Give ‘Em Health Revisited: Medicare for All

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2007 Mother’s Day Report
# Table of Contents

Acknowledgements .................................................. 4
A Message from OWL’s President ................................. 5
Executive Summary .................................................. 7
Introduction ............................................................. 9
Rising Costs, Shrinking Coverage ................................. 10
   *The Decreasing Number of Insured People*
   *The Health and Financial Consequences of*
   *Rising Costs and Shrinking Coverage*
   *America Spends More and Receives Less for*
   *Our Health Care Dollar than Any Other*
   *Advanced Country*
   *Who Benefits? Insurers, Drug Companies, and CEOs*

America Wants to Cover the Uninsured (And We Can) ........ 17
   *Medicare Avoids Most Nonbenefit Costs*
   *Universal Health Insurance Provided by Medicare—*
   *A Winner for All*
   *Savings by Medicare Could Generate the Funds to Help Cover All*
   *Proposals to Achieve Universal Coverage*

WARNING: Conditions and Choices Add Nonbenefit Costs .... 27
   *Means-Testing Adds Costs*
   *Tac Breaks and Subsidies Add Costs*
   *Provider and Insurer Conflicts Add Costs*
   *Cost Savers*
   *Medicare is More Transparent than Private Insurance*
   *Medicare-for-All: The Proposal Most Ready to Go*

OWL Supports Medicare-for-All .................................. 30
Real Voices: Americans Speak Out about Health Care ........ 31
Endnotes ................................................................... 32
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A Message from OWL’s President

Ellen A. Bruce, May 2007

Happy Mother’s Day!

OWL, the voice of midlife and older women, each year welcomes Mother’s Day as an important opportunity to highlight issues of great concern to women, families, and our country. This year we focus our attention on the national crisis created by our current health care system. As you will read in this report, the statistics on coverage, cost, and access are startling and reflect one of the most important challenges we now face as a nation.

Since the last attempt to bring universal health care to the American public in the early 1990s, health care costs have brought most of us to our knees. None are excluded from this explosion: individuals, families, small business owners, major corporations, and every level of government—local, state, and federal—face increased health care costs. Many struggle with reduced access and lack of affordability in the quagmire of our existing system of care.

Universal, affordable, and high-quality health care has been a top priority of OWL since the organization was launched in 1980. Following a mini-White House Conference on Aging, OWL’s founders, Tish Sommers and Laurie Shields, were appalled by the absence of consideration for the unique experiences women face in midlife and as they age. These pioneering women inspired hundreds of others to address the realities of women’s circumstances through education and advocacy. And so OWL was born. Seven years later, OWL issued a Mother’s Day report calling for universal health care, titled Give ’Em Health. The title of this year’s report, Give ’Em Health Revisited: Medicare-For-All, reflects the 20th anniversary of OWL’s national campaign to bring universal health care to our country.

Universal, affordable health care coverage is long overdue. This year’s Mother’s Day report highlights the crisis and proposes the changes we must embrace with courage and certitude. It can be done.

It is up to us to make it happen.

Ellen A. Bruce
President
OWL, the voice of midlife and older women
Executive Summary

Modern American medicine is mostly a marvel. America’s health insurance “system” is mostly a mess. Insurance is vital to assure access to necessary medical care—including preventive programs—because none but the wealthiest can afford medical care without it.

Americans do not have to look far for a model that works. We already have a nearly universal system of insurance for two groups of Americans—those age 65 and over and those receiving Social Security Disability Insurance (SSDI). It provides comprehensive coverage, minimizes nonbenefit costs more than any other health insurance, and is embraced by most Americans. It is called Medicare.

OWL advocates adopting a universal system of health insurance for all ages provided by Medicare as the most practical way to assure access. The savings such a program could generate when mature would pay for covering all. Those savings would come from eliminating unnecessary nonbenefit costs now incurred by health care providers, insurers, and federal and state governments as they administer the current chaotic “system.” Additional measures, such as computerizing records, eliminating provider conflicts of interest, and energetic efforts to identify the usefulness of treatments can produce savings.

Medicare has proven that it can bring patients, private health care providers and insurers together at low cost, and it has done so at a fraction of the cost of private insurance. It has addressed the thousands of issues that inevitably arise in a nationwide health care program. Medicare can be readily expanded to cover everyone, because all the essentials are already in place. And the program preserves the choice Americans most value: the choice of doctor.

Today’s patchwork of privately and publicly funded health care insurance fails all Americans outside of Medicare and society as a whole. Employment-based coverage, the basis for private American health insurance coverage for over 50 years, is crumbling.

- Cost is the single greatest barrier to health care insurance coverage.
- Nearly 47 million Americans lack health insurance in 2007. At one time or another in a two-year period, over 60 million lacked continuous coverage or were considered underinsured. As a result, nearly 100 million Americans are at risk of not having medical care insurance when it is needed. Of our country’s 93 million women ages 18 to 64, 19 percent are uninsured.
- As many as 50 percent of American bankruptcies may involve medical care costs. Of those, about 76 percent of the bankrupt individuals were actually insured at the time of the bankrupting illness.
- When a medical need arises, those without coverage often end up in hospital emergency rooms for medical care that is more costly, less effective, and more burdensome to society than regular, timely medical care.
- Americans pay more on a per capita basis for health care, receive less care, and experience less satisfactory health outcomes than those in other advanced countries with universal health care systems.
- Federal, state, and local governments find that medical care coverage for their employees, Medicaid, and other needs-based programs consume an ever-larger share of their budgets.
- Businesses find that the increased cost of health care coverage increases the cost of American products, which hurts the nation’s competitive edge.
- Increased costs result also in higher deductibles and co-pays for covered individuals.

Our current patchwork of public and private plans drives up nonbenefit costs. Doctors’ offices, hospitals, clinics, laboratories, and insurance and drug companies spend millions of clerical hours to match billions of billings with thousands of differing plan
provisions. Insurers spend billions more to advertise and pay commissions. Altogether, administrative and other nonbenefit costs can consume one-third or more of the private employment-based health care dollar. Means-tested public programs such as Medicaid require repeated determinations of eligibility which boost administrative costs to almost 7 percent.

The traditional Medicare program, Parts A and B, provides comprehensive medical care by the beneficiary’s provider of choice to those age 65 and older and to those eligible for SSDI. The simplicity of its administration holds nonbenefit costs to 2 percent or less.

Adopting a single insurance system for everyone under Medicare would trim billions of nonbenefit costs incurred by providers, businesses, insurers, and governments annually by:

- substituting one billing regime for the thousands providers and insurers must now use;
- eliminating advertising and commission costs;
- eliminating business expenses to explore, install, oversee, and make changes in employee plans;
- eliminating the administrative costs of public needs-based health care programs.

The Medicare infrastructure is up and running. There is no need to start up a giant new entity or attempt to patch a crumbling private system. Medicare currently uses private insurers as “intermediaries” for each region to receive medical bills from Medicare and process the claims. This cost is included within Medicare’s 2 percent administrative costs. Private insurers could continue to serve as Medicare intermediaries without additional administrative cost.

The country wants health insurance coverage for all. As a result, many proposals to provide or require more, most, or all of us to have health insurance have sprung up. Two proposals would expand Medicare coverage to all without competing private plans. Others propose a mix of private and public health insurance, mandates, subsidies, needs-testing or phase-ins.

Some proposals to extend medical care insurance package themselves under the Medicare banner. They use various stratagems to appear to address the crucial problem of costs. But those stratagems—“competing” plans, needs-testing for many plan features, tax breaks, subsidies, and phase-ins—do not, in reality, reduce costs; they only appear to do so. In sober fact, they add so many administrative tasks that they actually increase total cost.

To assess the cost, coverage, and feasibility of any plan that combines Medicare coverage with other public or private insurance, we must recognize that every condition a program places on the receipt of coverage adds nonbenefit costs:

- every test for eligibility or means-testing add costs;
- every subsidy or tax break to make coverage appear more affordable adds costs;
- every step to determine the amount of subsidy adds costs;
- every measure to compel compliance or to determine whether compliance should be waived adds costs; and
- every additional competing plan adds costs.

Not only do they add nonbenefit costs, they defeat the savings that can get us closer to covering everyone. Many financial analyses show that a universal system of health insurance for all ages provided by Medicare is the plan that can generate the most savings, which can in turn be used to provide coverage for all. Some experts project savings sufficient to cover the cost of assured medical care for everyone without additional outlays by business, government, providers, and individuals.

OWL advocates real Medicare for real people. Other proposals that get to Medicare for All step by intermediate and costly step are second best. Medicare could provide the largest amount of savings of all proposals. It might even save enough to pay for covering everyone.

LISTEN TO YOUR MOTHER: Give ’em health. Give ’em Medicare.
Introduction

OWL believes that assured and affordable health care is a necessity, a fundamental right, not a privilege. Yet the unduly costly hodgepodge of American health care insurance fails millions and constitutes one of the nation’s most serious challenges.

Imagine the confusion we would face if electric appliances used thousands of differently shaped plugs, each requiring a matching socket. That is the state of our health care “system.”¹ Health care insurance coverage is now provided by a chaotic mix of employer plans, public programs at the federal and state level, and individually purchased coverage. Employers must expend energy and funds to explore and monitor coverage alternatives for their employees. Doctors’ offices, hospitals, labs, and other providers must match their billions of billed services with thousands of differing insurance plan provisions and those of public programs. These determinations are costly and do not contribute to improved health. Advertising and commissions, the hallmarks of “competition,” add to the nonbenefit costs of private health insurance.² As plan costs skyrocket, the number of people with coverage shrinks. Nonbenefit costs of health care providers and insurers are beginning to receive the critical attention those vast outlays merit.

