New Prospects for Single-Payer Activists: Swimming in the Mainstream . . . With Sharks

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The events of the past year have imperiled many of our patients, but also generated new momentum for single-payer reform. More than half of the Democrats in the House of Representatives have signed on as co-sponsors of H.R. 676—that chamber's single payer bill—and 17 U.S. Senators (up from one last year) have endorsed single-payer legislation. This legislative progress reflects an upsurge of popular support for such reform—in part generated by Bernie Sanders' presidential primary campaign—and growing recognition of the ACA's inadequacies.

These advances have opened new opportunities for PNHP and other single-payer advocates. The virtual blackout on coverage of single payer in the mass media and in medical journals has been lifted. Unions, churches, community groups, medical organizations and other civil society groups want to learn about single payer. Activist groups and demonstration organizers have embraced single payer as part of their platforms. And politicians are open, even eager, to hear what we have to say.

But, as detailed below, single payer's mainstream status has already elicited frontal attacks - claims that it would be prohibitively expensive - as well as more subtle efforts to protect a role for private insurers and other powerful interests by blurring the lines between single payer and lesser reforms.

In this new context, PNHP must retain a clear vision of what's needed in health care reform. Inevitably, others will suggest compromises motivated by political feasibility. Indeed, for politicians, that's part of their jobs. But as physicians, we must give our best advice about the most effective remedy, recognizing that not everyone will (or can) follow that advice.

Here's what we recommend:

- Fight Trump's attacks on the ACA, Medicare and Medicaid, minorities, women and immigrants with calls to move forward to single payer and social justice in health care, not backward.

- Participate in the single-payer movement and the more general movement for social justice. Educate our peers and communities through talking, writing, demonstrating and organizing. Bring the single payer message to protest rallies. Push every medical organization to hold a single-payer grand rounds, conference, or forum. Ask city councils, churches, medical school classes, hospital departments (and even CEOs), etc. to publicly endorse single payer.

- Campaign for H.R. 676 and the Sanders Senate bill, while pushing to fix the flaws in the Senate bill.

- Push your congressperson/senator/state legislator to co-sponsor single-payer legislation, and help them understand how political compromises (discussed below) undermine single payer's medical and economic benefits.

The Frontal Assault: “Single Payer Would Break the Bank”

Both politicians and media outlets like the *Washington Post* and *New York Times* have touted absurdly inflated estimates of the cost of implementing single-payer reform. For example, a widely-cited report from the Urban Institute (targeting Bernie Sanders in the heat of primary battles) claimed that single payer would cause the utilization of outpatient and inpatient care to skyrocket, increasing health care costs by $6.6 trillion over 10 years. The Urban Institute also claimed single payer would cause a backlash among doctors by sharply cutting their incomes. (Neither the estimate's authors nor the media have noticed the contradiction between their assumptions that payments for medical visits would soar, but doctors' incomes would fall).

Meanwhile, the media have ignored previous estimates by the Congressional Budget Office, the Government Accountability Office, and several consulting firms (including one owned by UnitedHealthcare) that single payer could achieve universal coverage with little or no cost increase in the short term, and substantial savings over the longer term. These past estimates are consistent with experience in other nations that have implemented national health insurance, which all spend far less than the U.S.

It seems likely that additional scurrilous estimates claiming that single payer will “break the bank” will be forthcoming, in most cases buttressed by impressive micro-simulation modeling and elaborate spread sheets. PNHP activists can play a key role in exposing the flawed assumptions that lie behind these estimates. Economic modeling isn't nearly as complicated as neurosurgery, or internal medicine, or psychiatry.

Killing Single Payer Softly by Blurring the Lines

Obfuscation comes in several flavors, most of them aimed at protecting a role for private insurers.

1. Public Option – “Why not allow Medicare to compete with private insurers rather than fully replace them?”

a) Absent a sharp increase in government subsidies (and overall health spending), a public option would neither cover the uninsured nor upgrade coverage for those who have employer plans with unaffordable copayments and deductibles.

b) The public option approach would sacrifice part of single payer's savings on insurance overhead, and most of the potential savings from simplifying providers' billing-related paperwork. The persistence of multiple payers would preclude paying hospitals simple global operating budgets, and the imperative to allocate expenses to different insurers would perpetuate hospitals' need to maintain elaborate and expensive cost tracking and billing systems. Physicians would also continue to incur unneeded billing and coding hassles and expense.

c) Experience with the Medicare Advantage program indicates that the public plan would, in effect, become a high-risk pool, allowing insurers to inflate their profits by cherry picking profitable patients and shunting unprofitable patients to the public option, driving up system-wide costs. Medicare's decades-long effort to stop (or statistically adjust for)

Medicare Advantage plans' cherry-picking and other abusive behaviors has proven unsuccessful, leaving little room for optimism that a public option plan could avoid this pitfall.

