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Updated Feb 9, 2009

HR 676: 35 Questions and Answers

Q1: What is the name of this Act?
{Section 1(a)}

A1: This Act is called the "United States National Health Care Act" or the "Expanded and Improved Medicare for All Act."

Q2: What does this Act do?
{Section 2(1) and Page 1 Header}

A2: This Act establishes a Program, the United States National Health Care Program (USNHC). The purpose of this Program is to provide comprehensive health care for all United States residents and visitors.

Q3: Who would be eligible to receive benefits provided by USNHC?
{Title I, Section 101(a)}

A3: All individuals residing in the United States or in any territory of the US, as well as all visitors to the US. The bill directs the Secretary of Health and Human Services (HHS) to clarify the criteria to determine residency. It also directs the Secretary to address the issue of medical tourism by foreign nationals.

Q4: How does someone sign-up or register for benefits under USNHC?
{Section 101(b) (c)}

A4: Registration can be accomplished by filling out a (no more than 2-page) application, after which a USNHC CARD will be issued. Alternatively, all persons presenting themselves to a participating provider for covered services shall be presumed eligible for benefits. They can then fill out an application for a CARD. It's important to note that a Social Security number shall NOT be used for registration purposes.

Q5: What benefits are covered under USNHC?
{Section 102(a)}

A5: USNHC covers all medically necessary services. This includes but is not limited to: (1) primary care and prevention; (2) inpatient care; (3) outpatient care; (4) emergency care; (5) prescription drugs; (6) durable medical equipment; (7) long-term care; (8) mental health services; (9) dental services [excluding cosmetic dentistry]; (10) substance abuse treatment services; (11) chiropractic services; (12) basic vision care and vision correction [excluding cosmetic laser vision correction];

and (13) hearing services, including hearing aids; (14) palliative care; (15) podiatric care.

Q6: What happens to my coverage and benefits if I change jobs or move?
{Section 102(b)}

A6: Benefits are completely portable and would move with you. They would continue to be available through any licensed, legally qualified, health care provider in the United States.

Q7: Are there any co-payments, deductibles, or other types of cost-sharing with the USNHC Program?
{Section 102(c)}

A7: No. Nor is co-insurance, or any other form of cost-sharing allowed under the Program.

Q8: Who is qualified to be a participating provider?
{Section 103(a) (1)}

A8: A participating provider must be public or non-profit. Private physicians, private clinics, and private health care providers shall continue to operate as private entities, but are prohibited from being investor owned.

Q9: What happens to for-profit providers?
{Section 103(a) (2-5)}

A9: If they are investor-owned or for-profit, they must convert to non-profit as quickly as possible and will be compensated for the actual appraised value of converted facilities in the delivery of care. Payment for such conversions shall not be made for loss of business profits, only for costs associated with the conversion of real property and equipment. Costs for conversion to a not-for-profit system will take place over a 15 year period through the sale of U.S. Treasury bonds. The bill empowers the Secretary to create a specific mechanism to facilitate the conversion process.

Q10: What guarantees quality of care under USNHC?
{Section 103(b)}

A10: Health care providers and facilities must meet regional and State quality and licensing guidelines, including standards of safe staffing and quality of care. No clinician whose license is under suspension or who has other disciplinary action with a State may be a participating provider.

Q11: Can I keep my current HMO like Kaiser?
{Section 103(c)}

A11: Yes, if they are non-profit, deliver services from their own facility and employ clinicians on a salaried basis. Under USNHC they will receive global budgets or capitation payments. Other HMOs, which principally contract to pay for services delivered by non-employees shall be classified as insurance plans and shall not be participating providers.

Q12: Can I keep my current doctors?
{Section 103(d)}

A12: Yes, patients will have free choice of participating physicians and other clinicians, hospitals and inpatient care facilities.

Q13: What happens to private insurance companies?
{Section 104(a) (b)}

A13: They won't exist except to cover any additional benefits not covered under USNHC, such as cosmetic surgery or other services that are not medically necessary.

