REMAPPING DEBATE
Asking "Why" and "Why Not"

Should universal care advocates bite their tongues on single-payer?

Original Reporting | By Mike Alberti | Health care

June 8, 2011 — It was not so long ago that a universal, single-payer health insurance program administered and financed by the federal government looked like a viable policy option. Barack Obama supported a single-payer system on the campaign trail in 2008, and, in the early stages of the subsequent battle over health care reform, both a single-payer framework and a “public option” that would compete with private health insurance were solidly backed by many Democrats and a significant portion of the general population.

For many, the fact that the ACA represents far less than they had originally wanted has been put aside, with the legislation recast as a victory to be defended.

But by the final stages of the debate, amidst united Republican opposition, single-payer had largely been excluded as an option by the Administration. What became known as the Patient Protection and Affordable Care Act (ACA) did not include even a public option. And for the last year, as Republicans attempt to repeal the ACA and hobble it by underfunding, Democrats and health care advocates have rallied behind it. For many, the fact that the ACA represents far less than they had originally wanted has been put aside, with the legislation recast as a victory to be defended.

There is still a vocal group of advocates, however, who believe that the ACA does not go far enough in providing guaranteed access to quality, affordable health care. And indeed, at both the state and national level, there has been a resurgence of interest in moving the United States past the Affordable Care Act and into a single-payer system. Single-payer bills have been introduced at the federal level and in several states; this year, Vermont became the first state to pass a framework bill that could introduce a single-payer system in the next several years.

But these single-payer proponents are finding it hard to recruit those organizations who favor increased access and affordability, but who feel that support for single-payer could make the ACA more vulnerable, and that support for the ACA is obligatory because the legislation constitutes the only “realistic” policy choice. According to advocates who continue to press for a single-payer system, however, the acquiescence of those sympathetic to pro-access arguments has had a significant impact on narrowing the debate over how the health care system in the U.S. should work — and on moving the center of gravity of that debate further to the right.

AARP: a case study

AARP (formerly the American Association for Retired Persons), which describes itself as “the nation’s largest membership organization for people 50+” is perhaps the most visible example of this phenomenon. Claiming more than 40 million members, AARP is a powerhouse on Capitol Hill. In 2009 and 2010, the organization threw its full weight behind the ACA, and according to some, was instrumental in getting the final bill through Congress.

But AARP did not fight for a single-payer model during the debate over health care reform, and it has not endorsed any of the bills that are currently in play at the federal or state level. Single-payer advocates in Vermont as well as California, where a new single-payer bill was recently introduced, said that AARP has been largely absent from the debate. AARP representatives in both states acknowledged that the organization has not declared support for either of the bills.

“They are missing in action,” said Andrew McGuire, who founded the group California OneCare, which advocates for single-payer health care on the state level. “It’s a bit odd when you consider who they represent.”

Don Bechler, who chairs another California-based single-payer advocacy group called Single Payer Now, elaborated: “Private insurance is bad for seniors. Seniors use the health care system the most, so the problems with the private insurance market affect them the most.”

“We’re advocating for a health care system that spends its money on health care, not on insurance companies,” Bechler continued. “We don’t want people to go without health care. If those aren’t AARP’s priorities, it makes you question whether they have the best interests of seniors at heart.”

AARP is “missing in action,” in the debate over single-payer in California, said Andrew McGuire of California OneCare. “It’s a bit odd when you consider who they represent.”

What’s the justification?

The most prominent bill that was introduced at the federal level during debate over health care reform was H.R. 676, which was proposed by Rep. John Conyers (D-MI) in early 2009. Single-payer advocates quickly rallied around the bill, which provided a framework for moving the United States into an insurance system modeled on Canada’s. Later that year, AARP released a statement explaining to its members why the organization was not supporting H.R. 676:

> Starting over with a new, “single-payer” program will not eliminate the problems Medicare, Medicaid, and SCHIP currently face, such as the spiraling costs of procedures and prescription medications, as well as technological advances that are often not comprehensively tested to be proven safe or effective before marketing. H.R. 676 does not address the problem of increasing health-care costs. Rather, it allows costs to continue to grow, which will result in unaffordable coverage.

That statement did not add up for some advocates, like Dr. David Himmelstein, associate professor of medicine at Harvard University and a member of Physicians for a National Health Program.

“What a single-payer program like H.R. 676 allows you to do is set in place an overall budget,” he said. “If what you’re concerned with is controlling costs, [setting an overall budget] has been shown, here and in other countries, to be by far the most reliable way to do that.”

Remapping Debate asked John Rother, executive vice-president of policy, strategy and international affairs at AARP and the group’s chief lobbyist, whether AARP’s position on single-payer health care had changed since the passage of the ACA.

Rother explained that AARP’s priority was that “everybody should have health insurance, and adequate coverage that’s affordable,” and that the organization is “much more focused on the outcome than the mechanism for achieving that.”

