What Happens After ACA Destruction

I'm not going to talk about AHCA, BRCA, or any other GOP travesty today. I'm not even talking about ACA, which is challenged not only by the GOP but by our patchwork health care system and it's own imperfections, with about 21 million still uninsured. And we all know that any of the GOP plans will end up adding over 22 million to this number.

So today I'm going right to the heart of the matter. Universal affordable care. It's time has come. Many Democrats, including recently our own Kirsten Gillibrand, are coming around to supporting it.

But how can we change our current chaotic system, where we have the highest healthcare costs, the highest maternal and infant mortality rates, and the lowest life spans among all the equivalent industrialized nations? Currently the average life expectancy in the US is 79.3 years, about the same as Cuba and Costa Rica.

Think of our current healthcare system as a deep dark pond full of horrible creatures upon which a number of lily pads are floating, which we call Medicaid, insurance plans, Medicare, and being rich. Staying on these lily pads is determined by various factors -- age, the state you live in, income, employment status, what party is in power, or just plain luck. As long as the lily pad can hold you, you're ok, but fall off and you sink into that dark pool of disease, financial disaster, and social isolation. And the other lily pads are out of reach.

So how can we pull these lily pads together and form a single raft of coverage?

Starting the path to universal care with the Medicaid lily pad is not the answer. It's a patchwork program within a patchwork program. It's restricted to specific populations (kids, disabled, pregnant women), and its coverage varies wildly depending on your income and the state you live in. Children have been covered for years under Medicaid, even before the ACA, so at the time it was implemented only 7% of kids were not covered. Poor non-disabled single adults or the kids' parents, are totally out of luck if they live in states that did

not expand. In the typical non-expanded state, for example, a single men with an income over 44% of the poverty line ($7000) is not eligible for Medicate. And it can be worse, depending on the state. For example, in Texas, which does not have expanded Medicaid, parents of a single child with an annual income over $3000 receive no coverage.

New York, on the other hand, has among the richest Medicaid benefits in the country, with non-disabled single adults qualifying whose income is up to 138% of the poverty line ($16,394). After that they are eligible for tax credits on the NY insurance exchange until their income is over 400% of the poverty line ($64,000). https://www1.nyc.gov/assets/ochia/downloads/pdf/federal-poverty-guidelines-2016.pdf

More on New York, later.

Then we have the insurance lily pads. Employer based health insurance is still the cornerstone of our nation's coverage. The ACA health exchanges use insurers to expand coverage to the unemployed, underemployed, and the self-employed – in New York about 3.6 million people currently are enrolled in our exchanges, about 18% of our population.

Although the GOP has undermined the safeguards that the ACA had set up to protect insurers from high-risk and low-income patient, if they could put their money where their mouth is, basing a system using insurers might fit whatever ideology they have left. And there are many countries that use insurers successfully for providing universal care. Switzerland and German use what's called an insurance mandated system, in which citizens are required to buy premiums taken as payroll deductions, with employers contributing a certain percentage. In both countries insurance companies compete for customers but are required to cover essential benefits. France and Israel use the two-tiered system, in which the government collects mandatory contributions, which it uses to fund the public insurers that provide coverage. People can also buy supplementary insurance from private insurers. The French system, in fact, is considered to be one of the best in the world, combining universal health coverage, generous services, access without long waiting times, patient choice,

and high satisfaction. The insurers in these countries that receive funding are not-for-profit. And if the GOP only suppors insurance companies that are more responsible to their shareholders than their patients, such a system in our country would never be cost efficient nor would it ever truly serve the common good.

So, let's now look at the single payer system, which is used in Canada, UK, Japan, Italy, and Scandinavia, among other countries, to provide free essential care for everyone, including immigrants and new residents. Funding is from public sources, and primary care doctors are the coordinators of care. Most of these countries use a decentralized method for delivering care – in other words, regional or provincial governments (like our states) generally take care of administering the tax-funded plans. None of these systems are perfect, but in a 2012 poll 94% of Canadians view universal healthcare as a source of personal or collective pride. The Canadians in fact call their system Medicare.

Which leads to our last lily pad, Medicare, which is basically a single payer system. And like the Canadians, nearly everyone on our home-grown Medicare likes having it. It is paid for with payroll contributions and available to everyone 65 and over, who, after they are eligible pay a premium based on income, with supplementary health insurance available to those who can afford it. Its co-pays and deductibles can still be a great burden for older citizens whose source of income is only social security, but still everyone is covered for basic health benefits, Eventually, if we live long enough, we land back on the original lily pad, Medicaid. But in the meantime, Medicare gives our old age a little breathing space. We can perch on our pad and enjoy the sun. So some form of Medicare for all is the road we should take. It's administrative system works and probably could be expanded to cover everyone without severe bureaucratic trauma.

But there's one more thing, which has to be dealt with. In fact all nations have to deal with – and that's the high costs associated with advanced technology, prescription drugs, and an aging population. The US has a particular problem, because we have too many specialists compared to primary care physicians. In countries that have a higher proportion of PCPs than specialists (which is all of the other countries with universal care), costs are lower and health

quality is higher than in those with the reverse,

We already don't have enough internists and family physicians, and the rate is declining. One report found that 62 million Americans lack access to a family doctor. In Sweden, Germany, France, and the UK – all with universal care -- well over 80% of the population have fairly or very easy access to primary care physicians.

So in summary, there are four basic premises for establishing effective universal care:

- A guarantee by the federal government that every citizen from cradle to grave receives affordable essential health care.
- Mandatory contributions from everyone who can afford it, whether through taxation or payroll contributions, with the wealthier paying progressively more.
- A cost effective system for delivering care, which, as in many countries, can be through state governments, but should be coordinated locally by teams led by primary care clinicians.
- A system for containing and regulating costs, which include negotiated drug costs, and physician and procedural fees.

How do we get there? Although Medicare is the most logical federal program to start with, the GOP are unlikely to even think in those terms. So, maybe the place to start is with the states. In spite of the failure of the Vermont and California single payer acts to pass, increasing attention is being paid to starting this process in the states. And New York has many advantages. We have having already set up our own exchanges, independent from the federal program, which are working efficiently. And we have a successful expanded Medicaid program, and we're a relatively wealthy state. Our lily pads are almost raft-like.

Nevertheless, although analysis after analysis shows that single-payer systems reduce costs, we would still need federal funding; the states can't bear the entire burden themselves, and we need a pool of the existing federal funds that come in through Medicaid, Medicare, and insurance subsidies.

New York currently has a single-payer bill Senate Bill 4840 in committee

https://www.nysenate.gov/legislation/bills/2017/s4840/amendment/original So, now I'm going to turn over the floor to Cristin O'Neal, from the Campaign for New York Health, which is the main advocacy group for supporting the New York single payer bill.