Most persons over age 65 and those who qualify for Social Security Disability Insurance (SSDI) make up the only segment of the population entitled to comprehensive and assured medical care through Medicare. If the nation were to pool all of its medical expenditures, both public and private, into Medicare-for-All, not only could we as a nation afford to provide assured and affordable medical care for all Americans, we also could improve that care.³
Rising Costs,
Shrinking Coverage

While American medicine is mostly a marvel, American medical insurance is a mess. Individuals, businesses, and governments pay an increasingly large share of their resources for America’s fragmented health care “system.” But about one-third of health care dollars don’t pay for actual health care: 20 percent go to insurers; 12 percent go for administrative burdens on hospitals and providers who must deal with differing drug formularies, insurance provisions, and forms for over 1,000 different insurers, each with multiple plans.4

In addition to the overhead of private insurance companies, there is “an enormous amount of paperwork required of doctors and hospitals that simply doesn’t exist in countries with [universal systems].”5 “The average provider—doctors or hospitals—has between 5 and 100 reimbursement rates for the exact same procedure...[A] hospital chain may have 150 rates for the same procedure.”6

One gleans insight into a major cause of our rising costs by comparing the growth in the number of doctors to the growth in the number of health care administrators between 1970, the baseline, and 2006, by which time the number of physicians grew by less than 200 percent but the number of administers grew by about 2500 percent (see chart 1).7

Nonbenefit costs are not the only cause of increasing medical care costs. Improved technology in the prevention and treatment of injury and disease also contribute; but they can also mitigate the damage of disease and injury.8

As costs escalate, ever more millions of Americans lack coverage as companies eliminate or shrink employee and retiree health plans and increase deductibles and co-pays for employees.9 In five years, the percentage of employers offering health insurance coverage to their employees fell by 9 percent, from 69 percent in 2000 to 60 percent in 2005.10

Medical care cost increases in job-related coverage have outpaced increases in family income. Between 1992-93 and March 2003, the average monthly contribution required of employees for health insurance premiums rose about 75 percent.11 Increases in deductibles, physician and hospital co-payments, and co-insurance also added to out-of-pocket costs.12 By comparison, household income remained unchanged between 2002 and 2003 following two consecutive years of decline.13 Between 2004 and 2005, median household income rose 1.1 percent.14 Medical care insurance obviously constitutes an ever-larger chunk of employee compensation payments.

Between 2001 and 2006, insurance premiums rose 73 percent.15 From mid-2004 to mid-2005, premiums increased 9.2 percent. A 2006 study estimated that premiums would increase 6.7 to 9.9 percent, compared to the consumer price index increase of 2.8 percent.16

CHART 1

GROWTH OF PHYSICIANS & ADMINISTRATORS 1970-2006

Source: Bureau of Labor Statistics; NCHS; and analysis of CPS

GROWTH SINCE 1970
The impact on individuals is staggering. In 2006, the average annual premium for family health care coverage was $11,500, about equal to the entire annual earnings of a full-time minimum wage worker. Employee contributions averaged $3,000, or 10 percent more than in 2005. In a February 2007 poll, nearly half of employees with insurance reported that employers have increased the required employee contribution, reduced benefits, or both. Meanwhile, the ranks of those who are not offered, do not qualify for, or cannot afford the employee’s share of employer-based health insurance keep growing.

The Decreasing Number of Insured People
These higher costs price millions of families and individuals out of the insurance market. In 1976, about 21 million Americans were uninsured; by 2005, the Census Bureau reports, that number had grown to 46.6 million, or 15.9 percent of Americans (see chart 2).

In addition, at some point in 2005, 1.5 million people were underinsured. They had either skimpy insurance or interruptions in coverage.

About seven in ten of those without insurance are in working families. Of the uninsured in 2004, 20 percent were children, 82 percent were employed, and 19 percent were in families without a working member.

Among respondents to a 2006 survey, slightly more than half, 54 percent, could not afford insurance; 15 percent were refused insurance due to poor health or age; 14 percent said they were not eligible for or their employer did not offer health insurance; 4 percent said they “did not need it”; and 1 percent did not know how to get it.

For women, even employer-based insurance is less common than it is among men. According to an analysis of recent Census figures, of women between ages 18 to 64 in 2005:

- 38 percent reported job-based insurance in their own name (compared with 50 percent of men)
- 24 percent were dependents of a spouse’s job-based insurance
- 10 percent received Medicaid
- 6 percent purchased individual private policies
- 3 percent had other government insurance (including Medicare, Champus, and other types of coverage)
- 19 percent were uninsured

Most uninsured women, according to this analysis, did not qualify for Medicaid, did not have access to employer-sponsored plans, or could not afford individual policies. That means that almost one out of every five American women under age 65 is uninsured.

The underinsured lack access either to adequate insurance or to continual coverage throughout the year. When a worker becomes disabled, 27 percent of employers immediately stop health benefits for the worker; 24 percent do so after six to twelve months; 4 percent of employers offer no health benefits; and 18 percent of the disabled workers are over age 65.
Every hiatus in insurance exposes people to loss of insurability by private policies that typically exclude preexisting conditions. Untimely care exposes them to more serious illness and frequently increases treatment costs that are shifted to government programs and private insurance.

Although two federal laws attempt to bridge the gaps in insurance, the cost for the individual is often prohibitive. OWL helped shape legislation in the early 1980s that laid the groundwork for the Consolidated Omnibus Reconciliation Act (COBRA) of 1986. It allows certain employees to continue their group health insurance when they lose their job or plan coverage. The individual, though, must assume the full monthly premium cost. The Health Insurance Portability and Accountability Act (HIPAA) helps and protects consumers who transition from one plan to another, either a group or an individual plan, to avoid a break in coverage that could make one ineligible for plans with a preexisting condition exclusion. HIPAA coverage usually entails joining a high-risk pool plan, which is extremely expensive. Both COBRA and HIPAA have proved to be unaffordable for most people.

Women are especially at risk for lack of coverage. Fifteen percent of women age 0–4, more than one in seven do not have health insurance. Women age 55–64 are more likely than children to lack health insurance. More than one out of five women with children under 18 lacks health insurance; if they have insurance, it may not cover what they need. The largest out-of-pocket medical expense for women of childbearing age is birth control. Many health insurance plans do not cover contraceptives, though they may cover Viagra or similar drugs. Over half of uninsured low-income women, some of whom lose health care coverage through Medicaid when they get a paying job, delay or forgo health care because they cannot afford it. In addition, women, on average, have lower incomes, have less access to health care coverage under private plans due to employment patterns, and tend to have higher out-of-pocket medical expenses. (See chart 3.)

Medicaid, the federal-state program designed to provide coverage for low-income individuals, does not provide the answer. Not only is it more costly to administer than Medicare, many people with low incomes are not poor enough to qualify, and childless couples are not covered. Others who are eligible do not apply, do not renew, are too proud to apply for assistance, or are reluctant to have the government know anything about their finances.
The Health and Financial Consequences of Rising Costs and Shrinking Coverage

The accelerating upward spiral of cost and consequent downward spiral of coverage puts everyone’s physical and financial health at risk.

**Killer Costs Mean Less Care**

Cost is “the largest barrier to care” in the U.S. A 2006 survey found that within a twelve-month period, 28 percent of those interviewed had put off medical treatment for themselves or a family member. Of these, 70 percent had serious conditions.

In 2002, 22 percent of middle class families with incomes ranging between $25,000 and $49,999 reported that they postponed needed medical care, 13 percent did not get a needed drug, 23 percent had trouble paying medical bills, and 12 percent had collection calls due to unpaid medical bills. (see chart 4).

Even more affluent families, those with incomes up to $75,000, both insured and uninsured, went without basic screenings: for the insured, 5 percent failed to have pap smears, 14 percent mammograms, 11 percent cholesterol tests, and 35 percent colon cancer screening. For the uninsured, the numbers were larger: 16 percent failed to have pap smears, 35 percent mammograms, 23 percent cholesterol tests, and 54 percent colon screenings.

A 2004 analysis showed that of uninsured women ages 18 to 64, 40 percent had no pap test, 42 percent did not fill a prescription due to cost, 51 percent had no regular doctor, and 67 percent needed but didn’t get care due to cost.

In 2005, the uninsured were more than twice as likely to seek emergency room or hospital care for chronic conditions such as hypertension, high blood pressure, heart disease, diabetes, asthma, emphysema, or lung disease as the insured. They were more than three times as likely to skip doses or fail to fill prescriptions (see chart 5).

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**CHART 4**

Access Problems for Middle Class Families

<table>
<thead>
<tr>
<th>Percent of Families Reporting Problem in Past Year</th>
<th>Postponed Needed Care</th>
<th>Problem Paying Bills</th>
<th>Didn’t Get Needed Drug</th>
<th>Collection Agency Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td>22%</td>
<td>23%</td>
<td>13%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Source: NPR/Kaiser Survey, June 2002

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**CHART 5**

Figure ES-2. Adults Without Insurance Are Less Likely to Be Able to Manage Chronic Conditions

<table>
<thead>
<tr>
<th>Percent of adults ages 19-64 with at least one chronic condition*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured all year</td>
</tr>
<tr>
<td>Visited ER, hospital, or both for chronic condition</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td>27</td>
</tr>
<tr>
<td>35</td>
</tr>
</tbody>
</table>

* Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.

The same study reported that more than seven times as many U.S. residents as Canadian residents forgo needed health care due to cost. For the uninsured, 30.4 percent of Americans reported having an unmet health need due to cost. Some private policies contain conditions or exceptions to coverage that become known to the insured only when the excluded help is needed. Although some young and healthy people feel invulnerable and opt out of coverage, we are all subject to the same health risks of disease and accident. Devastating conditions can strike unexpectedly from unanticipated sources and require a lifetime of medical attention. That is why we need insurance.

