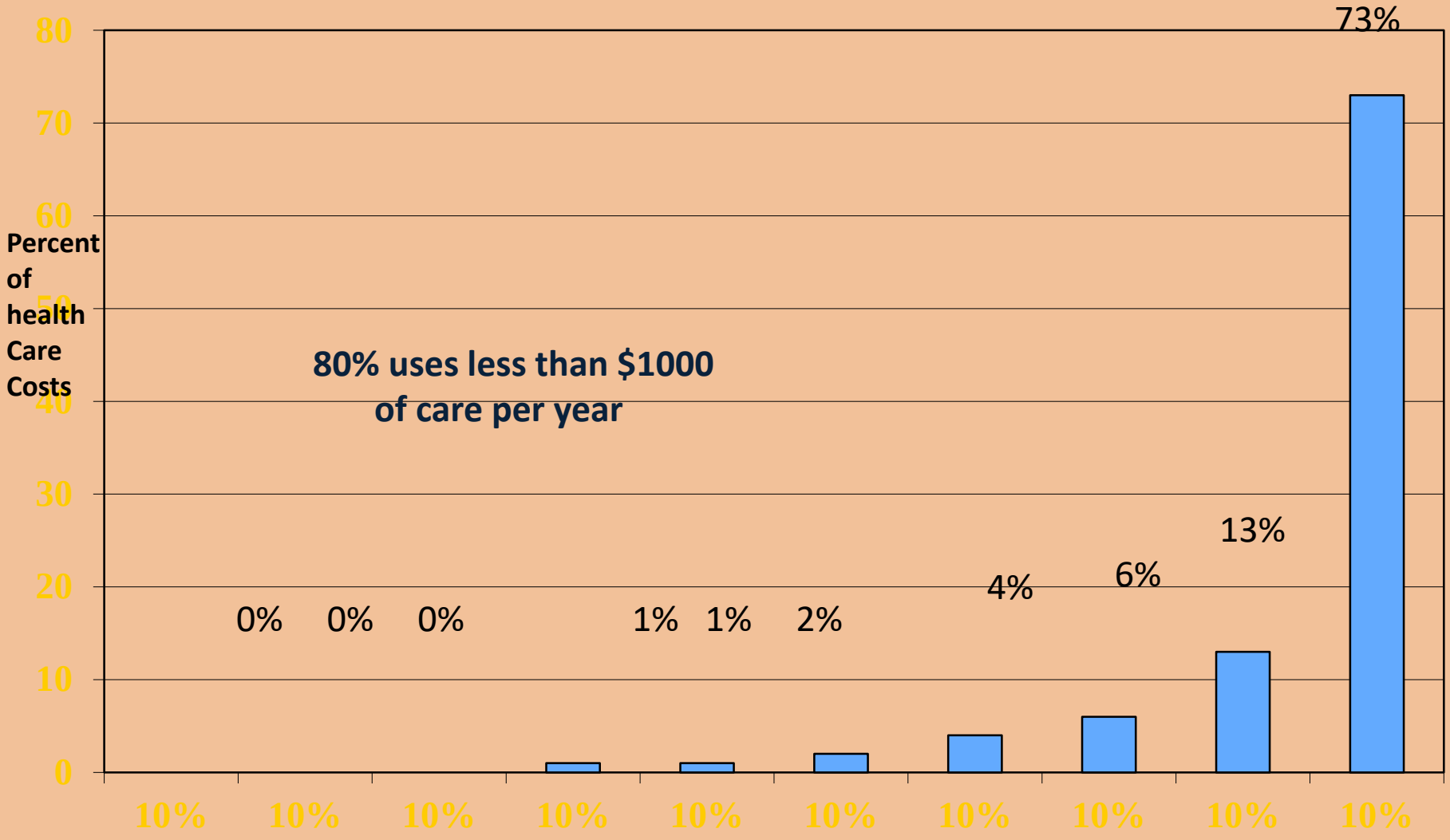
Burden it places on our economy/businesses

- Private health insurance premiums,co-pays, and deductibles are ↑ at unsustainable rate
- Far too many uninsured and underinsured
- Most expensive health care system in the world

How does a private insurance company maximize profits?

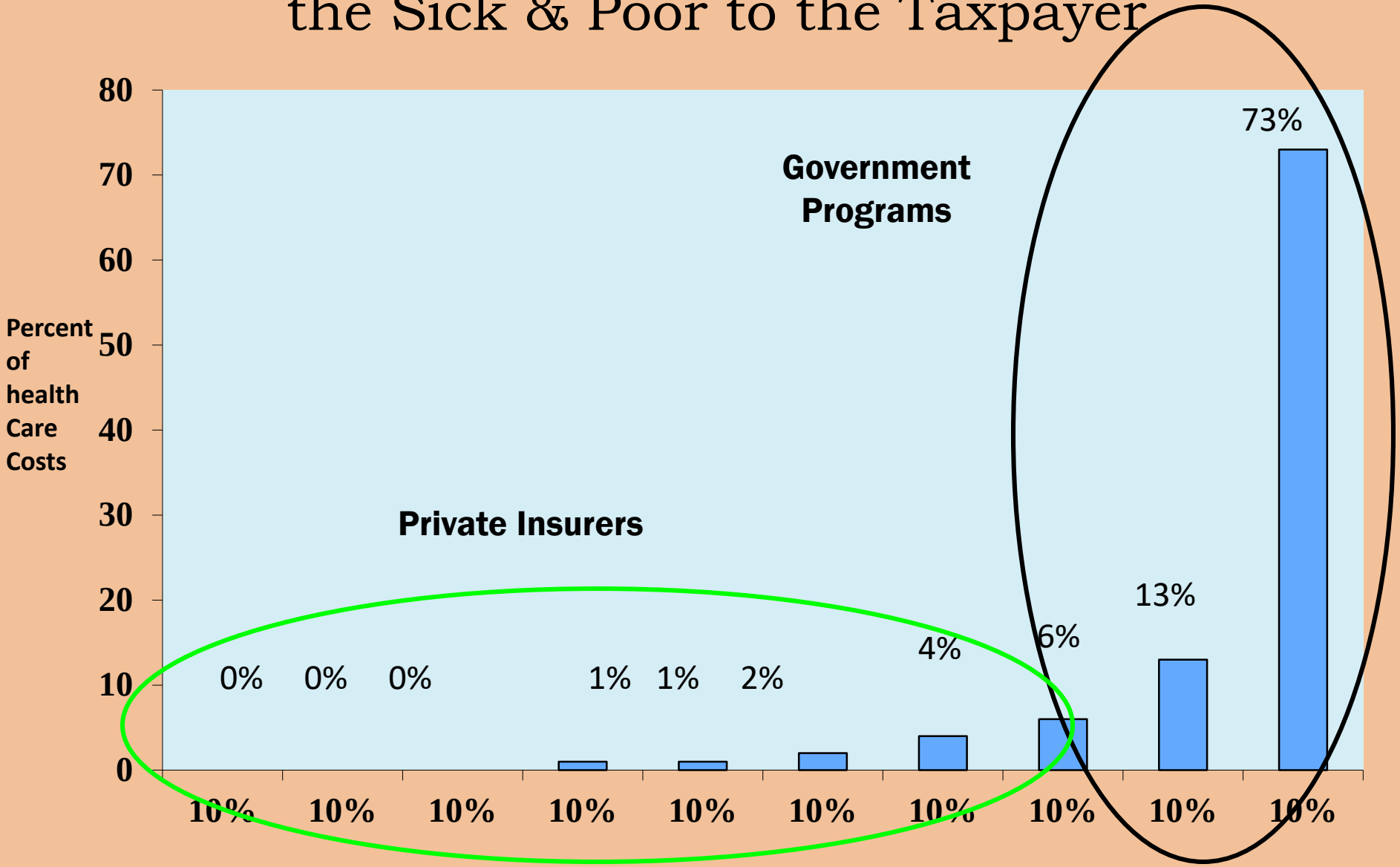
- Insure the healthy and avoid the sick
- Negotiate discounts
- Prepayment approvals
- Deny or reduce payments
- Highly controlled networks and providers
- Limited Rx drug formularies

