Invited Editorial

The Wisconsin Health Security Act: A necessity for people, business, and the economy

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The Problem: The rise of market-driven, investor-owned, for-profit health care has led to an increase in costs, and a decrease in access and benefits.

The Solution: The Wisconsin Health Security Act, a publicly funded not-for-profit health plan for Wisconsin.

The world has recoiled in shock at the devastation wreaked on the chronically poor people of New Orleans by Hurricane Katrina. A recent survey of those people evacuated to Houston shelters revealed some health-related facts about this suddenly visible population: 52% report having no health insurance coverage at the time of the hurricane. Of those with coverage, 34% use Medicaid and 16% use Medicare. Before the hurricane, 66% used hospitals or clinics as their main source of care and, of those, a majority (54%) used Charity Hospital of New Orleans substantially more than the second most common care site, (University Hospital of New Orleans, 8%).[1] These evacuees will face serious health problems as they also face being homeless and myriad other challenges.

Hopefully the situation in New Orleans will help us all open our eyes to the seriousness of the problem facing health care today. Here in Wisconsin it is too easy to blind ourselves to the plight of the poor—usually working—people who live among us and who do not have health insurance or access to public hospital services. Increasingly more of the middle class and those with inadequate insurance also suffer from less than optimal health care. It is unconscionable that the infant mortality in the Milwaukee African American population is 19.2 deaths/1000 live births in the first year of life versus 4.5 in the white population in Wisconsin.[2]

As doctors we are well aware of the growing crisis in health care: the escalating costs; the increasing number of people without health insurance; the burden borne by business and government entities; the uncompensated care; the cost shifting; the dismay of working people who are having to pay a greater share of the premium costs; the uncontrolled increases in prescription drug costs; the looming shortage of nurses and even doctors, especially primary care physicians; and, not least, the hours we spend doing paperwork and trying to advocate for our patients as we deal with the multiple insurance plans and their frustrating bureaucracies.

Fourteen years ago, the reform of the fragmented, inequitable, and increasingly costly health care in the United States topped the political agenda. With the defeat of the Clinton effort to change the system—a defeat led by the powerful wealthy players in the medical/industrial complex (pharmaceutical companies, insurance companies, the Hospital Association, and the American Medical Association)—health care has gone from a service profession to a business. The radical change has occurred without input from Congress, public health planners, the medical profession, or the American people. Rather, large corporations saw the trillion-dollar pot of gold (now $1.8 trillion)[3] and began the for-profit takeover, including:

- Buy-outs of not-for-profits by the huge for-profits.
- Increasing dominance of for-profit HMOs.
- Mergers of corporations producing too much power. Seven national for-profit plans now control 80% of private health care insurance in this country.
- Shareholders demanding profit but contributing nothing to health care.
- Downsizing of health care professionals and down-skilling of "nursing staff," with doctors paid more for giving less care. The

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number of US doctors and nurses has not increased appreciably during the past 15 years, but the number of administrators and staff who tell our doctors how to treat us has increased 2500%.[4]

- Marketing to the healthy and wealthy while rejecting the sick and poor.

Most physicians support the idea of universal health care. The problem lies in how we get there. Every other industrialized nation ensures care for all its people. In this country we have tried incremental approaches for decades, emphasizing private sector solutions, which have failed. Our costs continue to escalate, the number of uninsured has grown, and our health outcomes have fallen behind.

To understand how a publicly funded, one payer system works, we need to look at the one system in this country that provides universal coverage to a very large (40 million) pool of people: Medicare, which covers the elderly and those with disabilities. Insurance companies could not make profits from a group known to need increasing medical care, and the elderly, many with very low incomes, could not afford insurance. Medicare is an entitlement program with no bureaucratic means testing. The funding is collected by the government through payroll taxes, portions of social security taxes, and general revenues. The government is then the one payer reimbursing hospitals and health care professionals. The administrative overhead for Medicare is less than 3%, in contrast to the 16%-30% overhead for private insurance companies.[5]

It is time to expand and adequately fund Medicare by fully implementing a publicly funded, mostly privately run health care system, commonly known as Single Payer. The following thoughts should be kept in mind:

- Access to quality, comprehensive health care is a human right.
- Financial barriers to health care must be removed.
- Patients should have the freedom to choose their health care professionals.
- Personal medical decisions must be made by patients with their caregivers, not by corporate or government bureaucrats.
- Pursuit of corporate profit and personal fortune has no place in caregiving.
- In a democracy, the public should set health policies and budgets.

The United States in general, and Wisconsin in particular, already have the rich resources needed to provide for everybody. We have excellent hospitals, dedicated, well-trained physicians and other professionals, the latest in technology and equipment, and superb research. Current spending, which is generally twice as generous as any other nation, is sufficient to include everybody. The public sector already spends about 60% of the 1.6 trillion total health care dollars to provide care for about 45% of the people.[6] The groups in this population tend to have higher health care costs. They are the elderly, the people with disabilities, the poor, the veterans, the Native Americans, and all public employees, including federal, state, school district, county and city employees who generally have very good coverage. In Wisconsin, as in other states, health care costs are rising as premiums increase and as more people become eligible for the public programs such as Medicaid, Badger Care, Senior Care, and Family Care. One way to address this issue is through the Wisconsin Health Security Act.