Health Care Costs—A Frequent Cause of Bankruptcy
When faced with a medical condition, the underinsured and the uninsured often end up in bankruptcy. One analyst concluded that “nearly 27 percent of [bankruptcy] filings are a consequence primarily of medical debt, while in approximately 36 percent of cases medical debts co-exist with primarily credit card debts.” A 2005 Harvard Law and Medical School Study found that almost 50 percent of personal bankruptcies involve large medical bills. Almost 76 percent of the bankrupt actually had medical insurance at the onset of the bankrupting illness.

Everyone Pays for Uncompensated Health Care—The Insured Pay Twice
The cost of uncompensated services provided in a hospital emergency room, which under federal law must provide care regardless of the patient’s ability to pay, is passed on to insured individuals through their premiums. The insured also pay as taxpayers for medical care provided by Medicaid or other means-tested public programs. In 2001, private sources, including physicians, paid almost 25 percent of the approximately $40 billion cost of uncompensated health care, and the state and federal governments paid the other 75 percent.

High Health Care Costs Disadvantage American Business and Governments
Meanwhile, businesses struggle to meet the rising costs of health care for employees. They frequently reduce or eliminate coverage, fold the cost into the price of the services and products produced, or choose to locate outside the United States. General Motors reportedly pays $5 billion per year on health care. The automobile industry estimates that the cost of health care insurance adds $1500 to each vehicle sold and burdens U.S. competition in the global marketplace. Toyota passed up financial incentives to locate a plant in the U.S. and chose a Canadian location instead. The Canadian Medicare system saves automobile manufacturers the direct cost of employee health care, one of Canada’s “big selling points.” Starbucks’ CEO testified to Congress that the company pays more for health insurance than for coffee. Some unions and business leaders argue that the cost of employment-based health care hampers U.S. business in global competition.

Health care costs eat up an ever increasing slice of government budgets. States face nonstop increases in the cost of Medicaid, which now usually commandeers
either the first or second largest outlay of state funds. State and local governments face perennial double-digit increases in payments for their own employee health costs, thereby impairing their ability to meet other pressing needs and inflaming property tax rates.

**America Spends More and Receives Less for Our Health Care Dollar than Any Other Advanced Country**

The National Health Expenditures (NHE) report prepared by the office of the Actuary, Centers for Medicare and Medicaid Services, reports total national annual spending on medical care. Since the 1970s, the average annual growth rate for the NHE has significantly exceeded the growth rate for the nation's Gross Domestic Product (GDP), the total value of goods and services produced in the U.S. (see chart 6, preceding page).

In 2005, the U.S. as a whole spent $6,697 per capita on health care, about twice as much as other industrial countries such as Canada, France, Germany, and the United Kingdom; nonetheless, we cover a smaller proportion of the population than those countries do.

We're not getting our money's worth. The United States ranks below many other countries in health care quality, as evidenced by lower life expectancy and higher infant mortality rates. The World Health Organization ranks our health care system 37th in overall performance and 24th on health level attainment out of 190 countries. The Institute of Medicine reported that America's infant mortality rate ranks 27th in the world; life expectancy for women ranks 30th and for men 27th. When compared to Canadians, Americans were 42 percent more likely to have diabetes and 32 percent more likely to have high blood pressure. Of Canadians, 85 percent had access to a physician while only 80 percent of Americans did. Twice as many Americans as Canadians said they couldn't afford needed medications.

Another study ranked the United States last on infant mortality out of 23 industrialized countries, with rates more than double that of the three leading countries. The United States tied for last—with Portugal, Ireland, Denmark, and the Czech Republic—on healthy life expectancy at age sixty.

Despite allocating a much greater percentage of gross domestic product to health care than ten other first world countries (including Australia, Spain, Italy, Japan, and others), the U.S. has the worst outcomes on a number of measures: a significantly higher rate of infant mortality, lower life expectancies for females at birth, lower life expectancies for females at age 60, and a lower age at which health begins to fail.

**Who Benefits? Insurers, Drug Companies, and CEOs**

Despite the amount spent, as a society we do not receive the potential benefits of American medicine. So who does benefit?

Between 2000 and 2004, profits of the top seventeen U.S. health insurance companies rose 114 percent, while the profit growth of comparable S&P 500 companies increased on average only 5 percent. In 2005, the top seven U.S. health insurers had nearly tripled their profits from the previous five years. That same year, the twenty largest HMOs in the U.S. made $10.5 billion in profits. In 2004, the thirteen largest drug companies in the world earned $62 billion in profits. From 1995 through 2006, drug company profits far exceeded those earned by Fortune 500 companies.

In 2005, profits for the biggest health plans went up while the companies continued to cut the percentage of revenue earmarked for care. In the mid-90s, many large plans allocated percentages of revenue in the upper 80s and 90s to actual health care. By 2005, the highest percentage (of revenue allocated to care) among large, publicly traded companies was only 83.9 percent. Aetna insurance company's percentage, well into the 90s in 2000, fell to 76.9 percent.

The way that the “Medicare Modernization Act” added prescription drug coverage to Medicare is “an object lesson in how special interests hold America’s health care system hostage.” While providing billions of dollars of subsidies to private insurers and profits to drug companies, the law prohibits negotiation of drug prices by Medicare. Instead, it seeks to move seniors into private insurance with high overhead costs.

Drug companies say that research and development cause high prices, but company reports in 2002 showed that 17 percent of their outlays went to profits, 30 percent to marketing and administration, but only 12 percent to research and development. A 2001 analysis showed a similar spread in drug company costs: 18
percent to profits after taxes, 35 percent to marketing and administration, 13 percent to research and development, and 7 percent to taxes (see chart 7). 63

According to economist Paul Krugman, “The pharmaceutical industry spends approximately one-and-a-half times as much on marketing and sales as it spends on research and development.” 64 Contra...
It is a truth almost universally acknowledged that the current trends—increased costs and reduced coverage—reflect a failure to meet the needs of more and more American individuals, businesses, and governments. In 2006, even among the insured, 60 percent reported that they were very worried or somewhat worried about whether they could afford health insurance over the next few years. Among those with private insurance, 56 percent were very or somewhat worried about losing insurance because of job loss. One senator noted that “[e]mployer-based coverage is melting away like a Popsicle on the sidewalk in August.” In the 2006 congressional election, concerns about health care came in second to concerns about the war in Iraq as an issue important to voters.

As the medical insurance scene worsens, proposals for “universal coverage” for insurance are gaining traction at the national and state levels. Americans appear anxious to find a solution. A 2005 Kaiser Family Foundation poll found that “76 percent of respondents considered increasing health insurance coverage for Americans a very important priority for the President and Congress.” In 2006, 68 percent of respondents reportedly approved of expanding health insurance to the uninsured, even if it meant raising taxes, compared to 28 percent who said holding down taxes was more important, even if it meant some Americans do not have health insurance.

In February 2007, 55 percent of respondents in a New York Times/CBS poll said that health insurance for all is the most important domestic priority now. Seventy percent said that the lack of health insurance for many Americans was a very serious problem for the U.S. and another 25 percent said it was somewhat serious. Almost 50 percent stated that the federal government should guarantee health insurance for all Americans, even if that meant a modest increase in taxes. In addition, an “overwhelming” majority said the health care system “needed fundamental change or total reorganization.”

Respondents were asked: “Which would you prefer: the current health insurance system, in which most people have coverage through private employers, but some people have no insurance, or a universal coverage program, in which everyone is covered by a program like Medicare that is government-run and financed by taxpayers?” In response, 56 percent said they preferred a universal system, 40 percent prefer the current system, and 4 percent did not know (see chart 8). (NHI stands for national health insurance.)

The February 2007 poll found that 47 percent preferred a “national health insurance program covering everyone, administered by the government and financed by taxpayers,” while only 38 percent preferred the current system.
Americans do not have to look far for a model that works. We already have a nearly universal system for two groups of Americans—those age 65 and over and those receiving SSDI—that provides comprehensive coverage, minimizes nonbenefit costs more than any health insurance proposal, and is embraced by most Americans. It is called Medicare.

**Medicare Avoids Most Nonbenefit Costs**

Medicare comprehensively covers all “medically necessary” services for the diagnosis or treatment of a medical condition. “Original” Medicare Part A covers most inpatient hospital care, skilled nursing facility care, and some hospice and home health care. Part B covers medical services by doctors, outpatient care and some preventive services. Beneficiaries pay a monthly premium for Part B — in 2007, $93.50 for a single person with a maximum taxable income of $80,000 or, for couples filing jointly, taxable income of $160,000 or less. The services covered and fees are negotiated by Medicare. Beneficiaries are free to choose their own doctor.

Beginning in 1997, under the guise of “reform” and/or “fiscal responsibility,” Congress enacted Part C, Medicare + Choice, now called “Medicare Advantage,” offered by private insurance companies. Under Part C the beneficiary enrolls in a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), which may include prescription drug coverage. Participants must use the plan’s designated providers. The plan receives a subsidy from Medicare. Since 2006, Part D offers government-subsidized prescription drug coverage sold by private insurers. Drug plans vary in their monthly cost, deductibles, limits of coverage, and drug formularies.

The administrative costs of Medicare’s Parts A and B consistently run at or below 2 percent of benefits. Parts C and D administrative costs are higher. In comparison, means-tested public programs such as Medicaid and SCHIP (State Child Health Insurance Programs) spend almost 7 percent on administration, including costly determinations to ascertain whether tens of millions of applicants meet eligibility requirements—a task typically required anew every 13 weeks. Massachusetts uses eight different eligibility and benefit formulas for varying needs-based health care programs despite the similarity of the groups served.