If you were in an insurance CEO, who would you want to insure?



Source:Agency for Healthcare Research & Quality MEPS

The Health & Profitable to the "Market," the Sick & Poor to the Taxpayer



Source:Agency for Healthcare Research & Quality MEPS

What are the Attributes of the “Ideal” Health Insurance Plan?

Ideal Health Insurance

- Universal
- Comprehensive
- Portable
- Affordable
- Free choice of doctors and hospitals
- Eliminates medical bankruptcy
- Transparent and accountable to the public
- **Does private insurance meet these ideals?**

How do we attain the “ideal”?

- Pass legislation extending Medicare to all
- -improve and expand existing Medicare(all residents in risk pool)
- - dramatic reduction in administrative overhead(20 to 3%)
- - global budgets for hospitals based on actual costs
- - negotiate Rx drug costs
- - negotiate medical devices and durable goods pricing
- - set uniform reimbursement rates for all providers
- - capital spending based on need
- - transparency in quality measures and costs
- - funding through fair progressive taxes
- - cover all basic services prenatal through end of life.
- - eliminate most waste, fraud and abuse.

- What are the current proposed bills to reform health insurance in the U.S. Congress?

Public plan options (Federal Medicare)

- Keeping health Insurance Affordable Act of 2019 (Cardin)
- Choose Medicare Act (Merkley/Richmond)
- Medicare X Choice of 2019 (Bennet/Kaine/Delgado)
- The CHOICE Act (Schakowshy/Whitehouse)
- **All above plans add a Medicare Public Option to the existing PPACA market place private insurance options**
- **Keep and expands PPACA subsidies**
- **Limited to those who qualify for PPACA subsidies**
- **Premiums determined by Secretary of HHS**
- **$7,900 annualout of pocket limit**
- **Preserves employer based private insurance**
-

Medicare Buy-In for Older Adults

Medicare at 50 Act (Stabenow)

Medicare Buy-In and Health Care Stabilization Act of 2019

- Both prohibit those who qualify for Medicaid
- Allows Medicare Advantage as an option
- Cost sharing as in current Medicare

Medicaid Buy-In

- State Public Option Act (Schatz/Lujan)
- Limited to those eligible for PPACA Marketplace
- Premiums set by states
- $7,900 out of pocket 2019 limit

“Mislabeled” Medicare for All shortcomings

- Preserves private insurance marketplace
- Will cover a disproportionate share of the sicker more costly patients
- Burden of this increased cost placed on taxpayers
- Must be renewed yearly
- Those insured through their employer excluded
- Leaves many uninsured

A National Health Program for the U.S.

Expanded and improved Medicare for All

H.R. 1384 Medicare for All Act of 2019 Introduced by Rep Jayapal (108 co-sponsors)

S. 1129 Medicare foe All Act of 2019 Sen Sanders(14 co-sponsors)

Both Bills build on success of current traditional Medicare Program

HR 1384 Medicare for All Act of 2019

- Expanded to include all individuals residing in the United States
- Improved by:

  Eliminating Premiums, Copays, and Out-of-Pocket Expenses
  - Completely covering all necessary care for all beneficiaries **including long-term care,dental,vision, and hearing care**
  - Reforming payment systems to encourage accountable care and equitable compensation for physicians and institutions.
  - Allowing for planned expansions of healthcare infrastructure based on community need rather than profitability.

Eligibility and Benefits

- Can patients choose their health care providers?
  - "Benefits will be available through any licensed health care clinician and any hospital in the United States that is legally qualified to provide the benefits."
- What will patients be charged for covered services?
  - "No deductibles, copayments, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits"
- The bottom line:
  - There will be no financial or administrative barriers preventing patients from accessing care from the physician and hospital of their choice.

Qualification of Participating Providers

- Who will be the participating providers?
  - Public, Non-Profit and For-Profit Healthcare Institutions
  - Private physicians, private clinics, and private healthcare providers
  - Health Maintenance Organizations (HMOs) that deliver care in their own facilities, and employ clinicians on a salaried basis.

Prohibition Against Duplicating Coverage

- **It will be unlawful for any private health insurer to sell health insurance coverage duplicating the benefits provided under the Act.**
- Insurance coverage may be sold for additional benefits not covered by the act.

How will providers be paid?

- Institutional Providers will receive a monthly lump sum based on their annual budget.
  - "The budget shall be negotiated annually, based on past expenditures, projected changes in levels of service, wages and input, costs, a providers maximum capacity to provide care, and proposed new and innovative programs"

How will individual providers be paid?