The Wisconsin Health Security Act

The Wisconsin Health Security Act, introduced by Senator Mark Miller and Representative Charles Benedict, MD, is a comprehensive plan to provide quality health care to all Wisconsin residents.

Under the Act, a single insurer would replace the 700 or more different insurance plans. The administrative savings derived from eliminating the bureaucratic duplication, marketing costs, and profits often associated with these plans are immense. The state would be divided into six regions, which would be administered at the state and local level by the Department of Health Planning and Finance under the guidance of a Wisconsin Health Policy Board.

Coverage

A single public plan would cover every Wisconsin resident regardless of pre-existing health condition, age, sex, race, sexual orientation, geographic location, employment, or economic status. Only such a single comprehensive plan can address the disparities that characterize Americans' health care.

Benefits

Necessary medical services for maintaining health, and for diagnosis or treatment or rehabilitation following an injury, disability, or disease would be covered, including the following:

- Hospital and clinic services, including office visits and house calls
- Services of physicians, dentists, social workers, and other licensed professionals
- Prescription drugs
- Health promotion and illness or injury prevention
- Long term care, including home and nursing home care, and community health centers
- Mental health services, and alcohol and other drug rehabilitation services

Reimbursement
Health care professionals' organizations would negotiate a fee schedule with their state health plan yearly. Patients would receive no bills. Health care professionals would be reimbursed directly by the insurer. Hospitals' savings would come from replacing itemized billing with negotiated annual global operating budgets. Eliminating patient-specific cost accounting—documenting and billing for each item and/or procedure—would free resources for increased clinical care. Capital budgets and purchase of major equipment would be approved separately from an operating budget, based on health service delivery needs. Long-term care facility budgets would also be set by negotiations. Out-of-state health care professionals would be paid reasonable rates for providing emergency or urgent care to Wisconsin residents traveling outside of the state

Cost Sharing
There would be no direct billing by health care professionals, and no co-pays or deductibles.

Cost Controls
A single payer system, publicly administered, eliminates unnecessary administrative expenses, physician overcharges, cost shifting, and health care professionals and insurance industry advertising costs and profits. It would operate on a global state budget from which all health care professionals are paid.

Quality and Oversight
The Wisconsin Health Security Act sets up monitoring and oversight mechanisms in six regions of the state. It uses regional investigations of quality, access to medical services, and consumer complaints.

Financing
The Act establishes a Health Trust Fund in the Department of Health Planning and Finance. All revenues earmarked for health care would be deposited into the Fund, from which all health care professionals are reimbursed.

Revenue Sources
Revenue sources would include public funds already spent for health care (Federal and state shares of Medicaid and Medicare, General Assistance Medical, Healthy Start, HIRSP etc.); fair share taxes on employers and individuals, which would replace insurance premium payments with a health care tax; and savings from reduction of paperwork, streamlined administration, and cost controls. Between 90% and 95% of Americans would pay less for health care than they do now.

Insurance Industry Role
Health insurance coverage would be permitted only for services not covered by the the Health Security Act. Coverage would be the same for all, regardless of income. Risks and benefits would be shared by all.

The Effects

The plan would have the following effects.

Doctors
There would be no such thing as a non-paying patient or uncovered needed service, much less administrative overhead associated with billing multiple health care insurers with multiple policies, and no more business expenses associated with billing the patient or "dunning" for delayed payments. There would be more time for patient care and more free time for home life.

Hospitals
Hospital revenues would become stable and predictable. More than half of the current hospital bureaucracy would be eliminated, and the remaining administrators could focus on facilitating clinical care and planning for future health needs. Responsiveness to community needs, quality of care, efficiency, and innovation would replace financial performance as the "bottom line."

Families
There would no longer be a need to struggle to maintain health benefits, and people would be more free to change jobs. The risk for bankruptcy due to illness expense would dramatically decrease, and families would be free to choose their health care professional, and have greater continuity of health care.

Communities
The cost of health care coverage for school teachers, district employees, elected officials, and staff will be greatly reduced. (The Madison School District pays $13,000 per year for every teacher family.)

Businesses
Since health care funding would no longer be considered a major responsibility of businesses, businesses would be able to start up and develop without the associated health care expenses. Small businesses in particular would benefit from an increased supply of potential workers who no longer have to worry whether the job they get has health insurance as a benefit.

Tax Payers
Money now spent on health care premiums, co-pays and other out-of-pocket expenses would be more available for increased wages or beneficial programs. Taxes would go up for some, since some of the previous out-of-pocket expenses would be shifted to taxes, but for most people the total would be much less than they presently spend on health care.

Health Insurance Company Employees and Other Displaced Staff
All would have health care coverage and would be free to stay at home, take other employment, or be retrained using money designated for that purpose in the the Wisconsin Health Security Act.

Health Insurance Companies

The insurance/HMO industry would have virtually no role in health care financing, since public insurance administration is more efficient and single source payment is the key to both equal access and cost control. Indeed, most of the extra funds needed to finance the expansion of care would come from eliminating insurance company overhead and profits, and abolishing the billing apparatus necessary to apportion costs among the various plans.

Conclusion

Wisconsin has a proud history of socially responsible innovation and of caring for its citizens. For no greater (and perhaps at even less) cost than the state and the people are paying now, the Wisconsin Health Security Act could establish Wisconsin as a national role model for universal care. It is time that doctors support the only administratively simple, cost-saving, quality approach to assuring health care for all Americans.

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