Private insurance can take about 33 percent of the health care dollar to administer, advertise and sell. In 2003, the *New England Journal of Medicine* reported that the “health care bureaucracy” cost at least $399 billion, based on the insurance industry’s expenses and providers’ overhead, including doctors, hospitals, nursing homes, and home care agencies. Health care providers, insurers, and public agencies now must cope with thousands of formulas for eligibility, payment, and reimbursement. For example, the average doctor or hospital has between 5 and 100 different reimbursement rates for the exact same procedure. Matching billions of billings with differing provisions in thousands of plans requires millions of clerical hours and hundreds of billions of dollars. A study based on 1999 data showed that the United States spent a total of $1,059 per capita on health care administration alone, compared with $307 per capita spent by Canadians, who have a universal system similar to our Medicare. The estimates included the cost of insurers’ overhead, employers’ costs to manage health benefits, hospital and provider administrative costs, and home care administration.

The skirmishing of insurers to shift payment burdens to a “primary” insurer when two or more plans might apply adds to costs. This “coordination of benefits” process is the most frequent cause for delaying claims payments, according to insurers.

Original Medicare minimizes administrative costs, because it uses uniform objective criteria for eligibility (age 65 and over or eligible for SSDI) and national formulas for reimbursing providers (with allowance for regional variations in costs).

Not least, Medicare beneficiaries cherish Medicare, except for the confusion and added cost engendered by Part D. Decades of reliable health care delivered to hundreds of millions of Americans has built wide multigenerational support for the program. Researchers found Medicare beneficiaries more satisfied with their health care plan than those in employer-sponsored plans. Medicare beneficiaries strongly prefer original Medicare to Part C Medicare Advantage plans. In 2006, enrollment in Part C plans varied widely: 25 percent of Part C enrollees lived in only five states, and less than 1 percent were enrolled in four states. Part C plans are elected by fewer than one out of five of those eligible.
Medicare, itself, can stand improvement, such as eliminating or minimizing deductibles and co-payments. The current rationale for these costs is that they discourage unneeded care. However, Medigap policies, which cover more than half of Medicare participants, cancel that incentive while also increasing nonbenefit costs. In addition, deductibles and co-pays constitute a barrier to needed care for those who cannot afford a Medigap policy or who do not qualify for Medicaid.

Universal Health Insurance Provided by Medicare—A Winner for All
In the face of this mounting evidence of the failure of America’s health care “system,” OWL supports national universal health insurance provided for all by Medicare.

The original Medicare, Parts A and B, makes a solid foundation on which to build a system of universal, affordable, accessible and comprehensive medical care insurance. It’s a well-established system that has addressed the hundreds of issues a large-scale health care program engenders. It does not exclude those with preexisting conditions as private plans typically do. Applying it to all age groups promotes intergenerational fairness. Premiums that do not vary by age, gender, and medical condition would eliminate current employer incentives to discriminate against mid-life and older people, women of childbearing years, and the disabled.

Moreover, Medicare-for-All preserves the choice people most treasure—not the choice of which insurance plan they have, which for the most part, their employers select—but the freedom to select one’s own doctor and hospital or other facility.

Replacing the current patchwork of differing private and public programs with a comprehensive system of universal coverage with only one payment schedule would dramatically reduce nonbenefit outlays. With but one program, an improved Medicare, money now spent on nonbenefit outlays could instead pay for comprehensive coverage for all of us. In addition, a single system would eliminate the need to advertise and pay commissions—saving billions more.

Some fear that substituting Medicare for existing private insurance would lessen coverage they already enjoy. But current private plan coverage now varies from worrisome to precarious to disappearing. Medicare-for-All could stanch the hemorrhaging. In addition to covering the uncovered, it could apply some of its vast savings to improving Medicare—for example improving vision, hearing, dental, and mental health services and preventive and home care coverage. Beyond that, any plan provider could opt to supplement benefits up to levels existing before enactment of Medicare-for-All.

Bargaining over health care has poisoned and seriously disrupted both public and private employee-employer relations. Unions, their members and employers would gain if the whole bargaining package was not consumed by health care costs or, as so often has happened in recent years, by give-backs that shift direct burdens to employees. Employers would gain by having their health care costs stabilized, their labor relations calmed, and their competitive ability improved. Businesses and state and local governments would see their costs stabilize and probably go down. Medicare-for-All would promote stability in employment, reduce absences, and boost workplace productivity.

In sum: Medicare-for-All, in combination with other cost-reducing measures, could provide:

- Universal coverage—for all ages
- Beneficiary choice of doctors and other providers
- Expanded coverage to include preventive, mental health, home health, vision, hearing, and dental services
- No exclusion of coverage based on preexisting conditions
- Elimination of employment discrimination based on medical or high-risk conditions such as age, gender, and disability

Eliminating such discrimination would remove a major barrier to the employment of older people. In turn, that would increase their lifetime income and, by keeping them in the paid labor market, improve Social Security and Medicare trust fund revenue.

Frequent media reports that Medicare will “go broke” at some not too distant future—it keeps changing—lead many to conclude that Medicare is unsustainable. Repeatedly the projected doomsday comes and goes, but the calamity does not arrive. Such warnings result from an oversimplification of rather technical information and a resultant misunderstanding of what the projections contained in the Medicare and Social Security trustees’ annual reports signify.
First, projections are not predictions. Projections necessarily depend upon an array of assumptions about the future. These include, the trustees tell us, “the size and composition of the population eligible for benefits, changes in the volume and intensity of services, increases in the price per service..., the size and characteristics of the covered work force and workers’ earnings..., birth rates, death rates, labor force participation rates” and a host “of other economic and demographic circumstances.” The trustees illustrate the uncertainty and circumstances inherent in estimates of future Medicare trust fund operations by preparing projections under a “low cost,” “high cost,” and “intermediate” set of assumptions. The trustees also caution that, although more confidence can be placed in projections for the short term, even they are only an indication of expected trends. In other words, take the projections with at least a grain of salt.

For example, for the years 1991 to 1997, the number of years to “projected insolvency” for Part A plummeted from 14 to 4 years. In other words, the hospital fund should have been exhausted in 2001. That didn’t happen. Medicare Part A remains up and running. The report for 2006 projects another 12 years to “projected insolvency.” Between 1997 and 2002, the “projected insolvency” date for the Part A fund steadily grew from 4 to 28 years in the future. Starting in 2004, the projected longevity of the fund moved down, reflecting the same rising costs affecting the entire medical care field.

Although most discussions treat the projections as known and immutable facts, they are only best guesses based on underlying assumptions. One of the most important assumptions is the amount of medical care beneficiaries will need. That in turn depends upon projections of what will make people ill. Prior to the mid-1950s, polio afflicted tens of thousands, and the treatment, for example by iron lung, was expensive. The Salk vaccine banished that awful disease and with it the daunting expense. Before the Salk vaccine, Medicare projections would have had to take account of the expected rate of polio infection and the costs of resulting medical care. As 2006 ended, we learned of the development of a vaccine to prevent infections that may account for 70 percent of cervical cancers. That will enable Medicare actuaries to reduce their projections for the incidence and cost of that condition.

Reducing or eliminating these and other diseases means lower spending for expensive diseases and a larger and healthier work force – generating larger payroll tax revenues for the Medicare trust fund.

While it is prudent to pay close attention to future cost issues, we may achieve new modes of prevention and treatment that make profound changes in what we know about diseases, how to prevent them, and how to treat them.

Usually discussions of Medicare and Social Security funding limit policy choices to increasing payroll taxes or cutting benefits, or both. But we can reduce expenses by preventive health care and increase income by increasing employment, enlarging the work force and boosting employment income. The ability of the economy to produce goods and services determines how much there is to share. If wages and salaries expand with improved productivity, payroll tax revenue expands. “Economic growth, more so than demographic change, will affect the financial well-being of the nation, government budgets, and individuals' financial independence. However, economic growth requires public and private investment in education, training, basic research, applied research, and capital formation.”

Improved technology has repeatedly expanded our productive capacity. Output per person hour of work has soared and the costs of producing goods and services have declined in consequence. While many prophesy economic Armageddon because of the imminent retirement of the baby boomers, productivity improvements offset other cost-increasing factors such as the boomer retirement.

In addition, people are voluntarily working longer, which is good for their long-term income and beneficial to the Social Security and Medicare trust funds, as larger than predicted wages produce larger than predicted payroll tax yields. Between 1985 and 2004, labor force participation of those ages 65–69 increased from 18.4 percent to 27.7 percent; for the total over age 65 population, it increased from 10.8 percent to 14.4 percent.

Medicare has done a better job of constraining costs than private insurers. Medicare has been a leader in advancing quality care and improvements in health care service delivery. Moreover, Medicare today only covers the segment of the population—the elderly and
disabled—that requires more medical care than the population as a whole. If Medicare expands to cover all, the average cost per person should go down. With all Americans participating in a single system, the multi-age risk pool can significantly improve Medicare’s financial stability.

Savings by Medicare Could Generate the Funds to Help Cover All

In 2005, the latest year with such data, the total National Health Expenditures in the United States was more than $1.9 trillion. The estimated 2007 total amounted to $2.2 trillion. Of the 2005 total, over $902 billion was paid by federal, state, and local governments; this included spending by Medicare, Medicaid, SCHIP, the Department of Defense, the Veterans Administration, and other smaller public assistance programs. This amount does not include the $90 billion annual cost to the Treasury of the tax deductions for employer contributions for health care plans, nor does it take account of the nontaxability of employee health benefits.