- 1. Fee for Service
  - Physicians will submit bills to the regional directors and will receive interest on any balance not paid within 30 days.
- 2. Salaries within Institutions Receiving Global Budgets
- 3. Salaries within Capitated Groups
  - HMO requirement: Physicians will be reimbursed based on a salary and may not receive financial incentives tied to utilization.

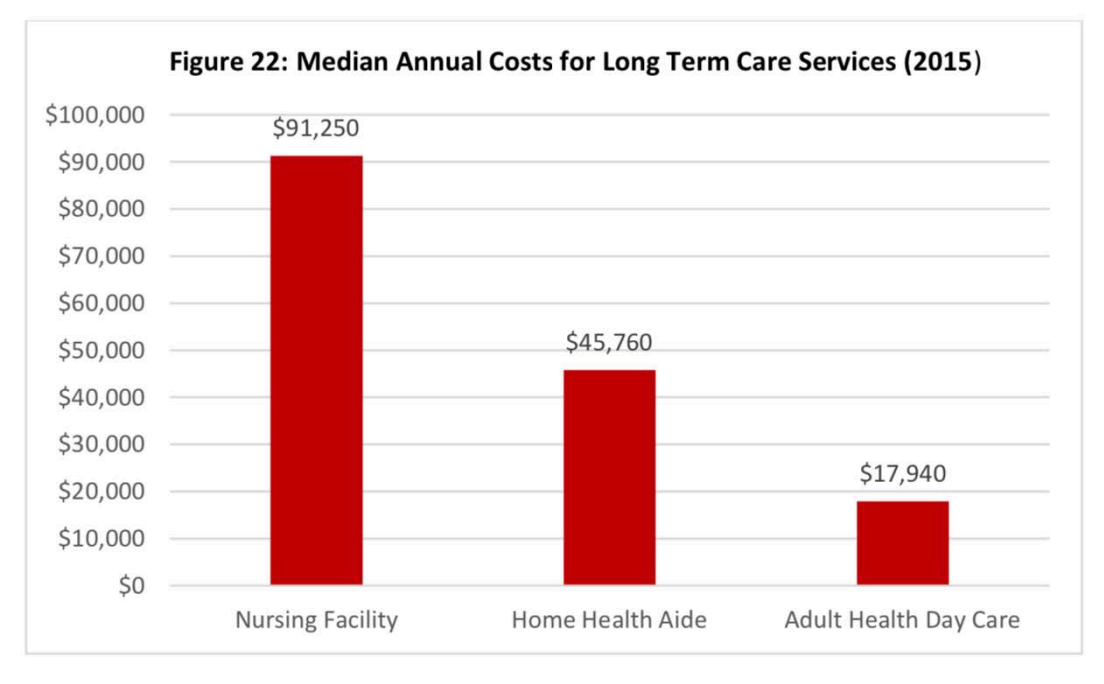
Budgets for other Services

- **Long Term Care**
  - **Regional budgets will include long term care including in-home, nursing home, and community-based care.**
- Mental Health Services
  - Licensed mental health clinicians will be paid in the same manner as other health professionals.
- Medications, Medical Supplies, and Assistive Equipment
  - Prices to be paid each year will be negotiated annually.
  - Formulary will promote the use of generics but allow the use of brand-name and off-formulary medications.
  - Patients and Physicians will have the right to petition to have drugs added to or removed from the formulary.

What additional costs will be incurred?

- Elimination of co-pays and deductibles
- Expanded coverage to 30 million
- Increased utilization by those underinsured
- Increased Medicaid provider payments
- Funding expanded benefits
- 1%/yr. for 5 years for retraining displaced workers

Largest additional cost



- Can we afford expanded and improved Medicare for All and how can we pay for it?

Universal Health Care Might Cost You Less Than You Think

We don't think of the premiums we already pay as taxes, but maybe we should.

By Matt Bruenig

The New York Times, April 29, 2019

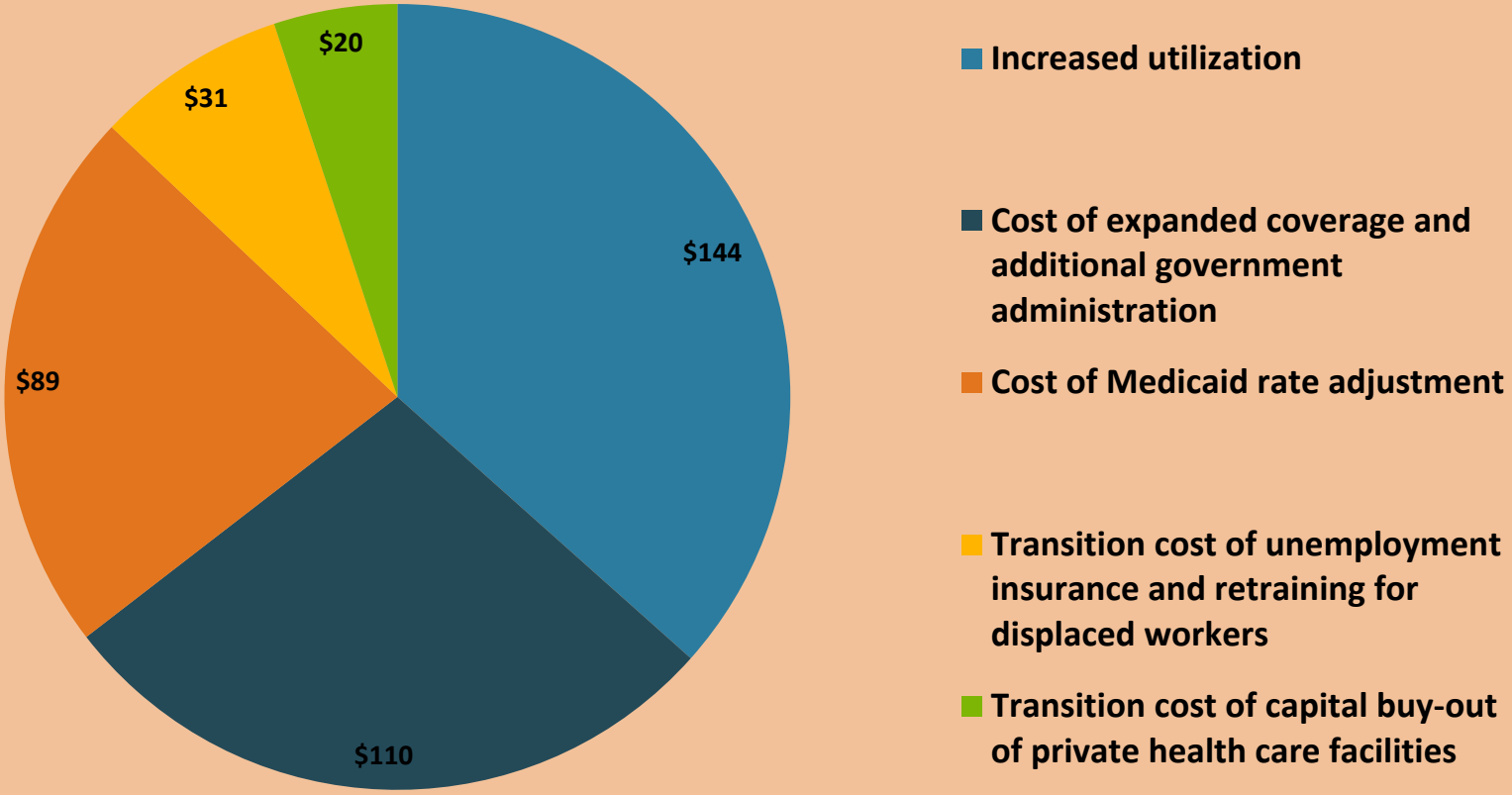
Cost Savings from Medicare for All?