Q14: How will USNHC money be spent?
{Title II, Section 201}

A14: The USNHC Program will have an annual operating budget, a capital expenditures budget, reimbursement levels for providers, and a health professional education budget, including money for continued funding of resident physician training programs. Congress will appropriate an annual budget, and then the Director of USNHC will allocate funds to each regional office to cover global budgets, reimbursements for clinicians, and capital expenditures. The operating budget will include payment for services rendered by physicians and other clinicians, global budgets for institutional providers (hospitals), capitation payments for HMOs, and administration of the Program. The capital expenditures budget will include construction or renovation of health facilities, and major equipment purchases. Co-mingling of funds for operations and capital expenditures is prohibited.

Q15: How will doctors and hospitals be paid?
{Section 202(a) (b) (1)}

A15: Hospitals will receive an annual global budget, HMOs will receive capitated (per patient) payments, and doctors who are fee-for-service

doctors will be paid for each service. Doctors who work in a hospital or an HMO will receive a salary determined by the hospital or HMO.

Q16: How are doctor and hospital fees determined?
{Section 202(b) (2)}

A16: Provider fees will be set through negotiations between physicians and other clinicians, and in consultation with the National Board of Universal Quality and Access and regional and State directors. Initially, prevailing fees would be the basis for fee negotiation.

Q17: How soon will doctors and hospitals be paid?
{Section 202(b) (2) (E)}

A17: Within 30 days of submitting bills.

Q18: Can doctors or hospitals charge more than the USNHC Program pays?
{Section 202(b) (2) (F)}

A18: No—no balance billing is allowed.

Q19: Can HMOs, group practices or other institutions selectively choose patients?
{Section 202(4) (C)}

A19: No—but patients shall be be permitted to enroll or disenroll from such organizations or entities with appropriate notice.

Q20: Will the USNHC Program pay for long-term care?
{Section 203}

A20: Yes, it will cover in-home, community-based, and institutional care with priority given to in-home or community-based settings.

Q21: Will USNHC cover mental health services?
{Section 204}

A21: Yes, the program will "provide coverage for all medically necessary mental health care on the same basis as coverage for other conditions." Community based services will be favored and institutional care will be provided for those in need.

Q22: Does this program cover prescription medications, medical supplies and durable medical equipment?
{Section 205}

A22: Yes.

Q23: How does USNHC save money on pharmaceuticals, medical supplies, and durable medical equipment?
{Section 205}

A23: As a single-payer, USNHC will have leverage to bring costs down, unlike our current multi-payer plan. USNHC will have a prescription formulary system that promotes the use of generic medications (but allows the use of brand-name and off-formulary medications when medically indicated). Prices for covered pharmaceuticals, medical supplies, and durable medical equipment will be negotiated annually. Reimbursement levels will be established after close consultation with regional and State Directors after the annual meeting of the National Board of Universal Quality and Access.

Q24: How will USNHC be financed?
{Section 211 and http://www.johnconyers.com/print/244} **See Appendix A**.

A24: First, switching to a single-payer system will lead to billions of dollars saved in reduced administrative costs. Those savings will be passed on through the system and allow coverage for all Americans. Additional savings in the overall cost of health care will come from annual reimbursement rate negotiations with physicians and negotiated prices for prescription drugs, medical supplies and equipment.

Second, a "Medicare For All Trust Fund" will be created to ensure a dedicated source of funding in addition to annual appropriations. Sources of funding will include:

- Maintain current federal and state funding for existing programs. **People would no longer have to pay Medicare Part B or D.**

- Closing corporate tax loopholes
- Repealing the Bush tax cuts for the highest income earners
- Establish employer/employee payroll tax of 4.75% (includes present 1.45% Medicare tax)
- Establish a 5% health tax on the top 5% of income earners; a 10% tax on top 1% of wage earners
- One quarter of one percent stock transaction tax.

Q25: What happens to Medicare, Medicaid, MediCal etc?
{Section 212}

A25: All Federal and state public health programs will become part of the USNHC Program.

