WMM4A KNOWLEDGE BASE /TALKING POINTS about Single Payer (6.16.19)
This is work-in-progress. Comments, feedback to info[at]wmMedicareforall.org

I. PART ONE: What is the problem? Current Health Care Crisis

A Insecure, chaotic

1. Different plans, coverages, changes in policies and eligibility
2. Insurance tiers / networks / panels limit choice of providers
3. Loss of coverage due to changing circumstances: if change or lose job, if employer changes plans, if insurer changes policies, if earn too much or too little, if miss verifications, if age out, if marital status changes.
4. Costs increase, benefits decrease. Unpredictable changes to coverage and costs.
5. Insurance information is complex, opaque. It's not a true market because you don't know what you might need or what exactly you're buying; can't "comparison shop" for care when you need it.

B Unfair

1. Nearly 200,000 people are uninsured in Mass.
2. Many more are "under-insured" – can't afford health care because of high out-of-pocket costs.
3. Mass. is one of the most unequal states in the country by income. HC is based on ability to pay, employment. Access to care and resources vary by zip code. Current system reinforces inequality and racial disparities.
4. Burden on businesses compared with global competitors.
5. "Job lock" for workers – workers under pressure to stay in a bad job because they need the health benefits.
6. Low-wage and part-time workers (majority are women and POC) are the ones most likely to receive worse benefits or none at all from their employers. Yet they may earn too much for Mass-Health.
7. With current system, HC is treated as a privilege, not a right.

C Expensive

1. Mass. is one of the most expensive states in U.S. for HC. U.S. spends about twice per capita compared with other countries – yet is below world quality standards on key indicators such as infant and maternal mortality.
2. Most current insurance plans do not cover vision, dental, or long-term care so these often add to out-of-pocket spending.
3. HC is a leading driver of personal debt and bankruptcy. Medical debt is now the largest category on "Go Fund Me." Many can't afford essential

drugs, such as insulin. Many must choose between health care and other basic needs.

D Unsustainable

1. Prices increase – there is no effective way now to rein them in: hospitalizations, drugs, medical devices.
2. The HC industry is rapidly consolidating (hospitals, pharmacies, insurers, etc.) to their advantage, not ours.
3. Deductibles are rising, benefits are shrinking.
4. Only "plan" now is to shift cost to consumers and decrease benefits.
5. State and municipal / school district budgets are increasingly squeezed by rising and unpredictable HC costs and future HC benefit obligations.
6. Providers have less time for direct care and higher levels of burnout due to paperwork, time spent on admin, pre-authorizations and denials, insurance interference with treatment options.

II. PART TWO: What is Single Payer?

A General Description

1. SP is a system of financing private health care through a publicly funded Health Care Trust. It would guarantee secure lifetime coverage for all medically necessary care to every resident. It is a social insurance program like Social Security and Medicare.

2. SP does not change how our health care is provided, only how it is paid for. It is not like the Veterans Administration that actually delivers care to vets or the National Health Service in England.

3. Currently we have multiple payers – many private insurers, private out-of-pocket payments, and public programs like Medicare and MassHealth. Single Payer sets up one Health Care Trust to pay all claims for health care.

4. Private insurance system would be largely eliminated. Insurers would not allowed to charge for benefits already provided by the Trust.

5. Almost everyone would pay less than they are paying now, and receive broader and more secure benefits. Taxes would be progressive so that the wealthiest individuals would pay more.

6. Another term for SP is “Medicare for All” or “Improved Medicare for All.” Under the new system, gaps in traditional Medicare would be filled and seniors would be covered like everyone else under the Health Care Trust.

B How the financing works

1. 65% of current health care costs are already funded publicly (by tax revenues) through Medicare, Medicaid, CHIP, the VA, etc. The rest is funded by private payments for insurance policies (mostly through employer plans) and private out-of-pocket spending for deductibles, co-pays, non-covered services, and so on.

2. With SP there are no financial barriers to care when you need it. All private spending for premiums, deductibles, and other out-of-pocket costs is replaced by a fair and progressive public tax.

3. There are many ways to finance SP. In Mass., current proposal is for a 10% payroll tax (7.5% employer, 2.5% employees) and 10% on unearned income above $30,000 (capital gains, interest, dividends). No HC tax on social security or pension income.