With more efficient use of these moneys, we could help fund Medicare-for-All and perhaps fund it completely from savings. In 1991, the Congressional Budget Office concluded that savings on nonbenefit costs of private insurers and health care providers about equaled the cost of providing coverage to the uninsured with Medicare-for-All. A 1993 study reached similar conclusions. It estimated that, with vision and dental services but without co-payments and deductibles, the National Health Expenditures would increase by 5 percent due to assumed greater utilization of health care services; with continued deductibles and co-payments, total spending would decline 1.9 percent.

Estimates for savings achievable by a Medicare-for-All type plan vary, reflecting differing assumptions extrapolated from the Canadian system’s lower administrative costs and other variables. A painstaking 1993 analysis by the Congressional Budget Office estimated the cost impact of H.R. 1300, a single-payer bill introduced by Representative Russo, and surveyed estimates made by others on the effects of adopting a Canadian-style program. It estimated that “H.R. 1300 would raise national health expenditures slightly at first but would reduce spending about 9 percent [after several years].” If that latter percentage were applied to the 2007 estimated National Health Expenditures of $2.2 trillion, the savings would be almost $200 billion a year.

All three of the studies reported by the Congressional Budget Office projected substantial savings for insurers, hospitals, and physicians. Their biggest differences were in regard to assumptions on the dimensions and cost of additional use.

More recent studies estimate that a unified system of universal coverage and benefits can save enough money to cover all. In 2003, a study based on 1999 prices concluded that the almost $300 billion annually that pays for estimated nonbenefit spending could pay to cover all of the uninsured and to upgrade coverage for the underinsured. In today’s dollars, these savings would be considerably larger. The National Coalition on Health Care studied four options to provide universal coverage and concluded that the greatest savings, $1.136 trillion over the period 2006–2015, would be realized by a universal, publicly financed, single-payer program compared with savings only of $320 to $370 billion from three other scenarios. Absorbing public means-tested programs into Medicare would free up their nonbenefit costs for universal coverage.

Whatever the savings turn out to be, it can be said confidently that no other proposal offers such substantial assured savings as Medicare-for-All. Nor would Medicare-for-All be the only device employed to curb costs without reducing needed care. Eliminating provider conflicts of interest, computerizing record keeping, and practicing evidence-based treatment can reduce costs and should be adopted, but these are neither singly nor in combination substitutes for the savings achievable by Medicare-for-All.

Moreover, a universal Medicare system spreading the risks over the whole population prevents the “cherry picking” common to private insurance whereby the insurer offers a lower-cost plan to a low-risk employee group. Current patterns, which vary insurance premiums according to the age, sex, and health condition of the covered group, provide incentives for employers to avoid hiring “high-risk” employees, notably women of child-bearing years, older workers, and the disabled. Although using such criteria for employment violates Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Americans with Disabilities Act, and similar state statutes, proof
of discrimination is difficult to show, not least because individuals lack the resources to sue, and most do not want to mark themselves as troublemakers.

The cited studies make clear that the money we already expend for health insurance could substantially expand medical care coverage under Medicare, possibly pay for covering all, if the wastefulness of private insurance and means-tested public programs is eliminated. How then do we mobilize these funds to achieve Medicare-for-All?

Proposals to Achieve Universal Coverage
Several different proposals seek to build on or incorporate the idea of Medicare-for-All. Despite shared terminology, however, proposals differ significantly in major design elements, funding, and especially in cost.

A brief description of the main health insurance proposals follows. The first would provide national health care insurance by extending Medicare to all. The second, H.R. 676; would provide national health care insurance with a universal, comprehensive plan for all. Others would extend or phase in Medicare for everyone or permit early buy-ins to Medicare. Still others would continue the mix of private and public programs but mandate health insurance coverage for all; they contemplate continued employment-based private insurance or insurance provided by a public or private entity sweetened by tax credits, tax breaks, and subsidies.

In assessing these plans, it is important to consider their budgetary implications. In 2007, Congress adopted pay-as-you-go (PAYGO) rules for budget neutrality. This requires that any expenditure that increases the federal budget must be offset by increased revenue or reduced outlays.

Medicare-for-All: Transforming Savings on Current Spending into Coverage for All
One proposal would extend an improved Medicare to all using the Medicare infrastructure already in place. It would redirect current public and private medical care insurance and expenditures (but not an individual’s out-of-pocket, Veterans Administration, or armed forces expenditures) to the universal program. Employer and employee contributions to public and private health care programs and Social Security and Medicare FICA taxes would continue.

Savings would help pay for universal coverage—indeed, they would pay the whole bill under some estimates, without additional spending. Transforming those savings into universal coverage only requires all current plan sponsors, both private and public employers, to maintain their already established level of spending on health care. Thereafter, the original average per capita rate would remain, but contributions would vary according to changes in the number of employees without regard to their age, gender, or health condition. That would take account of the fluctuating numbers of employees in a business but remove the incentive for discrimination on the basis of age, sex, and health condition. Plan sponsors, both profit and nonprofit, already maintain records that establish their medical care outlays. Taking such records for several years prior to the establishment of Medicare-for-All (to obtain a fair sample and to avoid gaming the system) would establish what each enterprise expends for the purpose of setting its contribution rate.

This is not a one-size-fits-all program; rather, by building on existing private plan contribution rates, it preserves some of the differing cost allocations already established by the private market. So, for example, hazardous enterprises would continue to pay higher rates than less risky businesses. Federal, state and local government agencies would continue their already-established contributions. This process would be as simple and low-cost as the withholding tax and FICA administration. Current FICA contributions to Medicare by employers and employees would continue.

Instead of the recent run of double-digit cost increases, plan sponsors could anticipate stable costs and, after a time, benefit from reduced costs. Employers who sponsor a plan with better coverage than Medicare offers could provide add-ons to preserve that coverage without paying more than they already pay.

This proposal does not compel any new contributions or greater total outlays. Its formulation satisfies PAYGO. Savings in current spending would pay for new coverage.

Some may question whether it is fair to require all public and private employers to continue paying what they currently expend for health care while other employers, those who have not provided health care coverage, get a “free ride.” The simple answer is that such unfairness already exists. Taxpayers and
plan sponsors today pay the tab for “free” care to the otherwise uninsured. Any perceived unfairness would build pressure to equalize burdens. In the meantime, not including mandates avoids a debate that has repeatedly derailed past proposals. If employer representatives protest such unfair competition, they should undertake recruiting support for a mandate that imposes uniform obligations.

Private insurers would continue their major role as intermediaries between claimants, providers and the Medicare program. They bring experience and expertise to Medicare bill processing. Utilizing them helps reduce apprehension that a more efficient system will lead to massive unemployment of insurance personnel. Moreover, displaced administrative staff and supervisors should have priority for employment under Medicare-for-All and retraining for the new jobs created by expanding coverage.

United States National Health Insurance Act (or Expanded and Improved Medicare for All Act)
H.R. 676 – The Conyers Bill
H.R. 676, introduced by Representative Conyers in 2005 and again in 2007 with over 60 co-sponsors, also comprehensively covers all U.S. residents with expanded and improved Medicare.111 It pays for the program with new taxes and reallocating current government health care spending.

In addition to current Medicare coverage, it includes long-term care, dental, and vision services that are not solely cosmetic, and parity for mental health services.112 “[A]ny licensed health care clinician anywhere in the U.S. who is legally qualified” could provide the services.113 Patients would have a free choice of providers from the ranks of participating physicians and other clinicians, hospitals, and inpatient care facilities.114

All institutional providers under the plan must be not-for-profit or public and meet regional and state quality and licensing guidelines. However, existing for-profit institutions that opt to participate as providers may convert to not-for-profit status and be compensated for that conversion.115 The bill prohibits private insurers from selling coverage that duplicates any coverage provided by the plan, although insurers may offer coverage for services and items for cosmetic surgery and other services deemed “not medically necessary.”116

The bill provides for federal administration, the appointment of a director by the Secretary of Health and Human Services, and the establishment of regional and state offices to coordinate billings and payments to health care providers.117 It also requires that clerical and administrative workers formerly employed by insurance companies, doctors’ offices, hospitals, and other facilities who are displaced by the reorganization would have first priority in retraining and job placement.118

Funding would derive from existing sources of government revenues already allocated to health care, increasing the personal income tax on the top 5 percent of income earners, instituting “a modest payroll tax,” and “a small tax” on stock and bond transactions.119 Lower administrative and other nonbenefit costs and bulk procurement of medications would produce savings compared to current programs. The plan eliminates cost-sharing; participants would not pay deductibles, co-pays, or coinsurance.120

AmeriCare Health Care Act – H.R. 5886
The Stark Bill
First introduced July 25, 2006 by Representative Stark with 36 cosponsors and reintroduced March 29, 2007, with 24 cosponsors, H.R. 5886 would amend the Social Security Act by adding a new Title, AmeriCare Health Benefits, and the Internal Revenue Code. It provides universal eligibility for all U.S. residents effective January 1, 2011. Children would be enrolled at birth. Individuals may opt out with proof of equivalent coverage under a group health plan that conforms with Medicare Part C rules and AAPCC rates.121

Under the proposal, Medicare would become the primary source of coverage for all Americans. Enrollees would receive Medicare Parts A and B benefits, preventive services, substance abuse treatment, mental health parity, and prescription drug coverage. Medicare benefits would be modified to conform to the AmeriCare benefit package.122

Beginning January 1, 2011, each enrollee would pay a premium based on the cost of coverage, state by state, and the class of enrollment (individual, couple, or family). Premiums would be reduced for low-income individuals and people who are employed, because the employer would make a proportional contribution on behalf of both full-time and part-time employees. The obligations of employers with fewer than 100 employees
would begin in 2013. The proposal exempts employers from Medicare's secondary payer requirements and establishes AmeriCare as secondary to Medicare. States would be required to maintain their Medicaid and SCHIP obligations.12