- Cost savings from current marketplace by
- Elimination of:
- Private insurance premiums, co-pays, and deductibles
- Out of pocket dental, vision,hearing and long term care costs
- Medicare Advantage payments and subsidies
- Need for supplemental Medicare insurance
- Marketing, billing, and collecting administrative overhead
- PPACA subsidies and administrative overhead
- Tax deductions for private insurance premiums
- **Most of our current waste, fraud, and abuse**
-

Sustainable Quality Health Care
Single Payer is not *an* Answer, it is *the* Answer

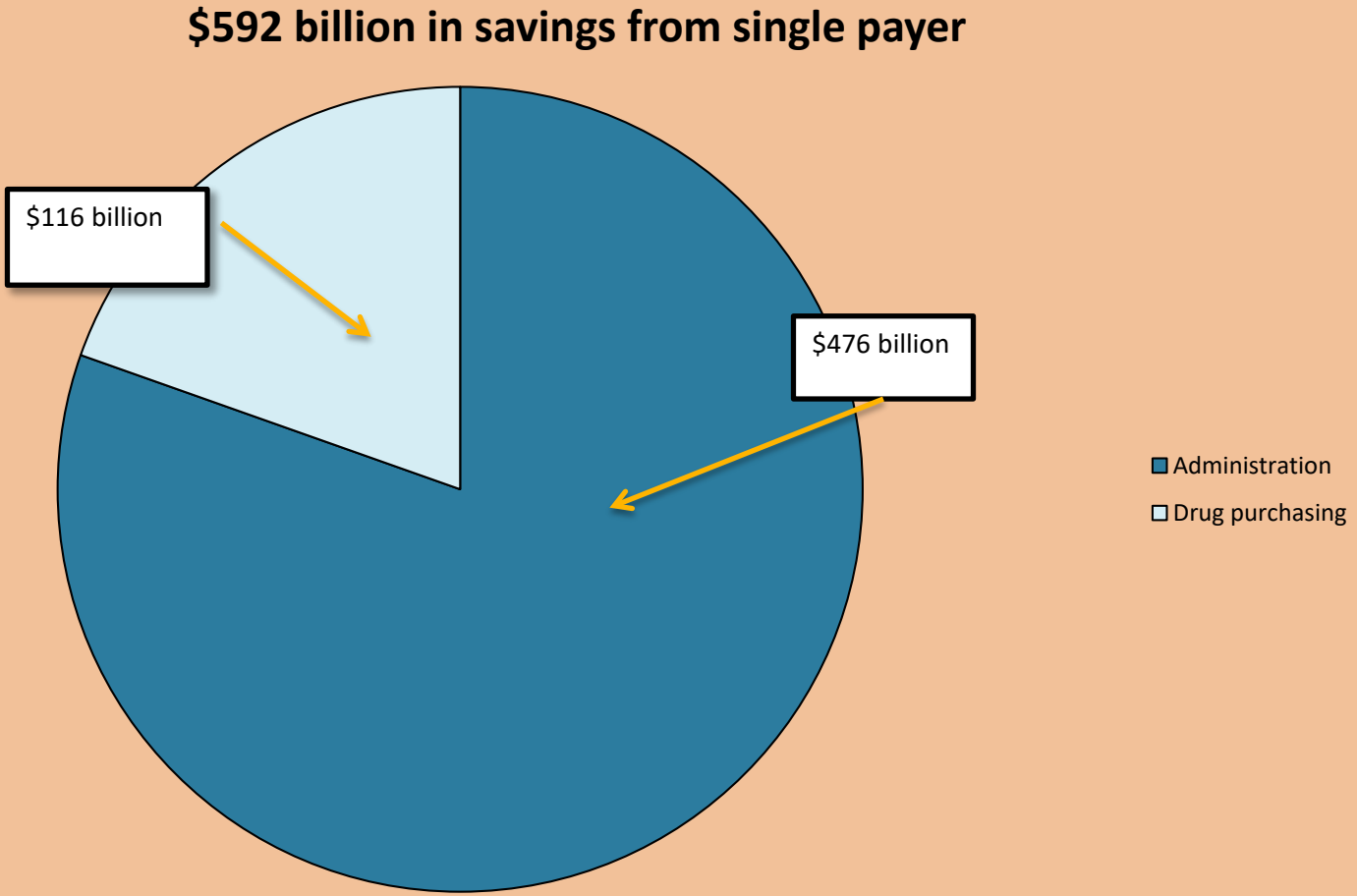
Gerald Friedman
Professor of Economics
University of Massachusetts at Amherst
July 29, 2013
gfriedma@econs.umass.edu
Twitter: @gfriedma