C How Single Payer brings down the cost curve

1. SP eliminates the admin bloat, inefficiency, complexity and confusion of the private insurance system.

2. The current system operates with 30% overhead (about half for overhead of insurers; the other half is provider overhead required to deal with the multiple insurers). Compare this with 3% for Medicare. |

3. SP also brings down the spending curve as it has the clout to negotiate fairer prices for drugs, equipment, hospitalizations, etc.

4. In the longer term, spending is also reduced because of better access to preventive and primary care, avoiding more expensive interventions later. SP focus is healthcare, not profit, so it can focus on best practices and long-term health improvement goals, with unified data across the whole system.

5. With SP, overall spending on health care is estimated to decrease by about 10% even after accounting for the additional costs of universal coverage and comprehensive benefits.

III. PART THREE: "A better world is possible" with Single Payer

A Security

1. Guaranteed comprehensive lifetime coverage for everyone
2. No financial barriers to care
3. Continuity of care – no gaps, changes in networks, etc.
4. Never one accident or serious illness away from financial catastrophe
5. Health care available when you need it – transparent benefits, no network constraints, no "pre-authorizations"
6. Transparent and consistent coverage
7. Providers always paid – no uncollected copays, uncompensated care
8. Better health outcomes resulting from universal coverage, access to preventive and primary care, coordinated data and best practices.
9. Comprehensive benefits including vision, dental, mental health, and long-term care

B More Equitable

1. Provides universal coverage, not tied to employment, income, or zip code.
2. Provides the foundation for addressing racial disparities
3. Fair, progressive public funding with comprehensive services for everyone.
4. Publicly accountable
5. Oversight of services, resources, and major capital investments so all geographic regions are well-served.
6. Moral imperative (UN, WHO) – health care as a human right not a privilege. Like clean air, water, fire protection, and so forth. All residents are covered regardless of their income, employment, health status, citizenship, etc.

C Freedom

1. Freedom to choose your provider – one system: no tiers, networks, levels of coverage
2. Treatment decisions by you and your provider – not the insurer
3. Every individual covered regardless of situation - not dependent on family coverage, marriage, employer, etc.

D Economic Development

1. Levels the playing field for small businesses and entrepreneurs.
2. Unburdens employers from the unpredictability, expense, and responsibility of administering health care benefits.
3. Ends job-lock for workers – promotes mobility, entrepreneurship.
4. Relieves municipal, school district, employer, and household budgets.

E Efficiency, cost management

1. No more subsidizing the private insurance industry – currently public dollars pay insurers if individuals can't afford their policies; 30% of health care dollars prop up the inefficient system of private health insurance industry.
2. More efficient and less expensive administration. Overhead is about 30% now; Medicare is 3%.
3. Bends cost curve downward– negotiating prices on drugs, medical devices, hospitalizations, etc.; universal access to preventive and primary care drives down costs of more complicated situations later.
4. Better value for our health care dollars: the only purpose of the SP system is health care, not profit.

IV. PART FOUR: State Legislation

A "An Act Establishing Medicare for All in Mass." – 2019-2020 legislative session; Lead sponsors: Sen. Jamie Eldridge in Senate (S683); Rep. Lindsay Sabadosa in House (H1194). Cosponsors so far include 57 representatives and 17 senators – more than one-third of the whole Legislature.

1. Establishes a Massachusetts Health Care Trust to hold all funds and pay all claims for medically necessary care for Mass. residents. This Health Care Trust would be the "Single Payer." The Trust would also fund capital investments to make sure all parts of the state have adequate facilities and resources.

2. Lays out the administration of the Trust headed by a 23-person board of trustees. The board would be comprised of the Secretary of Health and Human Services, Sec'y of Admin.and Finance, and Commissioner of Public Health; 12 appointees by Governor and Atty. General mostly nominated by

organizations representing health care providers, labor, consumer and other stakeholders, as well as 8 members directly elected by Mass. voters.

3. The Board of Trustees would hire an Executive Director to run the Trust and oversee the Directors and staff of five divisions: Planning, Information Technology, Administration, Quality Assurance, and Regional outreach.

4. Defines eligible participants (all Mass. residents) and providers (licensed to practice in the state as well as other criteria) and broadly outlines the scope of covered benefits – including among other areas preventive and primary care, outpatient, inpatient, rehabilitative, vision, dental, mental health, and long term care.

