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HEALTHCARE VALUE HUB

WELCOME TO:

SINGLE PAYER:
CAN IT BEND THE COST CURVE?

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Welcome and Introduction

Lynn Quincy
Healthcare Value Hub

Housekeeping

- Thank you for joining us today!
- All lines are muted until Q&A
- Webinar is being recorded
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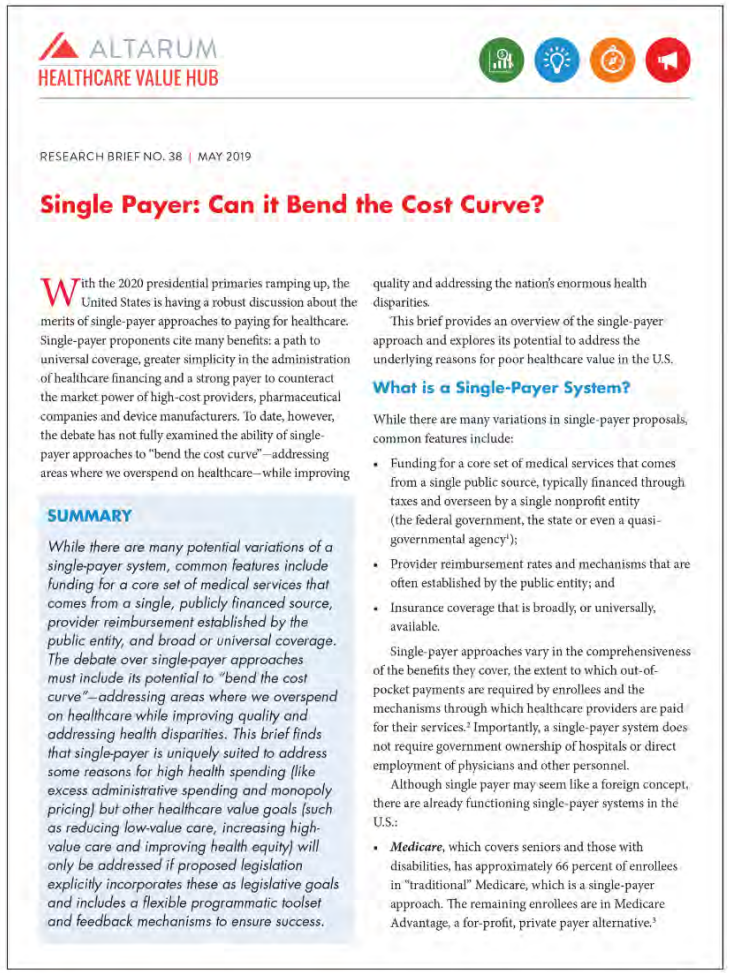
Agenda

- **Welcome & Introduction**
- **Addressing Administrative Costs**
  - **Gerald Friedman,** University of Massachusetts at Amherst
- **Review of Single Payer**
  - **Harold Pollack,** University of Chicago
- **Reactor**
  - **Eagan Kemp,** Public Citizen
- **Q&A**

Resources from the Hub



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RESEARCH BRIEF NO. 38 | MAY 2019

Single Payer: Can it Bend the Cost Curve?

With the 2020 presidential primaries ramping up, the United States is having a robust discussion about the merits of single-payer approaches to paying for healthcare. Single-payer proponents cite many benefits: a path to universal coverage, greater simplicity in the administration of healthcare financing and a strong payer to counteract the market power of high-cost providers, pharmaceutical companies and device manufacturers. To date, however, the debate has not fully examined the ability of single-payer approaches to "bend the cost curve"—addressing areas where we overspend on healthcare—while improving quality and addressing the nation's enormous health disparities.

This brief provides an overview of the single-payer approach and explores its potential to address the underlying reasons for poor healthcare value in the U.S.

SUMMARY

While there are many potential variations of a single-payer system, common features include funding for a core set of medical services that comes from a single, publicly financed source, provider reimbursement established by the public entity, and broad or universal coverage. The debate over single-payer approaches must include its potential to "bend the cost curve"—addressing areas where we overspend on healthcare while improving quality and addressing health disparities. This brief finds that single-payer is uniquely suited to address some reasons for high health spending (like excess administrative spending and monopoly pricing) but other healthcare value goals (such as reducing low-value care, increasing high-value care and improving health equity) will only be addressed if proposed legislation explicitly incorporates these as legislative goals and includes a flexible programmatic toolset and feedback mechanisms to ensure success.