Program Improvements with HR 676,) 2014 **(Added costs)**



$394 in extra spending

Savings from HR 676



New, Progressive Revenues

Tobin tax of 0.5% on stock trades and 0.01% per year to maturity on transactions in bonds, swaps, and trades.	$	442
6% Surtax on household incomes over $225,000	$	279
6% tax on property income from capital gains, dividends, interest, profits, and rents	$	310
6% payroll tax on top 60% with incomes over $53,000	$	346
3% payroll tax on bottom 40% with incomes under $53,000	$	27
Total additional revenues	$	1,404
Net surplus for deficit reduction	$	154

Bottom Line:

HR 676 (Improved Medicare-for-All) can be funded

- ***In 2014:***
  - ***Saves $592 billion in wasteful administrative spending and excessive drug prices***
  - ***After $394 billion in system improvements, saves nearly $200 billion***
  - ***Local and state governments save $283 billion in Medicaid and employee health benefits***
  - ***95% would save money***
- ***Over decade***
  - ***Funding program for would produce $3 trillion in federal deficit reduction***
  - ***State and local governments save $5 trillion***
  - ***Health care spending falls by over $8 trillion***

How do we fund Medicare for All?

- Revenues from:
- Existing federal and state Medicaid funding
- Progressive taxes on individuals/employers/ corporations
- Cost savings from:
- Global based budgeting of institutions
- Control of capital expenditures
- Rx drugs formulary and price negotiations
- Uniform controlled reimbursement for all providers
- Decreasing waste in the provision of medical care
- Increased prosecution of Medicare fraud

•

Economic Analysis of Medicare for All

BY ROBERT POLLIN, JAMES HEINTZ, PETER ARNO,
JEANNETTE WICKS-LIM, AND MICHAEL ASH

TABLE 27
Distribution of U.S. Health Insurance Coverage, According to *Primary Type* of Coverage, 2016

Primary coverage type	Percentage of population with primary coverage type	Total population with primary coverage type
Employer private	49%	162 million
Non-group private	7%	23 million
Medicaid	19%	63 million
Medicare	14%	46 million
Other public	2%	7 million
Uninsured	9%	30 million

Source: Kaiser Family Foundation. Health Insurance Coverage of the Total Population (2016).

TABLE 15
Overall Cost Saving Potential through Medicare for All Health Care System

Categories of spending	Cost saving within spending categories as share of total consumption expenditures
Structural categories	
Administration	9.0%
Pharmaceutical pricing	5.9%
Medicare rates for all providers	2.8%
Service delivery categories	
– Unnecessary services – Inefficiently delivered services – Missed prevention opportunities – Fraud	1.5% in Year 1
Total savings potential	19.2%

TABLE S1
Key Assumptions for Estimating Overall Costs of Medicare for All

1) Overall increase in health care demand through universal coverage	**12.0%**
Sources of system-wide cost savings	
2) Administrative restructuring	9.0%
3) Pharmaceutical price reductions	5.9%
4) Uniform Medicare rates for hospitals and physicians/clinics	2.8%
5) Improved service delivery/reduced waste and fraud	1.5%
6) Total cost savings *(= rows 2+3+4+5)*	**19.2%**

Sources: See Tables 8 and 15.

TABLE S2
Impact of Demand Increases and Cost Savings on Overall Health Care Costs

1) Actual health consumption expenditures in 2017 *(figure is exclusive of public health budget)*	$3.24 trillion
2) Health consumption expenditures with universal coverage and existing system *(with 12.0 percent increase in demand)*	$3.63 trillion *(=row 1 x 1.12)*
3) Total cost savings through Medicare for All provisions	19.2%
4) Health consumption expenditures with universal coverage and total cost savings	$2.93 trillion *(= $3.63 trillion x 0.808)*

TABLE S1
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3) Total cost savings through Medicare for All provisions	19.2%
4) Health consumption expenditures with universal coverage and total cost savings	$2.93 trillion *(= $3.63 trillion x 0.808)*

TABLE S3
Additional Public Revenues Required to Finance Medicare for All, 2017

1. Cost of full universal coverage under Medicare for All	$2.93 trillion
2. All current public sources of financing	$1.88 trillion
3. Additional financing required *(= rows 1 – 2)*	$1.05 trillion

Sources: See Tables 16 and 18.

TABLE S4
Revenues Generated through Four Proposed Funding Sources

Revenue sources	Revenue generated	Percentage of total revenue generated
1. Revenues from businesses *(= rows 2 + 3)*	$623 billion	57.6%
2. Premiums at 8% cut relative to current premiums	$615 billion	56.9%
3. Coverage for previously uncovered employees – *$500 per uncovered worker* – *Exemptions for small businesses*	$8 billion	0.7%
4. Revenues from individuals/families *(= rows 5 + 6 + 7)*	$458 billion	42.4%
5. Sales tax at 3.75% on non-necessities only – *Exemptions for current Medicaid-eligible families*	$196 billion	18.1%
6. Net worth tax at 0.38% – *Exemptions for first $1 million of net worth*	$193 billion	17.9%
7. Taxing long-term capital gains as ordinary income	$69 billion	6.4 %
TOTAL REVENUE	**$1.08 TRILLION**	**100%**

