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## **The single-payer path to genuine health care reform: The United States National Health Care Act, H.R. 676**

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### **Brief summary**

- The U.S. National Health Care Act, H.R. 676 (also known as “The Expanded and Improved Medicare for All Act”), would establish an American single-payer health insurance system.
- The bill would create a publicly financed, privately delivered health care system that builds on the existing Medicare program. It would improve and expand Medicare to cover all U.S. residents.
- Patients would go to the doctors and hospitals of their choice.
- The legislation would guarantee access to comprehensive, high quality and affordable health care to everyone who needs it, regardless of employment, income or health status.
- By replacing our nation’s fragmented patchwork of competing private insurance companies (with their wasteful administrative costs, profits and high executive salaries) with a single-payer program, the nation would save more than \$300 billion per year, enough to guarantee comprehensive health care to all, with no co-pays or deductibles.
- The program would be funded through a combination of existing federal and state health care spending, a modest payroll and income tax and surtaxes on very high-income groups. Payroll taxes would be fully offset by a reduction in premiums and the virtual elimination of out-of-pocket expenses.
- H.R. 676 would help contain rising health care costs through streamlined administration, bulk purchasing and global budgeting.
- The bill has been introduced by Rep. John Conyers Jr. of Michigan and, as of January 2009, is co-sponsored by over 70 additional members of Congress.

### **Who is eligible?**

- Every person living in the United States and the U.S. Territories would be automatically enrolled in the program and would receive a United States National Health Care (USNHC) card, which they would present at their site of care.

- The secretary of Health and Human Services would define residency criteria and have the power to create rules regarding medical tourism and establish reimbursement arrangements for visitors.

## **Benefits**

- The program would cover all medically necessary services, including primary and preventive care, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, long-term care, home care, mental health services, dentistry, eye care, chiropractic care, substance abuse treatment, podiatric care and palliative care.
- Patients would have free choice of physicians and other clinicians, hospitals and other inpatient care facilities; they would no longer be restricted to privately defined “in-network” providers.
- Patients would have no co-pays or deductibles, which, studies show, discourage patients from seeking necessary medical care.
- Preventive care would be emphasized, and patients would be encouraged to have a regular site for care. Such practices have been shown to improve the quality of care.
- On a national scale, a single-payer program would benefit the economy and stimulate job growth by reducing the burden of health care costs on workers, unions and businesses.

## **Cost containment and reliable reimbursement**

- Congress would establish annual funding outlays for the program ensuring that all facilities are adequately and optimally staffed.
- The program would annually negotiate prescription drug prices and reimbursement rates for physicians, pharmacists and other health care providers that reflect their expertise and the value of their services.
- Payment methods for health care providers would include fee-for-service payments that are uniform across regions, capitation payments for primary care facilities, and annual global budgets for hospitals.
- The program would also allocate funds to promote health professional education.
- Investor-owned, for-profit health care institutions, which studies show have a lower quality of care and worse medical outcomes than their not-for-profit counterparts, would be converted to not-for-profit institutions as quickly as possible. The secretary of HHS would have the power to establish the mechanisms for the conversion. Payment would be made only for real estate, buildings and equipment, not for loss of business profits, over a 15-year period through the sale of U.S. Treasury bonds.

## **Conversion to a nonprofit health insurance system**

- Private health insurers would be prohibited from selling coverage that duplicates the benefits of the USNHC program. They would not be prohibited from covering any additional benefits not covered by H.R. 676, such as cosmetic surgery and other medically unnecessary treatments.
- Those health insurance company employees who are displaced as a result of the transition would be the first to be hired and retrained under H.R. 676. Those not rehired would receive two years' unemployment benefits and retraining as well as access to a new trust fund that would give the unemployed salary parity up to \$100,000 for two years.

## **Funding the USNHC program**

- Nearly two dozen studies conducted since 1991 have shown that such a program could be operated – covering all those who are currently uninsured as well as the insured – without spending any more than we are now.
- It is estimated that there would be administrative savings (reductions in paperwork, etc.) of at least \$400 billion each year. These funds would be used to provide additional health services for those who are currently uninsured and underinsured. Additional savings would be obtained from the bulk procurement of medications.
- Funding for the program would come from a variety of sources and would be placed into a dedicated USNHC Trust Fund, to be administered by public or quasi-public regional boards:
  - Existing sources of federal government revenues for health care.
  - Increasing personal income taxes on the top 5 percent of income earners.
  - Instituting a modest and progressive excise tax on payroll and self-employment income.
  - Instituting a small tax on stock and bond transactions.
  - Additional annual appropriations as necessary to maintain maximum quality.

## **Accountability**

- Currently no one is held accountable for the inadequacies and inequities in our health care. With USNHC, nationwide quality assessment of our medical system would be possible. This would reduce medical errors, streamline administration, promote best practices and reduce costs.

## **Is it realistic?**

- Implementing such a system is certainly realistic, even in the context of the current economic turmoil. Our present arrangements – with over 100 million Americans uninsured or underinsured and our out-of-control health care costs – are simply unsustainable.