Cost sharing would include a deductible of $50 for individuals and $500 for a family and 20 percent co-insurance payment up to an out of pocket maximum of $2,500 for an individual and $4,000 for a family. Special eligibility categories with no cost-sharing, with subsidies, and with caps on total spending for premiums, coinsurance, and deductibles apply to those at lower income levels. All moneys collected under the bill would go into the AmeriCare trust fund.12

Applying the proposal’s provisions to 2007, AmeriCare would increase federal spending by $154.5 billion. However, the total costs of health insurance administration nationally would decline by $74 billion. It would result in substantial national health expenditures savings – an estimated $60.7 billion due to reduced costs of administration per premium dollar and spreading the risks across a large risk pool. Household health care spending would drop by $142.6 billion, with the largest savings for low and moderate-income families, probably offset somewhat by increased taxes to cover federal spending.12

Medicare for All Act - S. 2229/H.R. 4683

The Kennedy/Dingell Bill
These proposals, introduced in 2005 by Senator Edward Kennedy and Representative John Dingell, phase in Medicare for all persons “lawfully present” in the U.S.126 During the plan's first five years, those under 20 or over 55 would be eligible for benefits. During the second five-year period, those under 30 and over 45 would become eligible. Benefits become available for all, a small remainder, beginning in the eleventh year.127 The proposal permits individuals entitled to Medicaid, SCHIP, Veterans’ benefits, the Indian Health Services, or any other public program to continue participation in these programs with Medicare as the primary payer.128

The proposal specifically permits private insurance to continue offering supplemental plans129 and competing, authorized private health plans with “benefits as good as your congressman” or federal employees get.130

Benefits would include the Medicare fee-for-service benefits already available under Parts A and B, prescription drug coverage “at least as comprehensive” as that provided to Federal employees, parity in coverage for mental health benefits, preventive services, and home and community-based services.131 Beneficiaries would be free to choose their own doctor.

Funding relies on a combination of payroll taxes and general revenue. Moneys appropriated to the “Medicare for All Trust Fund” would come from current payroll taxes received by the Treasury and from the Treasury’s general fund.132 This subsidy probably would need to meet PAYGO’s requirements of budget neutrality. Beneficiaries would continue to pay deductibles, coinsurance, co-pays, and premiums, except for low-income people who would qualify for reduced cost-sharing.133

The proposal estimates saving $160 billion per year by using electronic medical records, $70 billion per year in reduced overhead, and $50 billion per year in reduced administrative costs for providers.134

Medicare Early Access Act of 2005
H.R. 2072/S. 3747 – The Stark/Rockefeller Bill

H.R. 2072, introduced by Representative Pete Stark and 112 other members of the House and S. 3747 introduced by Senator John D. Rockefeller and four other senators, would add a new Part E to Medicare. It allows individuals aged 55-64, who would be eligible for Medicare at age 65 and who are not eligible for Federal Health Insurance or other group health plans, to purchase Medicare coverage.135 Enrollees would pay a monthly premium136 and receive a 75 percent income tax credit for them.137 Their employers would pay 25 percent of the monthly premium.138 In effect, enrollees would pay nothing from their own pockets and tax breaks would bear most of the cost. This subsidy probably would need to meet the PAYGO requirement of budget neutrality. Premiums collected under Part E would be deposited in a trust fund specifically for this program along with reimbursements from other federal programs.139

“Medicare Plus”
Reborn as “Health Care for America”

This proposal relies on the continuation of employment-based health insurance. It requires employers to either “play or pay” for medical insurance: employers must
either provide private health insurance at least as good as an improved Medicare or pay a 6 percent payroll tax\textsuperscript{141} to enroll their employees in the “Health Care for America Plan,” a new “Medicare-like” entity. Those enrolled in the new plan, with benefits comparable to an improved Medicare, would pay a premium based on their income and family size. Others could choose among a range of private plans.\textsuperscript{142} The self-employed would either purchase private coverage or participate in the plan by paying the employer’s 6 percent payroll tax and the monthly premium required of employees. Individuals out of the work force could purchase coverage under the new plan, with the premium adjusted to income. All individuals would be required to have and to verify that they have health insurance.\textsuperscript{143} Those age 5 and over and those covered by Social Security Disability Insurance would continue in Medicare.

Nonelderly beneficiaries of Medicaid and SCHIP would be enrolled in the plan. Low-income enrollees in the plan, in addition to paying premiums that are means-tested, would have federal subsidies for cost-sharing deductibles and co-payments.\textsuperscript{144}

The plan would require new federal spending. The revenue could come from new “liquor and tobacco taxes,” other “dedicated levies,” and general revenue. The plan claims cost savings in the Medicaid and SCHIP programs and reduced tax subsidies from employment-based plans would aid financing.\textsuperscript{145} However, an independent financial analysis had not yet been undertaken when the plan was unveiled.\textsuperscript{146}

An analysis of Medicare Plus, the plan’s earlier incarnation, concluded that the proposal would require new financing at its start. The immediate cost would be “slightly more than $114 in additional health spending per person per year”\textsuperscript{147} (which amounts to over $40 billion a year) and greater National Health Expenditures than under current NHE projections, at least through 2012.\textsuperscript{148} Needed funds would derive from an increased payroll tax, premium payments by enrollees, and a transfer of both federal and state Medicaid “acute care” funding to the plan. It would also cap the amount of the tax exclusion for employer-provided health benefits and eliminate tax exemptions for supplemental plans for employers whose employees were enrolled in Medicare. The benefit package would have a $250 deductible per person or $500 per family, a 20 percent coinsurance on outpatient services, and prescription drug co-pays, but would cap out-of-pocket expenses at $2500 per person, $5000 per family. The analysis assumes that its projected funding shortfall would be raised by an increase in personal income taxes.\textsuperscript{149}

**Health Savings Accounts**

**Tax Breaks for the Well-to-Do**

Health Savings Accounts (HSAs), originally called Medical Savings Accounts, provide tax breaks for funds put in individual accounts to be used for medical care. They were promoted as a way for people to control how they spend their health care dollars. The accounts may be used to purchase insurance plans with a comparatively low premium in exchange for high deductibles.

In the real world, these accounts attract the wealthy and healthy—or those who think they are—thereby shrinking the risk pool for other insurance. Health Savings Accounts are “actually, a remarkably generous present from other less fortunate but always hopeful taxpayers” whereby a family that “tucks $5,450 into an HSA for 30 years, and earns 7 percent a year on their investments, will wind up with a nest egg worth well over half a million dollars—tax free.”\textsuperscript{150}

Health savings accounts are of dubious efficacy in expanding coverage. Moreover, they reduce tax revenues, thereby shifting tax burdens to those who cannot afford such accounts.

**President Bush’s Health Plan**

President Bush’s health care proposal would cover an estimated 9 million uninsured, less than one in five in 2007, fewer in the future, mostly through the individual insurance market. The cost of an employment-based private health insurance policy would become taxable income for both the employer and employee. However, people who purchased a private insurance policy would obtain a standard tax deduction for the cost of the policy, $15,000 for families and $7,500 for an individual. The fixed income tax deduction is projected to rise annually more slowly than the premiums. Therefore, the proposal is projected to cover more uninsured people in the first years and fewer in the future.\textsuperscript{151}

Under this proposal, household spending on health is estimated to fall by a net $31 billion in 2007 due to income tax savings. But these savings would disproportionately accrue to people in higher income brackets: by only $23 for families with annual incomes...
less than $10,000 and by $1,263 for families with annual incomes above $150,000.152

The proposal achieves savings by reducing the comprehensiveness of coverage and inducing lower utilization of services. The proposal would produce a net federal budget cost in 2007 of $70.4 billion.153 Congress’ Joint Committee on Taxation projected that this proposal would cost taxpayers $526 billion dollars through 2017.154

**State Plans – Skirmishes on the Front Lines**

Several states have enacted or proposed expansion of health insurance coverage in recent years, but none will result in a national solution.

Since the November 2006 election, health care coverage has become a hot topic as states struggle to find solutions to their budget increases required by the increasing cost of health care. Some efforts expand access to coverage, others merely push people into high cost plans, high deductible plans, or plans with skimpy coverage.155 California and Massachusetts have taken the lead.

**California**

In 2006, California’s House and Senate passed a universal health care bill similar to the federal proposal H.R. 7. An analysis showed that it would have saved about $8 billion in its first year by replacing a multi-payer public and private insurance system with a single insurance plan and by buying drugs and durable medical equipment in bulk.156

A study assumed the insurance plan would include medical, dental and vision care, prescription drugs, emergency room services, surgical and recuperative care, orthodontia, mental health care and drug rehabilitation, skilled nursing, adult day care, and many other services. It projected $343.6 billion in total health care savings over ten years from the plan starting in 2006 and savings for state and local governments of about $43.8 billion. Average family spending for health care under the act was projected to decline about $2448 per family in 2006. The study estimated that employers who offer health insurance would realize savings of 16 percent.157

Governor Arnold Schwarzenegger vetoed this bill. In January 2007, he rolled out his own plan requiring those without coverage to obtain health insurance, with subsidies varying in amount according to need. 6.5 million Californians lack health insurance, including 1 million illegal immigrants. The financing would require doctors and hospitals to pay 2 percent and 4 percent respectively of their revenues into a fund to cover the uninsured poor. The state would also rely on “billions” of additional federal matching funds through the state’s Medicaid program, Medi-Cal.158

**Massachusetts**

In 2006, Massachusetts enacted a much-heralded medical care bill that mandates all individuals in the state to obtain health insurance. Those who don’t will pay a tax penalty. It provides varying subsidies for those earning up to three times the federal poverty level, or about $60,000 for a family of four. However, in 2007, the state is struggling with financing the program. Having promised comprehensive coverage for serious health problems, it finds that affordable policies might only offer minimal coverage and require high out-of-pocket expenses.159 “For a large proportion of the folks not eligible for subsidized care, the bare minimum plan is flat-out unaffordable . . . .”160 Nor does the Massachusetts plan do anything to curb costs. While the plan “is being trumpeted as reaching ‘near’ universal coverage, the individual mandate is a false promise which is unlikely to ever be implemented, because it would require families to pay for coverage they simply will not be able to afford.”161 For a certainty, it does not mandate coverage for children.162
In general, according to a recent Commonwealth Fund report, the more targeted a proposal, the less expensive it is to the federal government. However, “the estimated savings to the overall health system from insuring everyone through Medicare or other near-universal mechanisms swamp those from incremental approaches. This results from the administrative savings from broadly pooling risk as well as other efficiency gains such as negotiating pharmaceutical prices on behalf of the full population.”