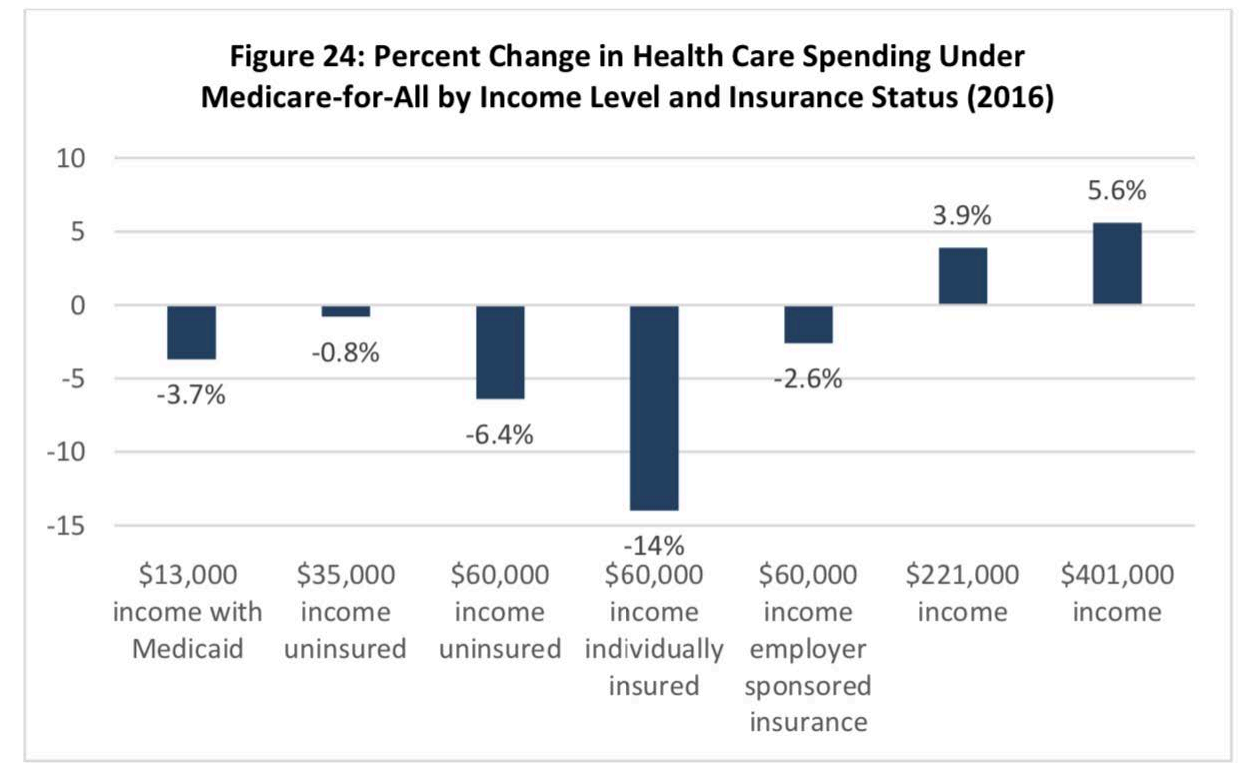
Source: See Appendix 4.

TABLE S8
Summary Figures: Comparative U.S. Health Consumption Expenditure Projections, 2017 – 2026

CMS Projection of cumulative Health Consumption Expenditures under existing system	$42.90 trillion
PERI projection of cumulative Health Consumption Expenditures under Medicare for All	$37.79 trillion
Cumulative 10-year savings through Medicare for All	$5.11 trillion
Cumulative 10-year savings, as % of cumulative GDP	2.1% of GDP

Source: See Table 39.

Who are the winners and losers?



Public Opinion Favors Single Payer National Health Insurance

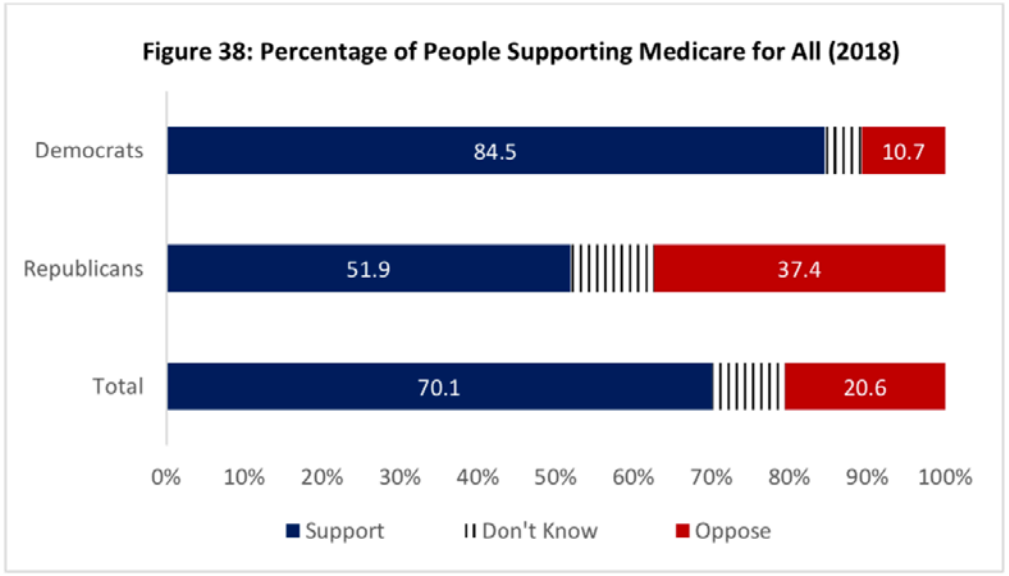
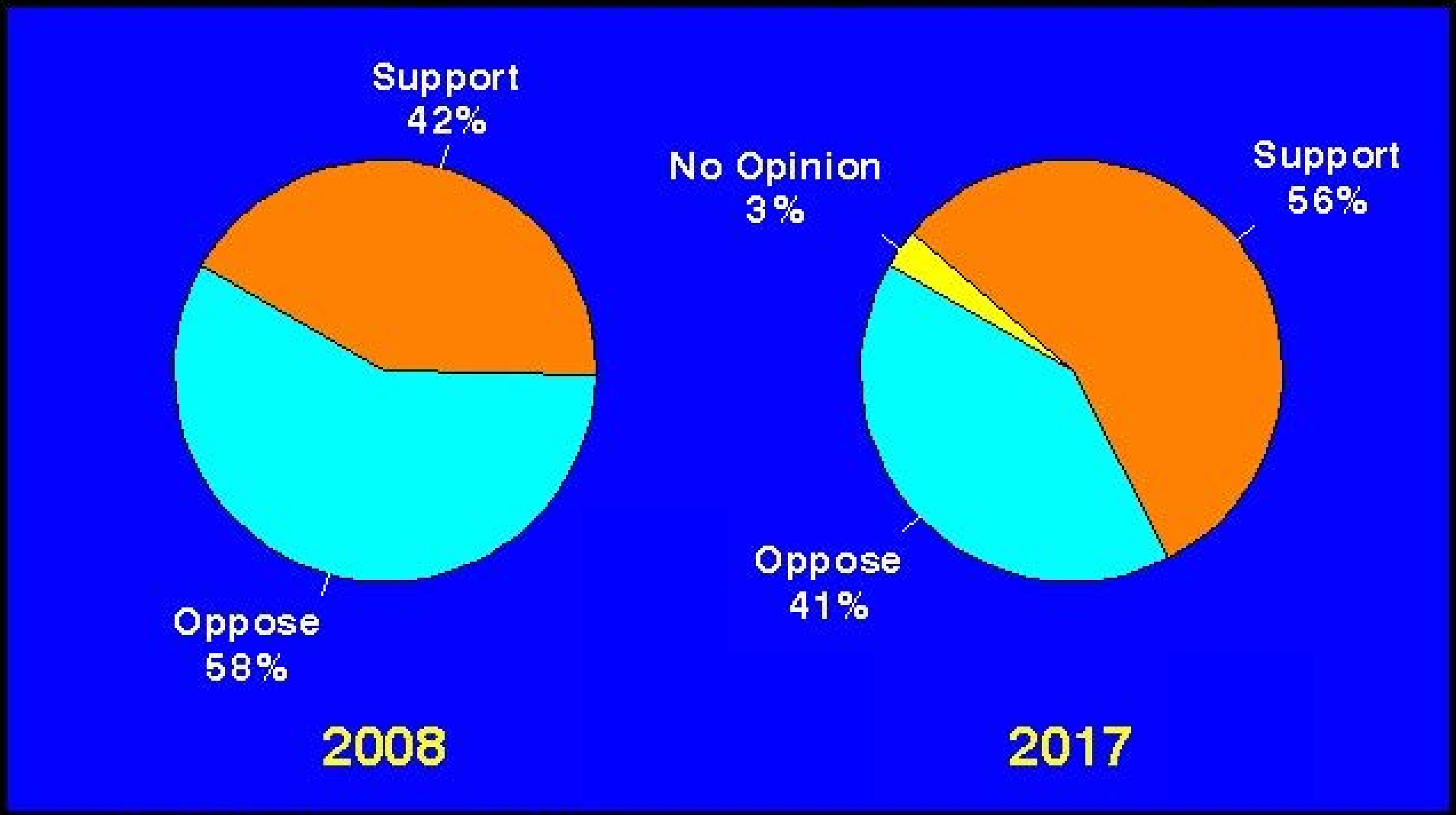