What is a Single-Payer System?

While there are many variations in single-payer proposals, common features include:

- Funding for a core set of medical services that comes from a single public source, typically financed through taxes and overseen by a single nonprofit entity (the federal government, the state or even a quasi-governmental agency[1]);
- Provider reimbursement rates and mechanisms that are often established by the public entity; and
- Insurance coverage that is broadly, or universally, available.

Single-payer approaches vary in the comprehensiveness of the benefits they cover, the extent to which out-of-pocket payments are required by enrollees and the mechanisms through which healthcare providers are paid for their services.[2] Importantly, a single-payer system does not require government ownership of hospitals or direct employment of physicians and other personnel.

Although single payer may seem like a foreign concept, there are already functioning single-payer systems in the U.S.:

- ***Medicare***, which covers seniors and those with disabilities, has approximately 66 percent of enrollees in "traditional" Medicare, which is a single-payer approach. The remaining enrollees are in Medicare Advantage, a for-profit, private payer alternative.[3]

NEW REPORT! Single Payer: can it bend the cost curve by addressing …

- Excess administrative spending?
- High unit prices and price variation?
- Too much low value care?
- Affordability of healthcare?
- Disparities in health outcomes?

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Resources from the Hub

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RESEARCH BRIEF NO. 30 | NOVEMBER 2018

Excess Administrative Spending in Healthcare: Significant Savings Possible

Administrative spending refers to the costs incurred by insurers, hospitals, doctors' offices and other entities to conduct the business side of healthcare. These costs reflect billing and insurance related activities (BIR), enrollment and member administration, marketing costs, provider and medical management, corporate services and other non-clinical functions.

Some administrative spending is valuable to the operation of the health system. Consequently, we define *administrative waste* as any administrative spending that exceeds that necessary to achieve the overall goals of the organization or the system as a whole.[1] The National Academy of Medicine's seminal 2010 work, *The Healthcare Imperative: Lowering Costs and Improving Outcomes*, identified unnecessary administrative costs as one of six key areas that need to be addressed to bring greater value and lower costs to healthcare consumers.[2] Administrative costs have been estimated to represent 25 to 31 percent of total healthcare expenditures in the United States, a proportion twice that found in Canada and significantly greater than in all other Organization for Economic Cooperation and Development member nations for which such costs have been studied.[3] Moreover, the rate of growth in administrative costs in the U.S. has outpaced that of overall healthcare expenditures and is projected to continue to increase without reforms to reduce administrative complexity.[4]

Current data collection approaches make it difficult for policymakers to grasp the total magnitude of administrative healthcare spending in the U.S. and even more difficult to identify when administrative spending is wasteful. Yet, the evidence discussed below suggests that these administrative costs can be trimmed, providing cost savings to the U.S. healthcare system.

SUMMARY

Unnecessary spending in the form of administrative waste has been the subject of fierce debates for years. All agree that some administrative spending is valuable to the operation of the health system. Similarly, most agree that there is waste to be trimmed, although strategies for addressing waste vary depending on whether our current multi-payer system is retained or replaced with a simplified payment system. Under all approaches, our first line of defense is to improve data collection as our current understanding of administrative waste relies on a patchwork of aging analyses, leaving policymakers very much in the dark when it comes to addressing this growing category of healthcare spending. Moreover, patient administrative burdens have never been tallied, representing the greatest gap in our understanding of the issue.

What is Included in Administrative Spending?

Understanding the full scope of administrative spending means considering the various healthcare stakeholders and types of expenses that each stakeholder incurs. Stakeholders ranging from insurers and payers, to hospital and other providers and patients are incurring administrative expenses (see Table 1).