5. States that insurance companies will not be allowed to charge premiums for coverage of services that are covered by the Health Care Trust.

6. Proposes a financing method that includes a 10% payroll tax – 7.5% to be paid by employers (exempting the first $30,000), and 2.5% by employees. Self-employed folks would pay 10% of payroll, exempting the first $30,000. Unearned income above $30,000 – on dividends, interest, and capital gains– would also be taxed at 10%. (SS, pensions, retirement accounts not taxed.)

7. Under the proposed financing, almost everyone would pay less for Single Payer than they currently pay for premiums, deductibles, non-covered services, and other out-of-pocket costs – and receive more comprehensive and secure lifetime benefits.

8. Up to 2% of the Trust's funds would be spent annually for training and retraining of workers displaced by the transition to Single Payer.

9. Links to the full text of the bills and to our slideshow about the bills can be found on the WMM4A website at www.wmMedicareforall.org

B The State Legislative Process

1. Similar legislation has been filed each legislative session for about 20 years but has never advanced out of committee – even though the legislature has a super-majority of Dems in both houses, and state Dem platform endorses SP.

2. The bill is now in the Health Care Financing Committee. There was a public hearing in June. Now the Committee will decide whether to advance the bill or not for this (2019-2020) legislative session.

3. If and when the bill does advance through other committees for consideration on the floor of the Legislature, there are bound to be debates and amendments that could radically challenge or change the legislation.

4. A M4A Legislative Caucus was recently formed (leaders: Sens. Eldridge and Comerford on the Senate side; Reps. Sabadosa and Gouveia on the House side). The Caucus is working with SP advocates to help advance the bill and educate the public and other legislators about SP.

5. There have been several Mass. SP cost studies done in the past. There has been no progress in the current session to fund another study.

V. PART FIVE: Organizing and Opposition

A Opposition to SP

1. Opposition to Single Payer is driven by vested interests: insurance corporations (BCBS is biggest insurer in state – it is technically a non-profit; Mass. Assn. of Health Plans); pharmaceutical industry (Biotech Council is a major lobby); big hospitals (such as Partners in Boston area); medical device manufacturers.

2. Opposition also comes from elected officials who are beholden to vested interests (due to financial contributions, political influence, personal career aspirations); not willing to take on the work involved with such a big policy issue; afraid they will lose support from constituencies or lobbies they consider important; afraid to oppose the leadership in House and Senate.

3. Some labor unions oppose SP because they offer better-than-average health benefits through their own plans (often called "Taft-Hartley" plans) and see these plans as a way to benefit and grow membership; or because they are beholden to politicians tied to vested interests.

B Organizing – how do we win?

1. Because of the strong opposition, winning SP requires building a powerful popular movement that is more difficult for the Legislature to oppose than opposing the vested interests.

2. Statewide, we intend to build that movement by developing activist hubs in all of the 160 state representative districts; public education and inoculation against opposition talking points; building a committed coalition of community and labor organizations; working with allies in the legislature and electing more legislators who pledge to support SP.

3. If the legislative road continues to be blocked, the statewide movement might consider running a ballot question instead, and let the voters decide.

4. WMM4A is a regional network of groups and individuals advocating for Single Payer. Our priority is working for SP in Mass. We are a member of the statewide coalition called Mass-Care and also work in solidarity with the national campaign.

5. WMM4A helps to develop and supports hubs in different towns and cities that organize neighbor to neighbor outreach, educational events, tabling, and lobbying of their local reps. We also promote regional campaigns and coordinate messaging, media, and training for the hubs. Western Mass. is recognized as a leader in developing grassroots organizing on a regional basis and a model for other parts of the state. A regional group in Boston is currently in formation.

6. Some of our achievements include: Visibility actions throughout the 2018 election season; successful non-binding ballot initiatives across 6 legislative districts in 2018; dozens of public forums, including Fix It showings with Q&A; resolutions in N'ton City Council and several Town Meetings; maintaining an active website and FB page; developing literature, media coverage; trainings, etc.

7. WMM4A holds a monthly General Assembly in Holyoke for individuals and hub members throughout the region. A Steering Committee coordinates messaging, training, literature, and regional events. Local hubs also meet monthly in their own area.

PART SIX: Responding to Questions - Coming soon!