With so much action in the air, Paul Krugman suggests, “now is the time to warn against plans that try to cover the uninsured without taking on the fundamental sources of our health system’s inefficiency. What’s wrong with both the Massachusetts plan and [others] is that they don’t operate like Medicare but funnel the money through private insurance companies.”

In assessing the cost, coverage, and feasibility of any plan, it is important to take into account that every condition a plan places on the receipt of care, every test for eligibility, every subsidy or tax break to make care appear more affordable, every step to determine the amount of subsidy, every proceeding to compel compliance, every measure to determine whether compliance should be waived, and the proliferation of competing plans add substantially to nonbenefit program costs.

Moreover, these conditions do not hold still. Most determinations must be redone repeatedly to stay up to date. To get a sense of the resulting costs, multiply those determinations by the tens of millions of individuals to whom they would apply in a national program.

At first blush, such conditions appear sensible and moderate. However, each condition—all of them in the Massachusetts plan enacted in 2006, most in the Schwarzenegger plan, and frequently elements in other proposals—adds significant costs, pushing plans past affordability and acceptability.

Multiplying Choices and Increasing Competition Add Costs

The usual law of supply and demand does not work in medical care. For one thing, none of us can predict what our family members and we will need in the future. Even apparently healthy people can suffer an unanticipated heart attack or other cancer diagnosis. No one expects to be injured in an automobile accident, but accidents happen. Medical insurance is designed to protect us from the medical consequences of life’s unexpected ills.

Some see competition as a way to curb costs. However, any cost advantages may derive from scanting some care whose absence may be undetected until that service is needed. So-called “consumer-driven” health care, touted as offering individuals control over their health care dollar, places unreasonable burdens on consumers who cannot possibly foresee their medical needs. Also, high-deductible policies discourage preventive care, although increasingly they exclude preventive services from the deductible.

To understand the false promise of competition, we need look no further than the complications and costs of Part D wrought by a multiplicity of pharmaceutical coverage plans, each offering its own smorgasbord of drugs. In short order, three insurers gobbled up most of the business, suggesting that competition did not affect many consumer decisions – but it cost beneficiaries and their adult children enormous amounts of time, anxiety, and possibly money. Moreover, the program’s costs were muffled by the sumptuous subsidies the program provided to private insurers and plan sponsors.

When the stock market is favorable and insurers’ investments make money, insurers often attract customers by initially offering low-cost coverage. The price advantage may disappear once the market cools, competition disappears, or the insured is hooked. For example, when Medicare began prescription drug
coverage in 2006, Humana offered the least expensive policy available in Massachusetts—$7.32 for “Humana Standard.” Beginning in 2007, the price would increase to $16.90 per month, a 130 percent increase for the most “popular plan” in Massachusetts. Boston’s Mayor said that he detected a “bait and switch” situation. Humana attributed the increase to a Part D subsidy formula that artificially underpriced premiums in 2006 and overpriced them in 2007.166

Any plan that sets up competition between private and public insurance can lead to the private insurers “cherry picking” low-cost employees groups by offering less expensive plans. For example, Blue Cross Blue Shield originally was nonprofit and used community rating; that is, insurance rates were uniform regardless of age, sex, or health condition. Private health insurers, however, offered rates that varied according to the age and sex of participants and excluded preexisting conditions. This enabled for-profit insurers to offer lower rates than the Blues, which eventually succumbed and matched the pricing practices of the for-profit insurers. Cherry picking could leave public programs saddled with the high-risk, high-cost employees.

S.2229 (Kennedy/Dingell), H.R. 2072 (Stark/Rockefeller), and Medicare Plus/Health Care for America are all multipayer systems that perpetuate the nonbenefit expenses of administration, sales, commissions, and the billing burden on providers and insurers. Moreover, when providers and insurers compete, they frequently do so by advertising, adding even more nonbenefit costs.167

Plans that require individuals to buy medical insurance coverage “force the poor or near poor to buy…policies that offer grossly inadequate coverage, guaranteeing an epidemic of medical bankruptcies.”168

Means-Testing Adds Costs
Any means testing to determine eligibility for a program or for a subsidy substantially increases costs. And it is a cost that must be incurred time after time to determine whether the beneficiary remains eligible. The Massachusetts plan, which means-tests eligibility for a dizzying number of program features, multiplies nonbenefit costs without offsetting savings.

Tax Breaks and Subsidies Add Costs
Tax breaks for health care already exist on a grand scale. In 2005, tax expenditures (tax breaks) for employer contributions to health care amounted to $90.6 billion.169 That considerable subsidy, which disproportionately benefits people with good pay,170 clearly has not achieved improved coverage on the scale desired.

Tax breaks, tax incentives, and subsidies not only hide increased total medical care spending; they shift the burden of those costs to taxpayers. In 2004, federal tax subsidies for private health spending ranged from $102 to $2700 per family (see chart 9).171 Recent research indicates that 33 percent of the cost of tax breaks goes to administration.172

Any plan reliant on tax breaks as a method of easing the cost of purchasing private health insurance does nothing to help those who do not owe income taxes because of low income. For them a tax break is irrelevant as an inducement or aid to purchasing health insurance.

The Downside of Phasing in Coverage
When coverage is extended step-by-step, starting with those with the most appealing claims, like children and the elderly, support for those left behind diminishes.
Gaining majority support for any piece of legislation takes enormous energy, time, and money. To make that effort repeatedly for each group to be added multiplies the effort while reducing the political clout of those left out. By the time their turn rolls around, other urgent issues may well intervene. The lag between establishing coverage under Medicare and Medicaid in 1965 and the addition of SCHIP, the means-tested program for children, in 1997, is a lesson we should take to heart.

A proposal that provides for early access to Medicare for those between ages 55–65 might help some members of a vulnerable group—particularly women—if they can afford the contribution or a feasible way can be found to pay the required subsidies. Such a measure, however, fails to address the underlying coverage and cost concerns for the population at large.

Provider and Insurer Conflicts Add Costs
No matter what else is done, policymakers should eliminate costly conflicts of interest for health providers. An unduly large supply of hospital beds and medical equipment encourages their use to recover capital costs. That greater use generates more total costs. When physicians have an ownership interest in facilities—for example, a testing lab or imaging equipment—it may affect their clinical judgment. A 1994 study showed that physicians who had a financial interest in a laboratory ordered more tests from the laboratory than other physicians. Representative Stark authored legislation banning such conflicts of interest in Medicare. However, the exception for services within the physician’s office comes close to canceling the effectiveness of the rule.

In addition, private facilities can also cherry pick their patients and their services. Such for-profit “facilities [that specialize in particular types of surgery or care] are taking patients away from general-service hospitals, which face steeper costs and generally must care for those without health insurance.”

Cost Savers
Other proposals are desirable but not substitutes for the savings from Medicare-for-All. Computerized patient record keeping can help contain costs by reducing mistakes. Avoiding treatment in emergency rooms, more preventive care, and separating doctors from medical facility businesses can reduce costs. These measures should be adopted. However, none matches the savings achievable by Medicare-for-All. Moreover, Medicare-for-All does not preclude delivery of services through an efficient system such as Kaiser Permanente.

Medicare Is More Transparent than Private Insurance
With hundreds of insurers offering many thousands of differing health insurance plans, keeping tabs on them—let alone policing what they do—is challenging and really impractical. Consumers cannot tell what is going on and can rarely influence insurers’ policy changes. In contrast, changes in a legislated plan like Medicare must go through either a formal congressional enactment procedure or rule making constrained by the Administrative Procedure Act (APA). These require open procedures and opportunities to debate and affect decision making. Medicare-for-All would promote transparency; private plans work behind closed doors.

Medicare-for-All
The Proposal Most Ready to Go
Medicare, enacted in 1964, went into effect in 1965. It started from scratch. Today Medicare is up and running. It has considered and resolved tens of thousands of issues. It has profited from its public-private partnership with private intermediaries who have helped shape the procedures for processing provider claims and learned to navigate them. Health care providers know the ropes. The basics are in place and readily expanded to deal with an enlarged system. It should not take long to set up new centers and train new staff for the program. Undoubtedly, the expansion of Medicare from more than 40 million to 300 million beneficiaries cannot happen overnight, but the framework is there.

Some point to the difficulties encountered with installing Part D of Medicare as a cautionary tale. Attempting to navigate choices for drug coverage and the complications of dual eligibility under the privatization of Medicare with Part D created confusion and caused delay. Medicare Parts A and B pose no such complications.
OWL supports a universal system of health insurance for all ages provided by original Medicare. It offers the most cost-effective route to assured, affordable, and high-quality health care for all. Its essentials are ready to go. It is a trusted program. It preserves the choice people most value, their choice of doctor. It is a proven public-private partnership in the processing of claims.