Q26: How will USNHC be administered?
{Sections 301 and 302}

A26: The Program will be administered by the Secretary of Health and Human Services through an appointed Director, who will have the ultimate authority over rule-making. Long-term care and mental health with each have an appointed Director. The Director will appoint a director for an Office of Quality Control who will consult with state and regional directors to provide annual recommendations to Congress, the President, the Secretary (of HHS) and other program officials to ensure the highest quality delivery of healthcare. The director of the Office of Quality Control will conduct an annual review of the Program and recommend any proposed changes to Congress, the President, the Secretary (of HHS) and other program officials.

Q27: Is there any more local administration of USNHC?
{Section 303}

A27: The Program will have regional offices which replace current regional Medicare offices. Each region will have a director appointed by the Director of HHS. Each State will have a Director appointed by the governor.

Q28: What will happen to workers displaced by USNHC?
{Section 303(e)}

A28: All workers whose jobs are eliminated due to reduced administration will have first priority in retraining and job placement under the new system and will be eligible to receive 2 years of unemployment benefits. A special federal trust fund is created to ensure salary parity. Laid off workers' yearly income will be equivalent to their last 12 months of employment, capped at $100,000.

Q29: How will patient medical records be handled?
{Section 304}

A29: A standardized, confidential electronic patient record system will maintain accurate patient records and simplify the billing process, reducing medical errors and bureaucracy. Patients will also have the option of keeping any portion of their medical records separate from

electronic records, though pre-existing conditions will never preclude care under USNHC.

Q30: How will access to and quality of healthcare be maintained under USNHC?
{Section 305}

A30: A National Board of Universal Quality and Access will establish a universal, best quality standard of care. The Board will consist of 15 members appointed by the President with the advice and consent of the Senate. Members will include at least one: (1) health care professional; (2) representative of institutional providers of healthcare; (3) representative of healthcare advocacy groups; (4) representative of labor unions; and (5) citizen patient advocate. The Board will report recommendations twice each year to the Secretary of HHS, the Director of USNHC, Congress, and the President.

Q31: What happens to VA health programs and Indian health service programs?
{Section 401}

A31: Health programs of the Department of Veterans' Affairs will remain independent for 10 years and then Congress will evaluate whether they'll stay independent or be integrated into USNHC. Indian health service programs will remain independent for 5 years after which they'll be integrated into USNHC.

Q32: What about public health and prevention?
{Section 402}

A32: USNHC will stress the importance of good public health through the prevention of disease. Public health will certainly improve with universal access to quality healthcare.

Q33: How will the Program reduce health disparities?
{Section 403}

A33: Current disparities in health based on race, ethnicity, income, sexual orientation, and geographic region will be reduced through the provision of high quality, cost-effective, culturally sensitive care to all individuals.

Q34: When will the USNHC Program go into effect?
{Section 501}

A34: The Program will go into effect the first day of the first year that begins more than one year after the date of the enactment of the United States National Health Care Act.

Q35: What can we do to make universal, single-payer healthcare happen?

Appendix A

Financing H.R. 676

Total Projected Annual Health Care Expenditures
Under Current System in 2010 = $2,776 billion [1]
(Total Spending under H.R. 676 is Projected to be Equal to Current Spending)

Public Expenditures	
Federal (Medicare, Medicaid, DSH, etc.)	$957 billion
State and Local (Medicaid, etc.)	$348 billion
Private Expenditures	
Private Insurance	$950 billion
Out of Pocket (co-pays, deductibles, over-the-counter drugs, etc.)	$317 billion
Other Private Funds (foundations, etc)	$204 billion
Total	**$2,776 billion** 2

Sources of Revenue That Must Be Replaced Under H.R. 676 Due to Elimination of Private Health Insurance Spending and Reduction in Out-of-Pocket Spending= **$1,187 billion** **3**

(Public Spending and Other Private Funds Still Available)

Private Insurance Spending (eliminated)	$950 billion
75% Reduction in Out-of-Pocket Spending (Consumers would pay only 25% of what they pay now, because they are no longer paying premiums, copays and deductibles)	$237 billion 4
Total Replacement Revenue Needed	**$1,187 billion**