There are no hard and fast rules for what should be included in estimates of administrative spending. As an example, profits and surplus are an important component

Administrative Spending In Healthcare:

- Defines administrative spending
- Finds there is excess but large gaps remain in our understanding
- Consumers' administrative burden of interacting with our complex system has never been tallied

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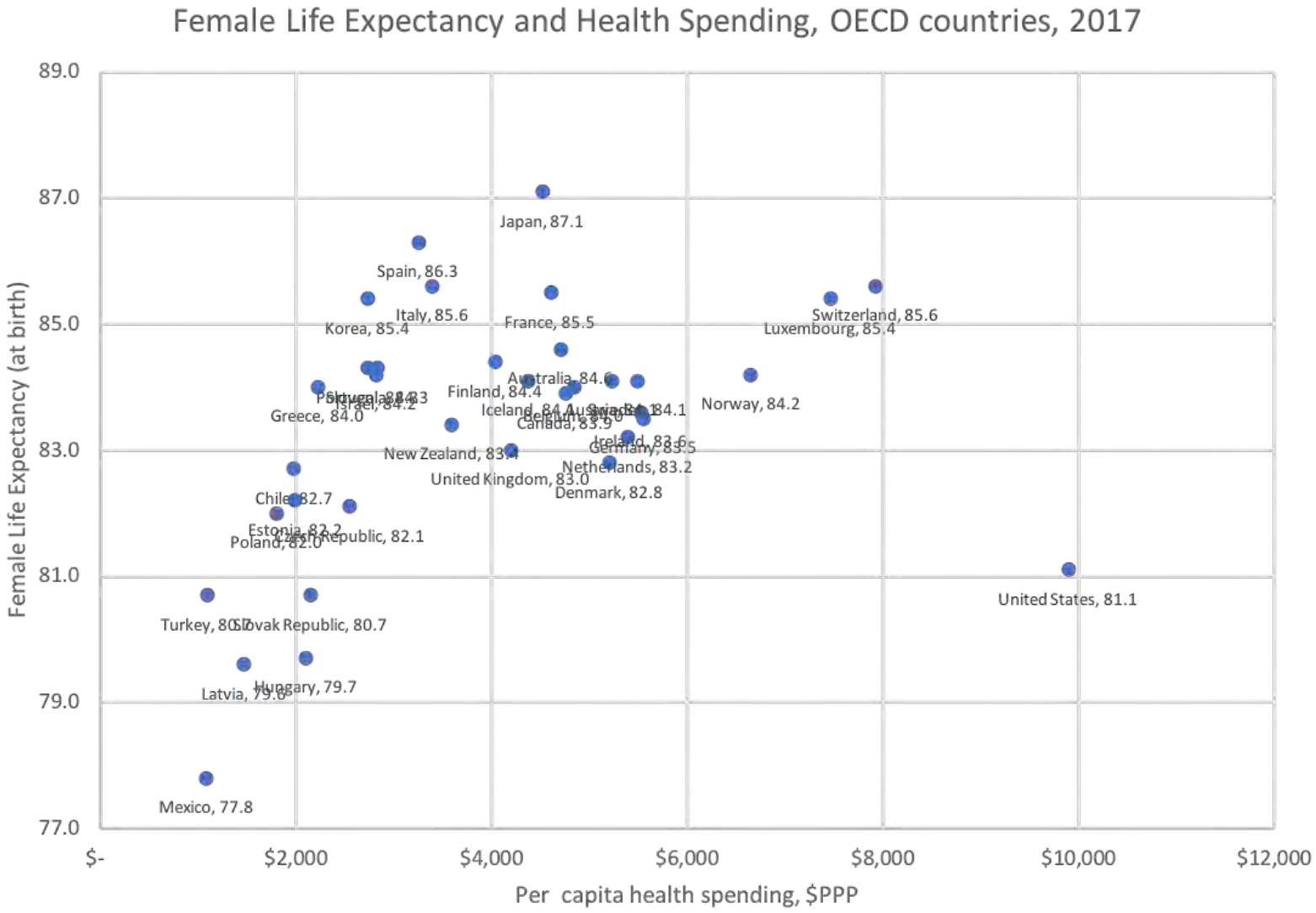
Addressing Administrative Spending