In sum, achieving universal coverage through a public option might provide help to some of those suffering discrimination at the hands of private insurers, but would cost far more than single payer. Inevitably this would lead to pressure to cut either the comprehensiveness of coverage or its universality.

2: **German-, Swiss-, or Dutch-style systems** – "If those nations have achieved universal coverage while including private insurers, why can't we?"

a) The usual descriptions of the German, Swiss, and Dutch systems omit the tight regulation, high levels of public funding and complex institutional structures required to sustain them. All three characterize their systems as social insurance schemes, not as private insurance. Moreover, these health care systems are among the world's most expensive, although not as costly as ours.

   In Germany and Switzerland only non-profit insurers are permitted to offer the mandated (and quite comprehensive) benefit package; they must all pay the same rates to providers; and include all (Switzerland) or almost all (Germany) providers in their networks. In both nations, government plays a major role in directly funding hospitals. Overall, government accounts for two-thirds of health spending in Switzerland and 85% in Germany, where the insurance plans are controlled by elected representatives of enrollees and employers.

   The Netherlands long had a German-style social insurance system based on non-profit insurers. A 2006 "market" reform mandated that individuals buy coverage, and allowed for-profit insurers to compete for their business. Yet the Dutch approach has been described (by Kieke Okma, an expert analyst of that system) as a small dose of competition with a much bigger dose of regulation. Government still accounts for 81% of health spending, paying the entire premium for all children, subsidizing the premiums for half of the population, and maintaining a fully-public insurance system for long term care. The government also administers a complex risk-adjustment scheme, and tightly regulates insurers. Under the "market" reform, cost increases have accelerated, 3% of the population is now uninsured or delinquent in paying their premiums, and the tax agency has had to hire more than 600 new workers to track people's eligibility for premium subsidies. In sum, the reform started with a quite functional social insurance system, and grafted on some market elements which have made it somewhat worse.

b) Extensive and strict regulation is not incidental to these systems; it is essential to whatever success they have achieved. Moreover, the regulations require ongoing tweaking, and insurers continue to cherry-pick and lobby for patient-unfriendly reforms (e.g. narrow networks). It's highly unlikely that U.S. officials would effectively regulate the powerful firms that dominate U.S. health care (and whom they often end up working for under the "revolving door" arrangement characteristic of Washington politics). We need to unseat private insurers through a mass movement for health reform, not rely on regulators to control them.

c) As with the public option, a system patterned after Germany's, Switzerland's or Holland's would sacrifice much of the administrative savings that could be achieved through single payer reform. In those three countries, both insurance overhead and providers' administrative costs are far higher than in single-payer nations. In all three nations, doctors complain bitterly about the increasing bureaucratic burden that "market reforms" impose on them.

d) All three of these nations have much more generous welfare systems, much less income inequality and far lower poverty rates than the U.S. For instance, a jobless single adult in Switzerland is eligible for public assistance totaling more than $21,000 annually, while the average income for a nursing aide in a hospital is about $65,000. Hence many more people can afford copayments. Greater economic equity is a critical underpinning of these nations' health care systems.

In sum, adopting the German, Swiss or Netherlands models for health care would require fundamental social and regulatory reforms that would face political obstacles at least as daunting as single payer. Moreover, these models incur substantial bureaucratic costs that would be eliminated through single-payer reform.

3: I'm in favor of single payer, but trying to get there all at once would be too disruptive. We need incremental reforms that move toward single payer.

a) A transition to single payer would be traumatic for the insurance industry, which is expensive but adds no value. But for patients, it would mark a welcome upgrade (and simplification) of coverage, and be no more traumatic than transitioning to Medicare, which 10,000 people do every day.

Doctors would continue in their current practices, but billing would be far simpler, and many financially-driven coding and Electronic Medical Record (EMR) tasks would disappear. Hospitals would stop billing for each patient and instead receive global budgets, as discussed below. Providers' budgets would remain at current levels, with the savings on billing and administration available to expand the clinical workforce and upgrade clinical services.

About 1.7 million financial, administrative and clerical workers employed by insurers and providers would be displaced. Many of them could find jobs in clinical positions, with funding for income support and job retraining easing the transition. It's worth noting that 60 million American workers are separated from their jobs each year, including 20 million who are fired or laid off. So although transitioning to new jobs for the 1.7 million people is certainly a major undertaking, it's equivalent to the number of workers who make such a transition every 31 days, few of whom enjoy the transitional support called for in the single-payer bills in Congress.

b) The vast majority of the administrative savings from single payer wouldn't be available until a single payer system is fully implemented. So halfway reforms are actually more expensive than a complete transition.

c) Other nations— e.g. Canada and Taiwan—have made rapid and smooth transitions to single payer. Moreover, contrary to predictions by the *Wall Street Journal* and the AMA

that Medicare's implementation in 1966 would cause chaos, that program was implemented smoothly, enrolling 19 million seniors less than one year after its enactment.