“Single-payer has some advantages,” he went on, “but it also has some disadvantages.” The disadvantages, he said, were that converting to a single-payer model would “disrupt the system that is currently in place” and that “it would require a very significant tax increase.”

Dr. Deborah Richter, the president of Vermont for Single Payer, the chief advocacy group that advanced the single-payer legislation in Vermont, called both of those arguments “disingenuous.”

WHAT IS AARP?

AARP, Inc. is a 501(c)(4) non-profit, and is the umbrella organization housing several others affiliated groups. AARP, Inc. owns two Limited Liability Companies, called AARP Global Network LLC and AARP Properties LLC. Additionally, it owns the AARP Insurance Plan, which works in tandem with several AARP-sponsored private insurance plans. AARP wholly owns AARP Services, Inc., which in turn wholly owns AARP Financial Inc. Both AARP Services and AARP Financial are for-profit companies, which select and develop services that are then made available to AARP members, including financial services.

AARP also directs two separate 501(c)(3) non-profits, the Legal Council for the Elderly and the AARP Foundation, both of which do charitable work. The AARP Foundation owns the AARP Institute, which is a public policy think tank and also a 501(c)(3) non-profit.

In 2010, AARP and its affiliates had net assets in excess of $700 million, operating revenues of approximately $1.3 billion, and investment income in excess of $125 million.

$679 million of operating revenues came from royalties paid to AARP by private companies for the right to use the AARP name, logo, or mailing list in their advertising. According to AARP’s financial statement in 2010, United Healthcare Corporation accounted for 65% of royalty revenue in 2010 and 2009.

“To argue that a single-payer system would require a tax increase is to discount the fact that Americans are already paying a huge amount for health care,” she said. In addition to the taxes that are paid into the Medicare and Medicaid programs, she explained, Americans are financing the current system through their insurance premiums, deductibles, and co-pays.

And while it is technically true that converting to a single-payer model would disrupt current insurance coverage, Richter explained that most single-payer bills include provisions that define a “floor” of benefits below which the new system cannot go. The legislation in Vermont contains several of these floors, one of which is the benefit package currently offered by Medicare.

When Remapping Debate asked Rother to respond to these points, he conceded that it would be possible to construct a single-payer model that met AARP’s standards, acknowledging that there were different models of single-payer health care, and that a single-payer framework could be developed to provide benefits that preserve or enhance existing benefit models.

“There are three elements that we consider,” Rother said. “One is benefits, the second is how effective it would be in curbing the rising cost of health care, and the third is how it is financed.” To find an example of a single-payer model that would meet those criteria, Rother went on, “you just need to look across the world to some other countries to see systems that actually function pretty well.”

Affordable care, plus?

The obvious question, then, is why AARP is not supporting the efforts to pass single-payer legislation that are currently percolating. Rother said that AARP’s current priority is to “protecting, to the extent we can, the current Medicare and Medicaid programs,” and to “fully implement the [Affordable Care Act].”

> “We’re advocating for a health care system that spends its money on health care, not on insurance companies.” — Don Bechler of Single Payer Now

One approach that the organization could take would be to continue the focus on implementing the ACA and on defending Medicare and Medicaid, while at the same time seeking to educate its members about the potential benefits of single-payer health insurance, and even advocating for legislation that goes above and beyond the ACA.

AARP rejects such an approach altogether: “Any criticism of the ACA in the current public debate…would really set back the prospects of successful implementation,” Rother said, adding that advocates who are pressing for single-payer health insurance now are effectively “undercutting” support for health care reform. “I think there are certainly additional steps that need to be taken, but…throwing out additional options could inadvertently support ‘repeal and replace.’”

Rother did not explain how those unintended consequences would come to pass. And other organizations have not found it difficult to simultaneously advocate for successful implementation of the ACA and against dismantling the Medicare and Medicaid programs. These organizations also point out that, while the ACA is a big step forward, it will not cure all of the country’s problems with access, coverage and benefits, and therefore advocate for taking other, additional steps to address those issues.

Jodi Reid is the executive director of the California chapter of the Alliance of Retired Americans (ARA), a national advocacy group focusing on issues affecting seniors that claims 4 million members. CARA has been spending much of its time lately organizing a campaign around the recently introduced single-payer bill in California.

"Health care reform [as reflected in the ACA] was a step in the right direction," Reid said. "But we need to keep moving forward. There's no conflict in our position [on both issues]; we simply have to explain a slightly more nuanced view."

Reid also pointed out that an organization can have a nuanced view of single-payer legislation, suggesting modifications to specific proposals that it doesn't agree with. Rother acknowledged as much, saying that it would be possible to propose various benefit "floors" and various financing mechanisms.