Figure note: Survey was of a random sample of nearly 3,000 American adults between June and July 2018.[232]

Most Doctors Favor Single Payer

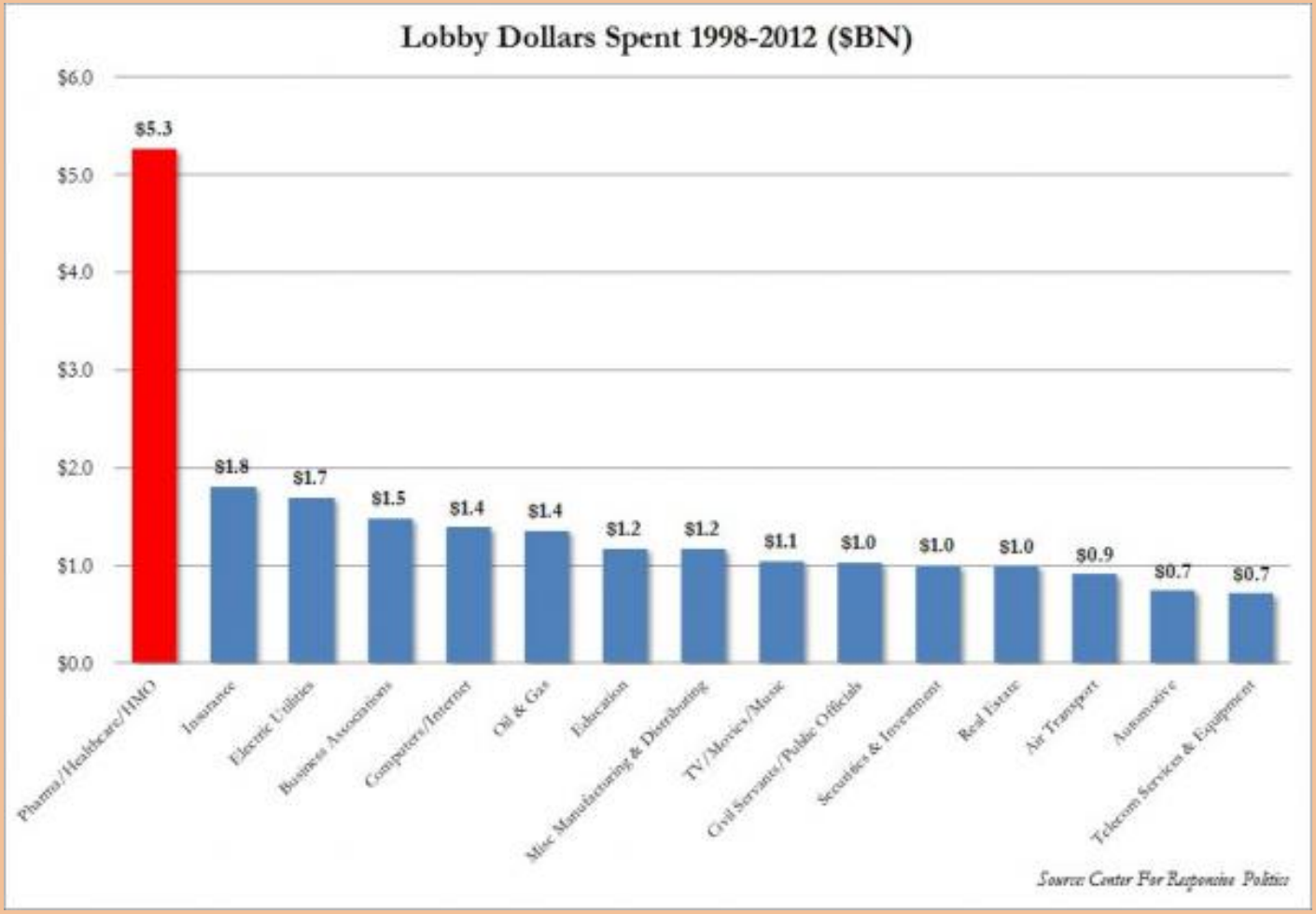
Support Has Sharply Increased



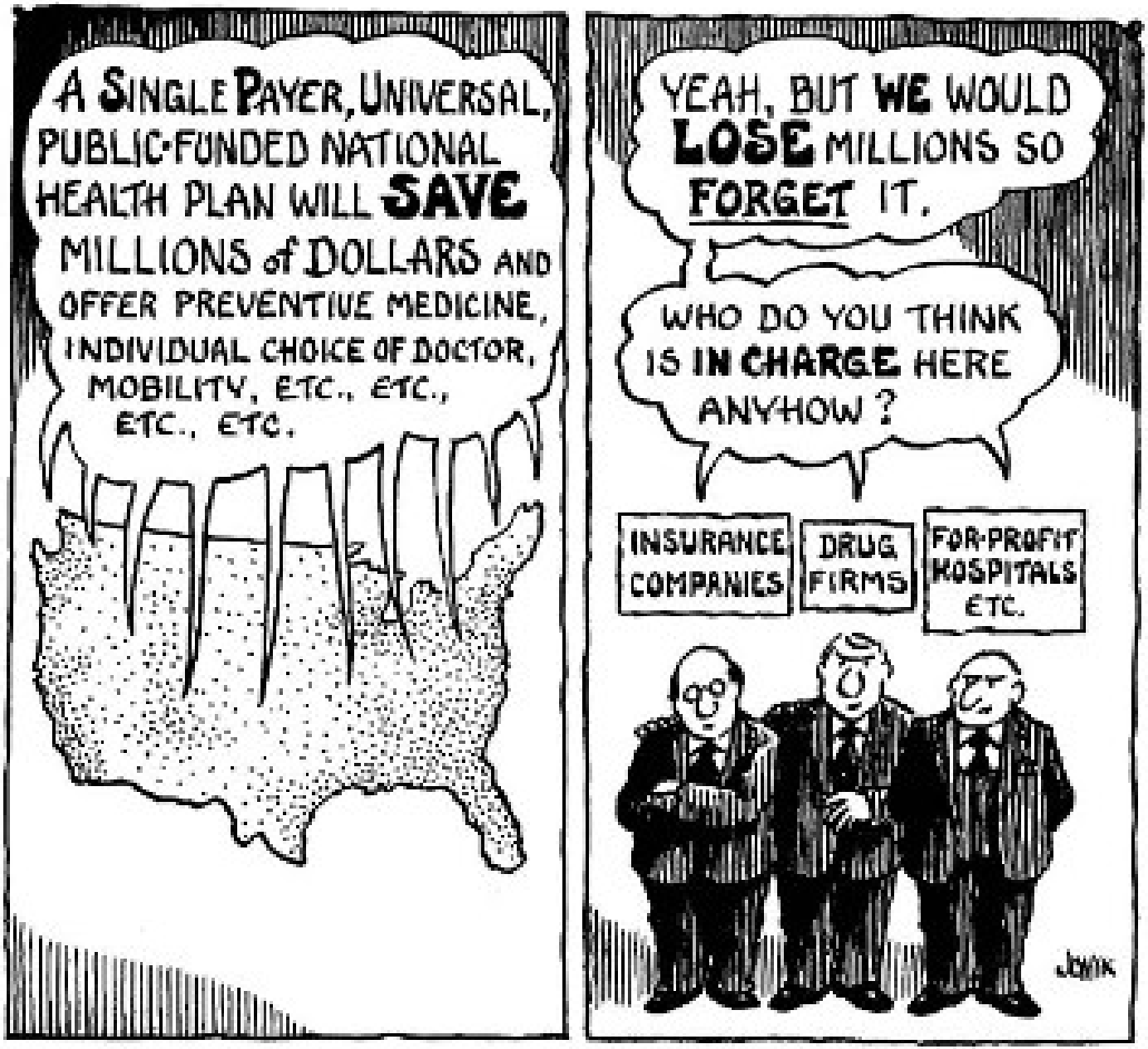
Source: Merritt Hawkins surveys of physicians

Impediments to Healthcare Reform

- SPECIAL INTEREST (Medical Industrial Complex) DOLLARS
- What many consider waste and abuse they consider salary and profit
- Huge contributions to legislators
- Unwillingness of our legislators **to work together for the public good.**


Lobby Dollars Spent 1998-2012 ($BN)
$6.0
$5.0
$4.0
$3.0
$2.0
$1.0
$0.0
$5.3
$1.8
$1.7
$1.5
$1.4
$1.4
$1.2
$1.2
$1.1
$1.0
$1.0
$1.0
$0.9
$0.7
$0.7
Pharma/Healthcare/HMO
Insurance
Electric Utilities
Business Associations
Computers/Internet
Oil & Gas
Education
Misc Manufacturing & Distributing
TV/Movies/Music
Civil Servants/Public Officials
Securities & Investment
Real Estate
Air Transport
Automotive
Telecom Services & Equipment
Source: Center For Responsive Politics


TOO PIG TO FAIL
HEALTH INSURANCE INDUSTRY
CONGRESS
'REFORM'
©2011 MORIN


A SINGLE PAYER, UNIVERSAL, PUBLIC-FUNDED NATIONAL HEALTH PLAN WILL SAVE MILLIONS of DOLLARS AND OFFER PREVENTIVE MEDICINE, INDIVIDUAL CHOICE OF DOCTOR, MOBILITY, ETC., ETC., ETC., ETC.
