

# Physicians push for universal health coverage in Indiana

Health Care Crusade

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Some heart muscle had already died by the time family members coaxed the 50-something uninsured man into visiting Bloomington Hospital a few weeks ago.

The patient had suffered severe chest pains two days before his hospital visit but didn't seek treatment, said Dr. Rob Stone, an emergency-room physician there.

"It was clearly because he was afraid of the bill," Stone said.

By the time he made it to the hospital, the man was suffering a second heart attack. Now he faces a bill even larger than the one he tried to avoid—and possible bankruptcy, Stone said.

The Bloomington doctor said he sees similar cases all the time in his emergency room. If it's not a heart patient, it's someone who walked around for days on a broken ankle to avoid paying for an X-ray.

Those scenarios have motivated Stone and a small group of colleagues to push for giant change in Indiana. They want to ditch private health insurance provided by companies like Indianapolis-based WellPoint Inc. and adopt a government-funded, privately administered system that covers every Hoosier.

They envision massive cuts in bulky overhead costs that come with private insurance, generating more money to provide care under the so-called single-payer plan. They see a system that doesn't exclude people based on pre-existing conditions.

Detractors, however, question those administrative savings. From their view, the system would bog down in bureaucracy and lead to rationed care.

"You tell me one system that the government's gotten involved with that does work well," said Norm Springer, president of the Indianapolis chapter of the Washington, D.C.-based National Association of Health Underwriters.

Stone and his group—a half-dozen doctors and professors in Bloomington and Indianapolis—hope to introduce a bill to the Indiana General Assembly by 2007, even though they know they'll face a fierce battle and near-impossible odds.

At the very least, they want people to start talking about this option, said Dr. Chris Stack, a retired Indianapolis surgeon.

"All people know is, they've got insurance or they don't have insurance and it's a pain in the ass," he said. "We basically feel that if people knew the details of a single-payer plan ... a majority of the population would support it."

## **Coverage for everyone**

The group, all members of a local chapter of the Chicago-based Physicians for a National Health Program, started meeting in Bloomington a few months ago to flesh out this Medicare-for-all idea.

"We're trying to just get some traction, recruit more people and sort of get more leverage," Stack said.

Currently, most people receive coverage through private insurance or the government-funded Medicaid or Medicare programs. The single-payer plan would end employer-backed insurance and put everyone

under the same coverage umbrella.

“What this would gradually do is redeploy money which is currently spent on overhead and profit in the private health care segment into health care for everybody,” said Stack, who also boasts an MBA from Northwestern University.

Private companies such as WellPoint, the nation’s largest health insurer, and its subsidiaries like Anthem Blue Cross and Blue Shield in Indiana might have to shift their focus—and business model—from providing coverage to administering it.

Stack points to Canada, Australia and Japan as models for Indiana. He said his group is not asking for Great Britain’s system, where doctors and nurses are essentially government employees.

In Indiana, such a plan might be funded by blending Medicaid and Medicare money with the state Worker’s Compensation pool and taxes, Stone said. Other states have pitched a similar approach.

Although the details are still sketchy, the group sees crystal-clear reasons for change.

### **Cutting reams of red tape**

The current, public-private system leaves roughly 46 million Americans without insurance, said Dr. Stephen Jay, chairman of the Department of Public Health at the IU School of Medicine.

In Indiana, about 800,000 people have no insurance—a total that amounts to nearly 14 percent of the population, according to the Indiana Family & Social Services Administration.

Stone’s group sees other reasons, too.

About 30 percent of a private plan’s total cost goes toward overhead or administrative expenses—things like keeping the office lights on or marketing the policy, according to Stack. The group envisions huge savings by slashing that percentage with a single payer.

“The basic contention we have is, they don’t add any value to health care,” he said. “This is just a business.”

Having a single payer also would trim the pre-authorizations and pre-certifications for care that frustrate doctors, Stack said.

”[A single payer] would not screen out anybody because they’ve been sick,” he said. “There would not be any disqualifying feature.”