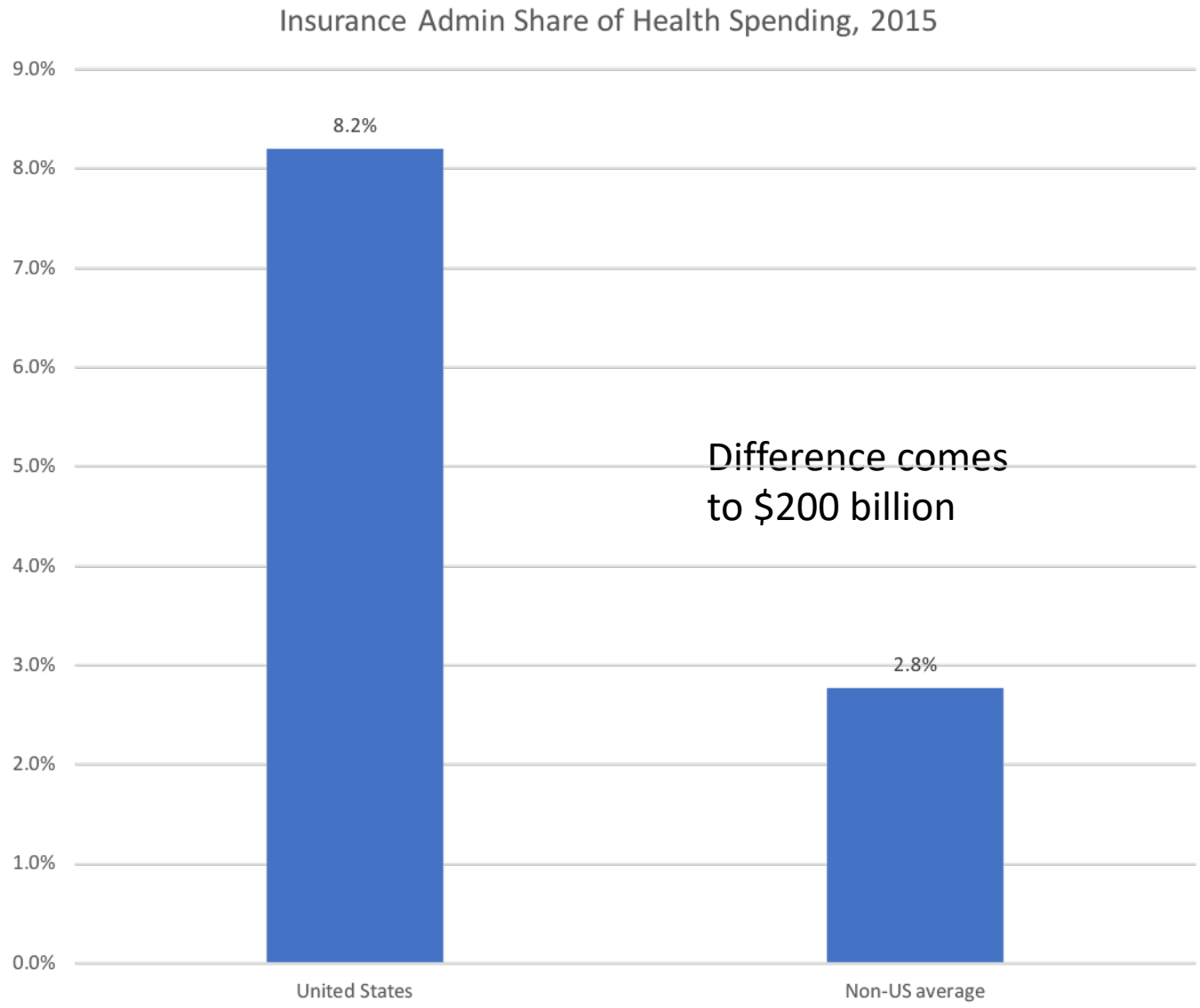
Gerald Friedman
University of Massachusetts at Amherst

Familiar story: US spends too much and gets too little

$500 billion in excess spending because of administrative waste, the cost of insurance administration and billing and insurance related costs in provider offices