Green Mountain Care

At the end of last month, Vermont Governor Peter Schumlin signed into law a framework bill that outlines the process through which the state will convert to a single-payer health insurance system over the course of the next several years. The new system, to be called Green Mountain Care, would be available to all Vermont residents, and would use money from the federal and state governments as well as private insurers, such as Blue Cross/Blue Shield, which is the state's biggest insurer.

The bill still faces several obstacles, however. For one, it does not specify how, exactly, the single-payer system will be paid for. And it does not specify what the benefit package will look like, though it does say that Medicare recipients will receive no less than they currently do, along with several other "floors" for coverage. The bill sets up an independent board, which will produce a draft of the benefit plan by September 2012, and a financing package to be delivered to the legislature for a vote during the 2013 legislative session.

And these activities are contingent upon receiving several waivers from the federal government to incorporate funds from Medicare and Medicaid into the single-payer system. While some states have successfully received Medicaid wavers in the past, no state has ever received one for Medicare. And under the Affordable Care Act, the earliest that a state can even apply for some of these crucial wavers is 2017. Members of Congress from Vermont and other states are currently trying to get the date moved up to 2014, so that Vermont can begin the transition earlier.

If fully enacted, the bill would equalize payments rates across Medicare, Medicaid and private insurers, create a uniform package of benefits, and, according to advocates, greatly reduce administrative costs while providing robust, universal coverage.

Ask for more, get more?

"The key issue underlying all this is trust in government, and that's the exact thing that's most lacking in the public debate today" Rother said. "To go to a single-payer you do have to trust government. The climate we're in right now is a very hostile climate for something like that."

Rother acknowledged, however, that AARP views itself as having the power to shape the debate and influence the political climate, both through its direct advocacy work and its educational initiatives.

In that context, then, why wouldn't AARP attempt to reframe the political debate over health care, so that the ACA no longer looks like the ultimate goal but simply a positive step in the right direction?

Rother said that advocating for more by way of benefits, eligibility and coverage in order to open the debate up and increase the likelihood of achieving meaningful steps "works in a collective bargaining context, but doesn't work in the U.S. Congress…because there's no necessity of coming to an agreement. There's no incentive for people to reach a final outcome." He didn't explain why "asking for more" would not help shape debate in the Congressional context.

According to Richter and other single-payer advocates, AARP's position represents exactly the attitude that has marginalized efforts on behalf of single-payer in the past. "In Vermont, we were lucky to have some officials at both the state and national level that were open to single-payer," Richter said. "We had to increase the political pressure on candidates and the more hesitant officials to get the bill passed, which we successfully did."

ARE WE ASKING THE RIGHT QUESTIONS?

According to Don Bechler, the chair of Single Payer Now in California, Americans are currently asking the wrong questions about improving the health care system.

"I'm not for a single-payer system because it will reduce costs, although it would," Bechler said. "I'm for it because we are not supplying quality health care to millions of people in this country."

Bechler said that the focus on reducing costs has distracted Americans from the real goal, which, he said, should be increasing the level of care for everyone. "People say, we spend 15 cents on the dollar for health care in this country, and that's too much. But if we spent 18 cents, and people would live five years longer, would you go for that?"

Remapping Debate asked AARP's John Rother whether the debate over health care should first start by asking how we can achieve the highest-quality care possible for all, not with questions of cost.

"That's exactly the right question," Rother said, "and we're a long way away from that."

And that's exactly what CARA and dozens of other groups are currently doing in California, said Reid. "We're trying to get the message out to our officials and also to the public," Reid said. "Health reform was a very historic effort to get us started on this conversation, but our role is to continue the con-

versation where the national legislation left off, because it cannot end here if we want everybody to have health care they can afford. We would never have advanced this far if we had simply stopped at health care reform."

Because at least part of the single-payer bill in California will likely be put on the ballot in coming years for residents to vote on directly, Reid said that public education is also a huge part of the coalition's work.

An incremental approach?

Rother, reciting AARP's extensive experience in conducting educational campaigns, says these campaigns can often take several years to be effective. Nevertheless, AARP has not published any material relating to single-payer health insurance on its website, in its several hundred page policy book, or through its Public Policy Institute. He did say that he thought it was useful for other groups to do research and education on a single-payer model could function in the United States.

AARP representatives in California and Vermont explained that the organization's strategy, which is largely determined by the national organization, was currently to wait and see how the debate over single-payer played out in those states.

"Reasonable people can disagree about the best system for universal health care," said Mark Beach, communications director for AARP California. "As far as single-payer goes, it would be nice if there was a robust public discourse about that…but our focus at this point is to do our best to see the [Affordable Care Act] implemented."

Beach explained that, when it came to policies that would radically alter the way that health care is delivered, "AARP takes a more incremental approach to that kind of thing."

"It's fine to take incremental steps," CARA's Reid countered, "but you need to have a vision of where you want to end up, and how you're going to get there."