4: Why shouldn't a single payer system adopt Medicare's current payment strategies?

The initial draft of the Sanders single payer bill mandated that hospitals and other institutions be paid global operating budgets— as in Canada and Scotland—with separate capital grants. But prospective Senate co-sponsors preferred to retain Medicare's current payment system for hospitals and Accountable Care Organizations (ACOs), and the bill was revised accordingly.

That's a big mistake. It would undermine health planning, perpetuating inequalities in hospital resources between affluent and poor communities; continue to reward hospitals for financial gaming (e.g. upcoding), providing lucrative services like joint replacements, and avoiding unprofitable ones like mental health care; and sacrifice a big share of potential administrative savings. Finally, retaining Medicare's costly pay-for-performance (P4P) initiatives ignores convincing evidence that such incentives undermine morale and distract from real quality improvement, and continuing the move to ACOs will bolster the corporate takeover of care.

a) Under the Medicare payment rules (and the Senate bill), hospitals' profits ("operating surpluses" for non-profits) are the main source of funding for capital investments in new buildings and equipment, and for paying off the loans used to make those investments. That system allocates new capital based on hospitals' financial success rather than community needs, giving hospital administrators powerful incentives to focus on the bottom line. It also drives up costs by allowing uncontrolled expansion of facilities, which encourages the provision of low-value care.

   As Blue Cross' late policy director Donald Cohodes wrote in 1983: "Capital is the lifeblood of the hospital industry, and a hospital's capital investment decisions have lasting and extensive effects on the quantity, quality, and accessibility of health care services. Without adequate capital investment, hospitals cannot replace or modernize outdated facilities; [or] respond to changing demand conditions by providing new programs, plant, amenities, or services."

   "Capital expenditures increase hospital costs through the addition of interest and depreciation. Two other consequences of capital expenditures dwarf those of interest and depreciation: the operating costs of capital expenditures and the increasing per capita consumption of health services caused by provider-induced demand. For every $1invested in capital projects . . . second-year costs increase, on average, to 30% of the capital costs of a project."

   In sum, continuing to rely on market incentives to allocate capital among hospitals assures the continued maldistribution of resources, drives up costs, and mandates that hospital leaders give primacy to schemes likely to generate profits and avoid losses.

   It's far preferable to fund hospitals through global operating budgets and forbid them from retaining any surplus. Capital investments should be funded through separate grants, based on careful consideration of where investments are needed, and where they would be redundant and wasteful. That's how we allocate investments in most other public

services (e.g. the military, schools and fire departments), and how nations such as Canada and Scotland fund hospital investments.

b) Paying hospitals and other institutional providers global operating budgets also abolishes the need to bill for individual patients and services. That's key to reducing administrative costs from their current level (about 25% of total hospital spending) to the levels in Canada and Scotland (about 12%). Hence, retaining Medicare's current payment system would sacrifice about $150 billion annually in potential administrative savings, savings that are needed to upgrade and expand care.

c) Continuing Medicare's move to so-called "value-based" payment (e.g. ACOs that receive quasi-capitation payments, and P4P programs that pay doctors and hospitals bonuses or penalties based on their quality scores) will fortify corporate control of medical providers and augment bureaucracy. Although economists and policy wonks continue to forecast vast benefits from these programs, to date Medicare ACOs and P4P have produced no savings and little or no improvement in patient outcomes. What ACOs have done is increase administrative costs and drive small hospitals and practices into the clutches of giant corporate systems. P4P programs have absorbed enormous efforts of clinicians and administrators, yet (as a large body of behavioral economics research predicted) have failed to meaningfully improve quality.

   Capitation-style payment like the ACO program favors large-scale organizations, since a few very expensive patients can spell financial ruin for a small provider. Moreover, small providers lack the resources needed to invest in the information technology and administrative systems that are essential for managing risk, documenting comorbidities (which boost capitation payments), and reporting on (and gaming) the myriad quality and pay-for-performance metrics that Medicare now requires and rewards in the ACO and other P4P programs. Finally, small providers lack the bargaining power to drive down the prices of services and supplies they must purchase, such as drugs and some specialized care. Since the beginning of the ACO era in 2010, large systems have bought up hundreds of community hospitals and tens of thousands of physician practices.

   This consolidation of health providers has been accompanied by an increase in hospital administrative costs, from $190 billion in 2009 to $276 billion in 2016. While consolidation is often justified as a way to improve "coordination of patient care," coordination requires collegiality and communication between providers, not their joint ownership. In the absence of any clear-cut benefit seven years into the ACO strategy, it is time to abandon this model and pursue cost containment through proven methods such as global budgeting.

Even as we applaud the main thrust of the Senate single payer bill—truly universal coverage under a single public program—it's important for PNHP activists to explain and advocate for correcting the important structural flaws described above, as well as its continued reliance on Medicaid for coverage of long-term care.