Total Annual Savings Under H.R. 676 = $387 billion

Administrative (paperwork, etc.)	$278 billion 5
Bulk Purchases	
Prescription Drugs	$87 billion 6
Non-Durable Medical Supplies	$13 billion 7
Durable Medical Equipment	$9 billion 8
Total Annual Savings	**$387 billion**

New Sources of Revenue Under H.R. 676 = $1,259 billion

Payroll Tax (3.3% additional on employer/employee)	$538 billion 9
Stock Transfer Tax (0.25% on seller and buyer)	$150 billion 10
Reduce Corporate Welfare	$100 billion 11
Reverse 2001 and 2002 Tax Cuts	$251 billion 12
Tax Surcharge: 5% on Richest 5% of Taxpayers; 10% on Richest 1%	$200 billion 13
Total New Revenue	**$1,259 billion** 14

The Bottom Line: Savings and New Revenue Under H.R. 676 More Than Enough to Cover Costs

Total Replacement Revenue Needed	**$1,187 billion**
Total Savings and New Revenue Raised Under H.R. 676	**$1,646 billion**
Total Savings	$387 billion
Total New Revenue Raised	$1,259 billion

Notes

1. Projected for 2010.

2. All figures are from the Centers for Medicare and Medicaid Services Health Care Cost Projections for 2010.

3. Total costs are expected to increase initially because of increased utilization by the previously uninsured. Over time, however, these costs would decrease as the formerly uninsured receive appropriate primary care and no longer end up in emergency rooms with advanced conditions that are very expensive to treat. We therefore assume level spending.

4. H.R. 676 would eliminate spending from private insurers and reduce out-of-pocket costs to consumers by approximately 75%. In order to meet spending needs, revenue is needed to “replace” these spending sources.

5. Estimated reduction in out-of-pocket costs from "Health Care Options Project," The Lewin Group, 2002.
6. This figure represents 10% of total administrative costs projected by CMS. Estimated 10% reduction in administrative costs from "Health Care Options Project," The Lewin Group, 2002.
7. This figure represents a 30% reduction in prescription drug costs from the CMS projection. Estimated 30% reduction from CBO, 2004b, "Would Prescription Drug Importation Reduce U.S. Drug Spending?" Washington, D.C.: Congressional Budget Office, and U.S. Department of Commerce, International Trade Commission, 2004. "Pharmaceutical Price Controls in OECD Countries," Washington, D.C.: U.S. Department of Commerce.
8. This figure represents a 30% reduction in non-durable medical supplies costs from CMS estimate. 30% reduction estimated from studies in footnote 6, above. Non-durable medical supplies have similar mark-ups as prescription drugs under the current system.
9. Ibid.
10. Projection based on "The 2006 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds," Washington, D.C.: Government Printing Office, May 2006.
11. Pollin, R., D. Baker, and M. Schaburg, 2001. **"**Securities Transaction Taxes for U.S. Financial Markets," *Eastern Economic Journal*, 2003.
12. For example, closing corporate tax loop holes and greatly reducing or eliminating subsidies to corporations.
13. Derived from the Congressional Budget Offices' estimates of the cost of the 2001 and 2001 tax cuts in 2010.
14. The top 5% of taxpayers earn at least $184,000 annually. The top 1% earns at least $280,000.
15. Estimates of the revenue from tax surcharges are based on mechanical estimates of tax revenue as a share of income. Estimates derived from Mishel, L., J. Bernstein and S. Allegretto, 2007. *The State of Working America 2006/2007.* Economic Policy Institute and Cornell University Press. Table 1.1
16. Revenue sources outlined above are intended as a "menu" of choices for raising revenue. Taken together, they raise more than what is needed to replace spending by private insurers out-of-pocket spending by consumers. However, these numbers are not strictly additive. For example, closing corporate tax loopholes will reduce the income to the richest 1% and therefore lower the revenue that can be gained by raising their taxes.