In addition, OWL supports measures to preserve and improve the original Medicare to reflect the experience of decades and changes in modern medical care and technology, and to better serve all the medical needs of people of all ages.

The worsening health care insurance situation has created a hunger for real reform. Nothing less than the economy; businesses’ ability to compete; federal, state, and local government budgets; and personal physical and financial well-being are at stake. Many financial analyses show that a universal system of health insurance for all ages provided by Medicare is the only plan that saves enough to get us on the road to coverage for all.

We now costantly pay more for less assured medical care as a nation. We can change that to assuring the care we need while spending no more than we currently do. By reducing per capita costs, the nation can afford assured Medicare-for-All. Most importantly, the tragedies often caused by unmet medical needs can be reduced. A healthier nation will be happier, more productive, and more secure.

When Medicare was enacted, many of its advocates believed that its coverage for those age 65 and over would be only the first step towards universal medical care coverage.

Isn’t it time we fulfilled that promise?
Real Voices: Americans Speak Out about Health Care

OWL is pleased to work in partnership with Healthcare-NOW to build the grassroots movement for universal health care in the United States. The following comments are from ordinary Americans who registered their concerns on Healthcare-NOW’s Web site, www.healthcare-now.org.

New York
Since retiring and becoming eligible for Medicare, I have benefited greatly from the universal health “insurance” available to seniors. The pharmaceutical plan under Medicare, however, leaves much to be desired and reformed. Indeed, the same prescriptions are more costly for me than my Medigap insurance coverage that previously included prescription drugs. Universal health coverage under a Medicare-like plan is to be highly recommended for all now.

Oregon
I’m a self-employed person in my late 50’s, with two serious health conditions in the last two years. I take extremely good care of myself. My health insurance is $527 per month, and I have to pay $0 for each visit, including all tests on top of this. If I were to get sick enough not to be able to pay my premiums, I’d probably lose my house, and where does that leave me? Plus, as self-employed people, how are we supposed to save for retirement so as not to be a burden to others?

Oklahoma
My husband is self-employed and we have health conditions that prevent us from purchasing health insurance on the open market. Fortunately, I was recently able to increase my part-time hours at my job to purchase group insurance. However, we pay the entire premium, which is about $950 a month. Counting insurance premiums, co-pays, deductibles, etc., we paid $18,000 in healthcare expenses in 2006! Our 27-year-old self-employed son has multiple health problems and no insurance so is unable to receive the care he needs. We are not in a position to help him. We are hard-working people. We are not looking for a handout. What we are looking for is equitable treatment for all. As a former nurse, I witnessed the pharmacy reps shower doctors with gifts when they came calling. I know that they have two lobbyists for every elected person on Capitol Hill in D.C. I believe that this most powerful lobby group has to be brought under control or completely stopped before anything else can change.

New York
As a primary care physician, I cannot stress enough how important it is to move toward a universal coverage, single-payer health care system NOW. It is becoming almost impossible to deliver quality, equitable health care in this country, and it is clear that so many vital dollars are wasted. A vast majority of doctors support a universal coverage plan, because they see the consequences. Please act NOW.

Tennessee
I am a registered nurse and health care administrator (recently retired). I spent a huge part of my 37-year career finding ways to get coverage for the medical needs of patients. If health care providers were freed from this laborious concern, there is no telling how much talent and skill would be freed up to care for patients—the impact would be wonderful and dramatic!
1 Merton C. Bernstein, “Medicare-for-All would save money and cover everyone,” The Kansas City Star, Sunday, November 6, 2005, B7.


3 Veterans care, currently the most successful and cost-effective American medical care system, could continue to remain separate.


8 Other measures to reduce costs and improve outcomes are desirable. This Mother’s Day Report focuses primarily on the most promising way to reduce costs without reducing care so as to extend coverage within contemporary cost restraints.


12 Kaiser Family Foundation, “Figure 2. Some of the cost-sharing changes that employers offering health insurance consider likely,” Employer Health Benefits Survey, 2003.


21 Ibid., p. 3.


25 Ibid.


28 Ibid.


30 Ibid.


38 The Commonwealth Fund Biennial Health Insurance Survey, 2005, Figure ES-2.

39 Ibid.


48 Centers for Medicare & Medicaid Services, Office of the Actuary: Data from the National Health Statistics Group, National Health Expenditures Aggregate, Per Capita Amounts…Calendar Years 2005-1960.


59 Ibid. The ratio for Cigna was 82.3 percent, 83.9 percent for Health Net, 83.2 percent for Humana, 78.6 percent for United Health Group, 80.6 percent for WellPoint, based on company 10-K, year-end filings with the Securities and Exchange Commission.


61 On April 18, 2007, Republican members of Congress blocked legislation that would have allowed the government to negotiate drug prices for the Medicare program. The legislation would have put Medicare in the company of the Department of Veterans Affairs (VA), which has long been successful in negotiating directly with pharmaceutical companies for lower prices.


78 Ibid., pp. 33-39.

79 Ibid., pp. 43-56.

80 Computations are based on the administrative costs as a percentage of total benefits from the Medicare Trustees, *Annual Reports*, (2004, Table I.C1, p. 3), (2005, Table II.B.1, p. 4), (2006, Table II.B1, p. 5). The 2005 report mistakenly presented administrative costs as $6.4 billion; the corrected total figure was $5.9 billion, which computes as administrative costs of 2 percent.

81 As of 2007, Part C payments to plans will be adjusted based on the basis of their enrollees’ risk profiles. The Kaiser Family Foundation, “Medicare Advantage,” *Fact Sheet*, February 2007, p. 2.

82 National Health Expenditures, Table 11, FY 2004; Medicaid paid out $290.9 billion with administrative expenses of $19.9 billion. See http://www.cms.hhs.gov/NationalHealthExpendituresHealth (last viewed September 23, 2006).


87 HIAA, Health Insurers Association of America, “Results from an HIAA Survey on Claims Payment Processes,” March 2003, p. 8.


92 These reports summarize the “projections” of program funding for the short term (next 10 years) and long term (75 years).

93 2005 Medicare Trustees Report, p. 5.

94 Ibid.

95 Kaiser Family Foundation, “HI Trust Fund solvency projections are sensitive to changes in Medicare and the general economy,” Exhibit 20, based on intermediate projections from 1970-2006 Annual Reports of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.


98 Ibid. National output of goods and services doubled from 1940 to 1959, doubled again by 1965, doubled yet again by 1987, and grew from then to the end of the century by 55 percent.


100 Ibid., p. 6. (“Medicare costs have been contained more effectively throughout the history of the programs than have private insurance costs.”)

101 Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditures, Table 1 for calendar years 2001-2006, January 2007.


110 The kinds of mechanisms utilized by excess profits taxes (as, for example, for new enterprises) could be adapted to this new purpose. As with the income tax, this program would depend upon self-reporting; few businesses would attempt to finagle their numbers. Nonconformance should have discouraging consequences.

111 H.R. 676, Title I, Sec. 101(a). Note that bill numbers here and in the following cites are for the
109th Congress which ended in 2006. H.R. 676 was reintroduced in 2007 with the same numbers for the 110th Congress.

112 H.R. 676, Title I, Sec. 102(a).
113 H.R. 676, Title I, Sec. 102(b).
114 H.R. 676, Title I, Sec. 103(d).
115 H.R. 676, Title I, Sec. 103.
116 H.R. 676, Title I, Sec. 104.
117 H.R. 676, Title III, Sec. 303 (c).
118 H.R. 676, Title III, Sec. 303 (e).
119 H.R. 676, Title II, Subtitle B, Sec. 211(c), Sec. 212.
120 H.R. 676, Title I, Sec. 102(c); the 2007 PAYGO requirements of budget neutrality would require that programs be funded by new taxes or offsetting savings.
122 Ibid.
123 Ibid.
124 Ibid.
126 S. 2229, Title XXII, Sec. 2202 (a)(2)(A)(i)(II) and (B).
127 S. 2229, Title XXII, Sec. 2202 (a)(3).
128 S. 2229, Title XXII, Sec. 2202 (d).
129 S. 2229, Title XXII, Sec. 2202 (d)(1)(B).
130 S. 2229, Title XXII, Sec. 2204.
131 S. 2229, Title XXII, Sec. 2203 (a).
132 S. 2229, Title XXII, Sec. 2205.
133 S. 2229, Title XXII, Sec. 2203 (b).
135 H.R. 2072, Part E, Sec. 1860E-1(b).
136 H.R. 2072, Part E, Sec. 1860E-3, Sec. 1860E-4.
137 H.R. 2072, Part IV, Subpart C, Chapter 1, Subchapter A, Sec. 36.
138 H.R. 2072, Part E, Sec. 1860E-5.
139 H.R. 2072, Part E, Sec. 1860E-6.
140 Former Senator John Edwards’ proposal is quite similar; it would meet its additional added cost of $80 to $120 billion by rescinding some tax cuts and increasing excise taxes. Senator Edwards contends that his proposal would help pave the way for Medicare for All.
141 It is unclear whether this is in addition to the Medicare payroll tax currently paid by employers.
143 Hacker, EPI Briefing Paper #180, p. 3.
144 Ibid., p. 4.
145 Ibid., p. 7.
146 Ibid., p. 10, note 10.
152 Ibid.
153 Ibid.


159 See http://www.boston.com/business/globe/articles/2006/11/30/legislators_fear_some_health_plans_could_prove_limited_costly/.


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