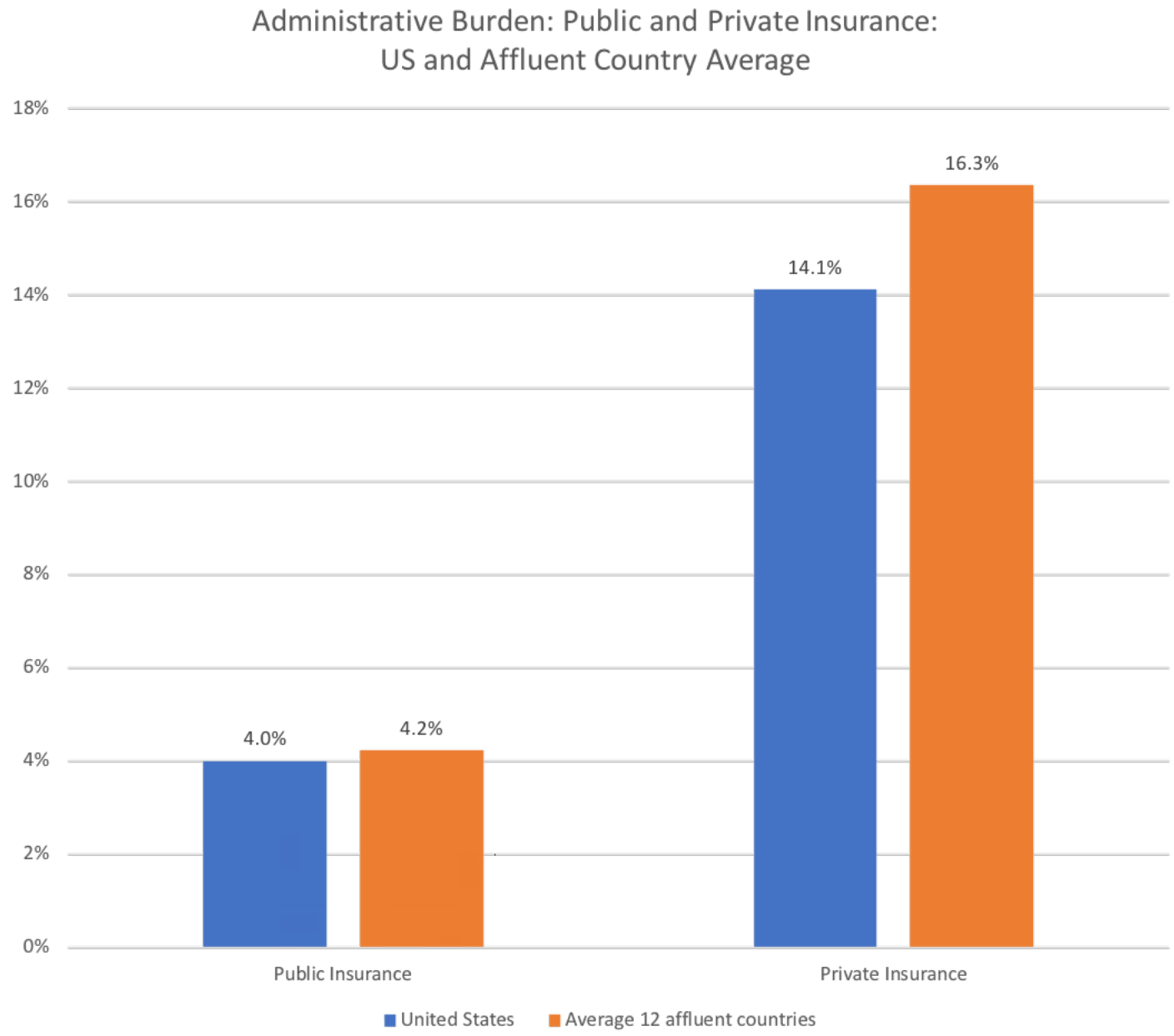
US spends more on insurance administration



These are costs associated with signing people up with insurance, collecting premiums, processing payments, and, for private companies, profit.