The idea of efficient spending for the private insurer, he contends, involves weeding out the sick and unhealthy.

The business emphasis in the current system also undermines the trust between patient and provider, IU’s Jay said.

“Health care is viewed as a business just like any other,” he said. “There are worries about whether the people in that business are looking after my health concerns.”

### **Clunky bureaucracy**

Those who don’t love the idea of universal coverage—insurance industry representatives, for instance—see several flaws.

Anthem spokesman Tony Felts doesn’t buy the great overhead savings predictions. He contends the competitive private market compels insurers to work efficiently and breeds innovation.

He offers up the new health savings account plans as a prime example of how insurers react to demand from employers.

“When you have a large bureaucracy that is running a health care system, it’s not nimble and isn’t as responsive to changing market forces,” he said.

Single-payer systems like Canada’s also can lead to rationing of care, especially for expensive treatments, Felts said.

“There’s no guarantee, even in a single-payer system, that promises universal care ... that a certain medical procedure won’t be eliminated or rationed to reach the savings that are projected,” he said.

A single insurance provider also would limit the number of coverage options a person can choose from, Anthem Vice President Dr. David Lee noted at a panel discussion hosted this fall by IBJ.

Medicaid and Medicare also reimburse providers at rates lower than private health insurance, the National Association of Health Underwriters’ Springer said. He’s not sure many doctors would back the pay cut that might come from a single-payer system.

Indeed, Stone and members of his group are in the minority among doctors. Specialty surgeons might see a pay cut under this system, while doctors who treat a large number of poor patients could come out ahead.

However, he believes the single-payer system is growing.

“I think more and more physicians are realizing the current system really interferes with the doctor-patient relationship and is just full of headaches,” he said.

### **A popular idea in some circles**

Single-payer proponents have kept a low profile so far, but the idea has attracted some high-level attention in central Indiana.

Health care needs to undergo big changes to its market-driven system—or something drastic like a switch to a single payer, said Alex Slabosky, president and CEO of The HealthCare Group LLC, which owns and operates the state’s second-largest insurer, M-Plan Inc.

Slabosky cited the number of uninsured Americans as proof the current system doesn’t work.

“I personally believe in a single-payer system, but if you want to preserve the market, we need to change the way the market system works,” he said during the IBJ-sponsored panel discussion.

A single-payer system that cares for everyone is the inevitable answer, said Robert J. Brody, president and CEO of Beech Grove-based St. Francis Hospital & Health Centers. Most hospitals or providers make up for the money they lose on Medicaid, Medicare and the uninsured by hiking charges to private insurance.

That leads to double-digit insurance premium increases, which leads to more people dropping coverage, which leads to more uninsured.

“I don’t see how we can maintain the status quo and expect any good result,” he said.

### **A tall order**

At least 18 states introduced legislation this year advocating a universal, coverage-for-everyone health care system, according to Physicians for a National Health Program. None of those proposals made it out of their respective legislatures.

Still, the state level remains the best place to build traction for this push, said Dr. Ida Hellander, the program’s executive director. Neither political party has taken the leadership reins nationally on this issue.

She noted that Canada's national health care system started in the province of Saskatchewan and spread. In the States, Wisconsin gave birth to Social Security.

"There is precedent for both health care and our other safety-net programs to start in one state and spread from there," she said.

Just don't look for that precedent to come from Indiana.

A single-payer system involving the government would be "very difficult" to work through the General Assembly, said State Sen. Patricia Miller, R-Indianapolis, who chairs the Senate's health finance committee and health and provider services committee.

The idea raises too many questions for her about funding and whether people would want to give up their private benefits. She sees much more support for measures that focus solely on helping the uninsured.

"The single-payer issue to me makes it much more complicated than just getting people who don't have health insurance covered," she said.

State Rep. Charlie Brown, D-Gary, pitched a bill for universal coverage in the late 1980s. It didn't survive the Legislature.

Brown said he still doesn't see enough support there.

"But that does not mean it should not be tried," he said, "and I am willing to carry that banner again."