- Everyone faces the possibility of poor health. Under a single-payer system, risks are shared broadly to ensure fair treatment and equitable rates, and everyone contributes to the system through progressive financing.
- Taiwan was the latest country to adopt a single-payer system. Since it adopted a single-payer plan in 1995, health care coverage of Taiwan's population has increased from 57 percent to 98 percent. Life expectancy has improved. And total health care spending has been manageable, at 7 percent of the GDP, unlike the 16 percent of GDP spent by the US.
- Public financing of health care in other countries reduces waste in the system, leads to better outcomes for patients and provides greater equality of access.
- A survey published in the Annals of Internal Medicine (April 2008) shows 59 percent of U.S. physicians support national health insurance, a jump of 10 percentage points from five years ago. Other surveys show even stronger support among the U.S. population for a "Medicare for all" approach.

### **Co-sponsors of H.R. 676 as of April 1, 2009**

**Sponsor: Rep. John Conyers Jr. [MI-14]. Co-sponsors: 74**

Rep. Abercrombie, Neil [HI-1]	Rep. Honda, Michael M. [CA-15]
Rep. Baldwin, Tammy [WI-2]	Rep. Jackson, Jesse L., Jr. [IL-2]
Rep. Becerra, Xavier [CA-31]	Rep. Jackson-Lee, Sheila [TX-18]
Rep. Berman, Howard L. [CA-28]	Rep. Johnson, Eddie Bernice [TX-30]
Rep. Bishop, Sanford D., Jr. [GA-2]	Rep. Johnson, Henry C. "Hank," Jr. [GA-4]
Rep. Brady, Robert A. [PA-1]	Rep. Kaptur, Marcy [OH-9]
Rep. Brown, Corrine [FL-3]	Rep. Kennedy, Patrick J. [RI-1]
Rep. Capuano, Michael E. [MA-8]	Rep. Kildee, Dale E. [MI-5]
Rep. Clarke, Yvette D. [NY-11]	Rep. Kilpatrick, Carolyn C. [MI-13]
Rep. Clay, Wm. Lacy [MO-1]	Rep. Kucinich, Dennis J. [OH-10]
Rep. Cleaver, Emanuel [MO-5]	Rep. Lee, Barbara [CA-9]
Rep. Cohen, Steve [TN-9]	Rep. Lewis, John [GA-5]
Rep. Costello, Jerry F. [IL-12]	Rep. Loeb sack, David [IA-2]
Rep. Cummings, Elijah E. [MD-7]	Rep. Lujan, Ben Ray [NM-3]
Rep. Davis, Danny K. [IL-7]	Rep. Maloney, Carolyn B. [NY-14]
Rep. Delahunt, William D. [MA-10]	Rep. Massa, Eric J. J. [NY-29]
Rep. Doyle, Michael F. [PA-14]	Rep. McDermott, Jim [WA-7]
Rep. Edwards, Donna F. [MD-4]	Rep. McGovern, James P. [MA-3]
Rep. Ellison, Keith [MN-5]	Rep. Meek, Kendrick B. [FL-17]
Rep. Engel, Eliot L. [NY-17]	Rep. Meeks, Gregory W. [NY-6]
Rep. Farr, Sam [CA-17]	Rep. Miller, George [CA-7]
Rep. Fattah, Chaka [PA-2]	Rep. Moore, Gwen [WI-4]
Rep. Filner, Bob [CA-51]	Rep. Nadler, Jerrold [NY-8]
Rep. Frank, Barney [MA-4]	Rep. Napolitano, Grace F. [CA-38]
Rep. Green, Al [TX-9]	Rep. Olver, John W. [MA-1]
Rep. Grijalva, Raul M. [AZ-7]	Rep. Pastor, Ed [AZ-4]
Rep. Gutierrez, Luis V. [IL-4]	Rep. Payne, Donald M. [NJ-10]
Rep. Hastings, Alcee L. [FL-23]	Rep. Pingree, Chellie [ME-1]
Rep. Hinchey, Maurice D. [NY-22]	Rep. Polis, Jared [CO-2]
Rep. Hirono, Mazie K. [HI-2]	Rep. Roybal-Allard, Lucille [CA-34]

Rep. Rush, Bobby L. [IL-1]  
Rep. Ryan, Tim [OH-17]  
Rep. Schakowsky, Janice D. [IL-9]  
Rep. Scott, Robert C. "Bobby" [VA-3]  
Rep. Thompson, Bennie G. [MS-2]  
Rep. Tierney, John F. [MA-6]  
Rep. Tonko, Paul D. [NY-21]  
Rep. Towns, Edolphus [NY-10]  
Rep. Velazquez, Nydia M. [NY-12]  
Rep. Waters, Maxine [CA-35]  
Rep. Watson, Diane E. [CA-33]  
Rep. Welch, Peter [VT]  
Rep. Wexler, Robert [FL-19]  
Rep. Woolsey, Lynn C. [CA-6]  
Rep. Yarmuth, John A. [KY-3]