Data extracted on 09 May 2019 16:51 UTC (GMT) from OECD.Stat

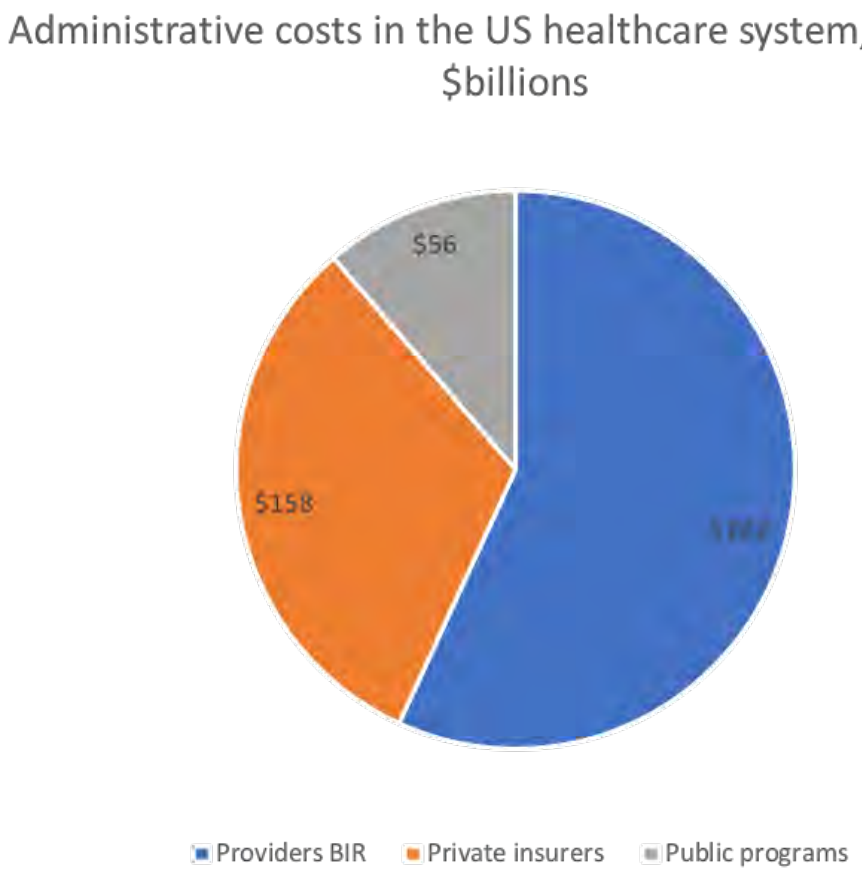
Due to our mix of insurance. Within insurance types, administrative costs are lower in US than other countries



https://www.who.int/health_financing/documents/dp_e_10_08-admin_cost_hi.pdf

We spend more on billing and insurance related activities within provider offices

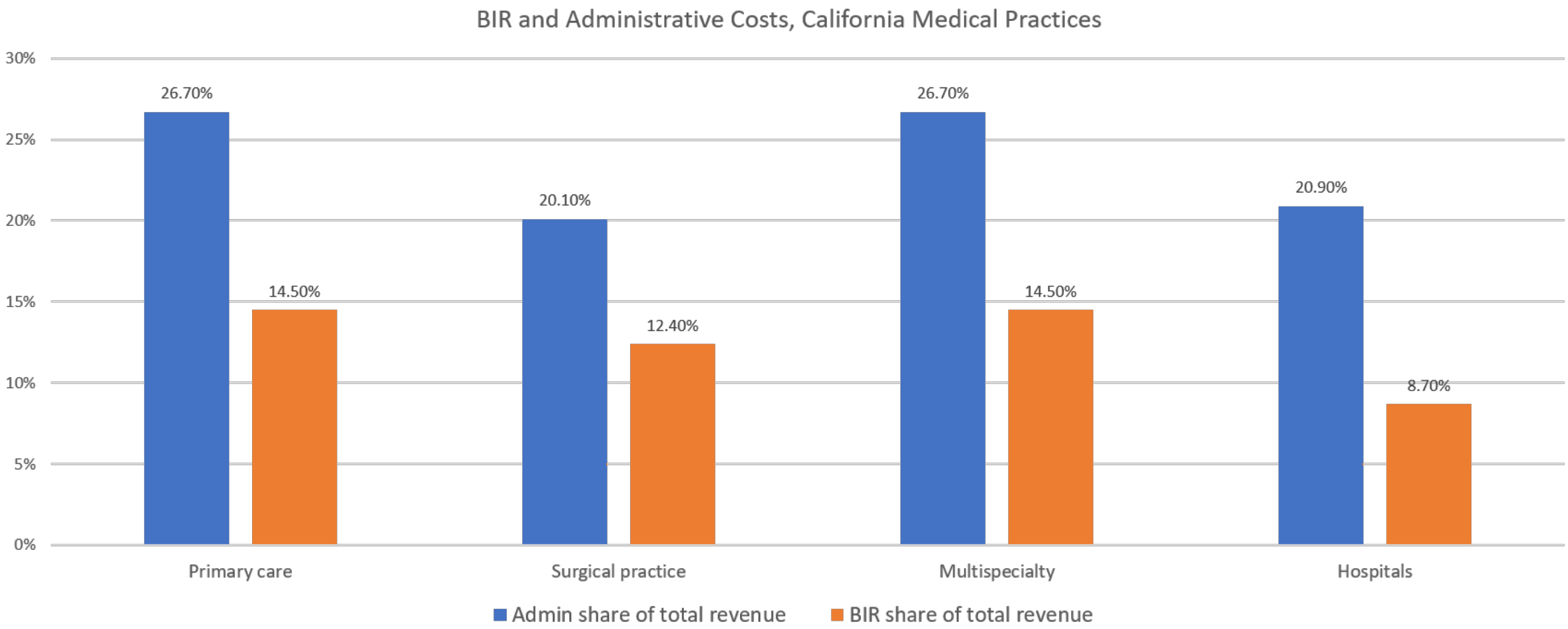
Total spending of $496 billion, or as much as $395 billion more than if our billing was as efficient as Canada's