YEAH, BUT WE WOULD LOSE MILLIONS SO FORGET IT.
WHO DO YOU THINK IS IN CHARGE HERE ANYHOW?
INSURANCE COMPANIES
DRUG FIRMS
FOR-PROFIT HOSPITALS ETC.
JOHN

In 1965, our parents and grandparents created Medicare and began to create a healthier, more productive America.

Let’s finish their work.
HR 1384: costs less today, costs less tomorrow, covers everyone

What can I do to help “fix” our broken dysfunctional health care marketplace?

- Educate your friends and neighbors
- Continue to educate yourself on this issue
- Join and support Healthcare for All Colorado (HCAC)
- Join and support Physicians for National Health Program (PNHP)
- Lobby elected officials and representatives
- Question and push back against excessive charges and abuses in the system

Internet Educational Resources

- www.healthcareforallcolorado.org
- www.kaiserhealthnews.org
- www.commonwealthfund.org
- www.don@mccanne.org (daily healthcare blog)
- Physicians for a National Health Program
  www.pnhp.org
- Health Care for All Colorado Foundation
  www.hcacfoundation.org

Questions/Comments?


10 T
The U.S. HEALTH CARE SYSTEM
WE TRIED EVERY FIX THE INSURANCE COMPANIES ALLOW BUT IT STILL WON'T FLY!