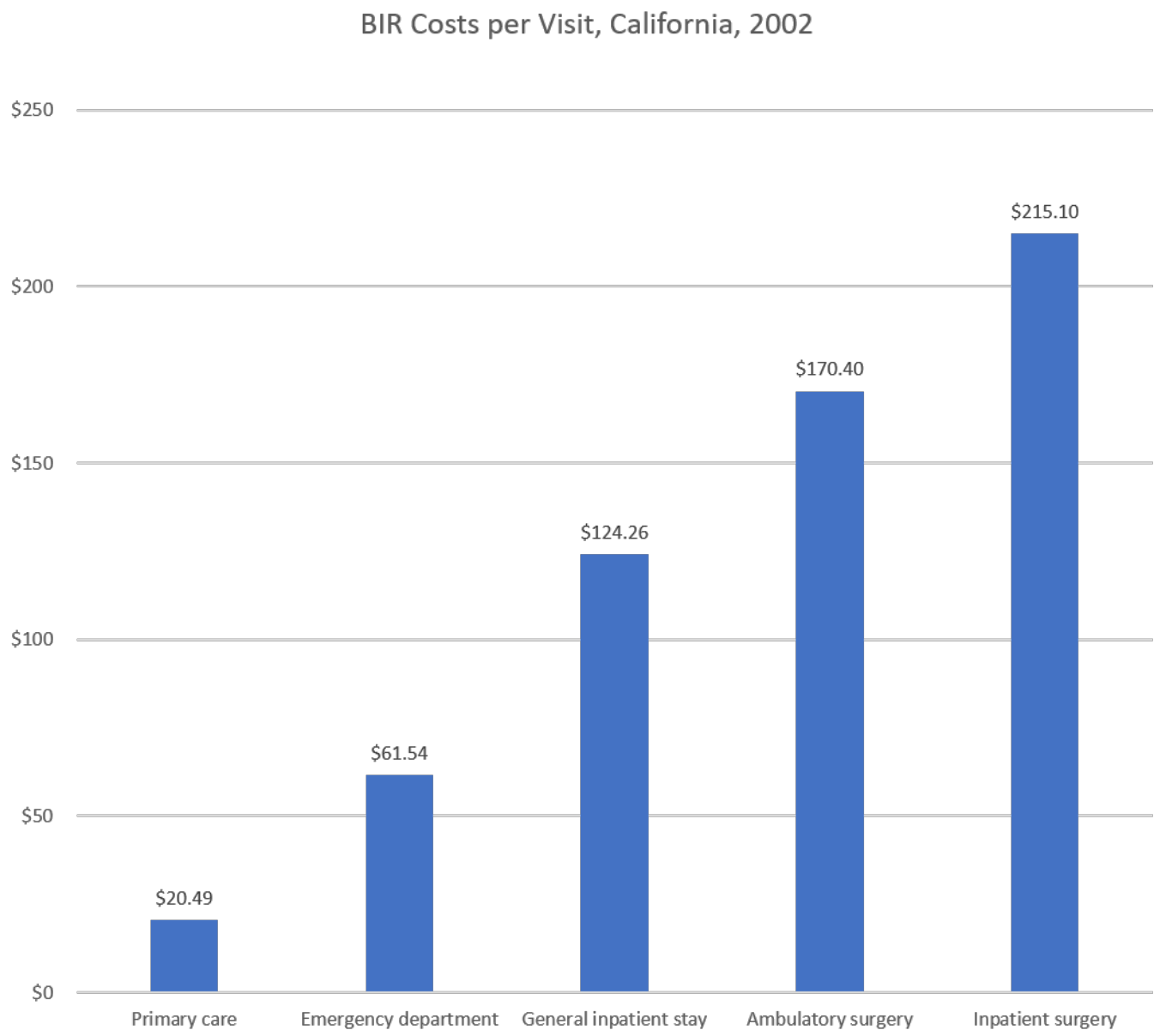
Providers BIR (Billing and Insurance Related) costs are the costs of processing bills and providing information and getting approvals required by insurance companies.

https://cdn.americanprogress.org/content/uploads/2019/04/03105330/Admin-Costs-brief.pdf

Our providers spend a lot processing bills for insurance companies



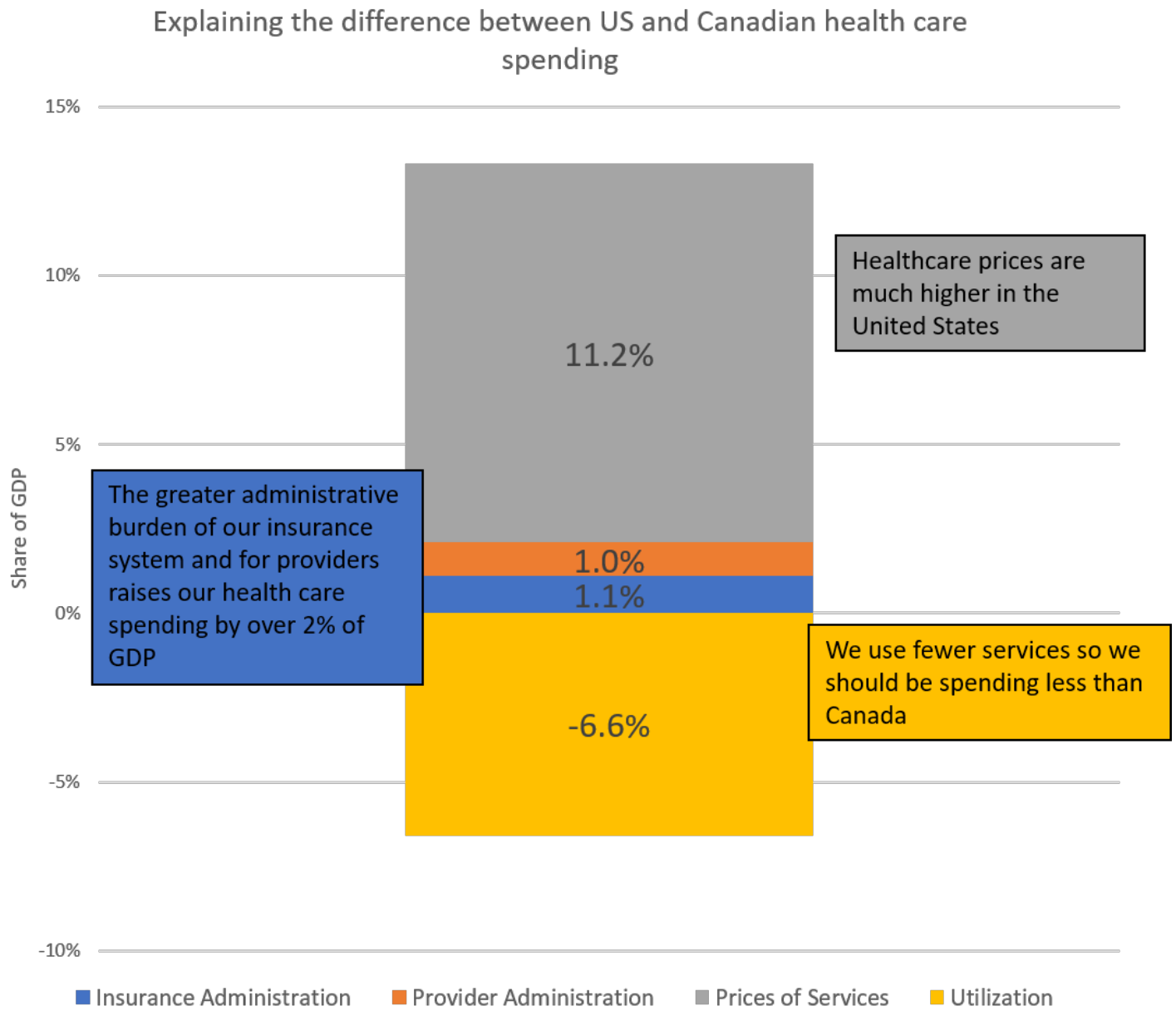
A lot processing bills



US spends more than Canada *Even though we get fewer services.*

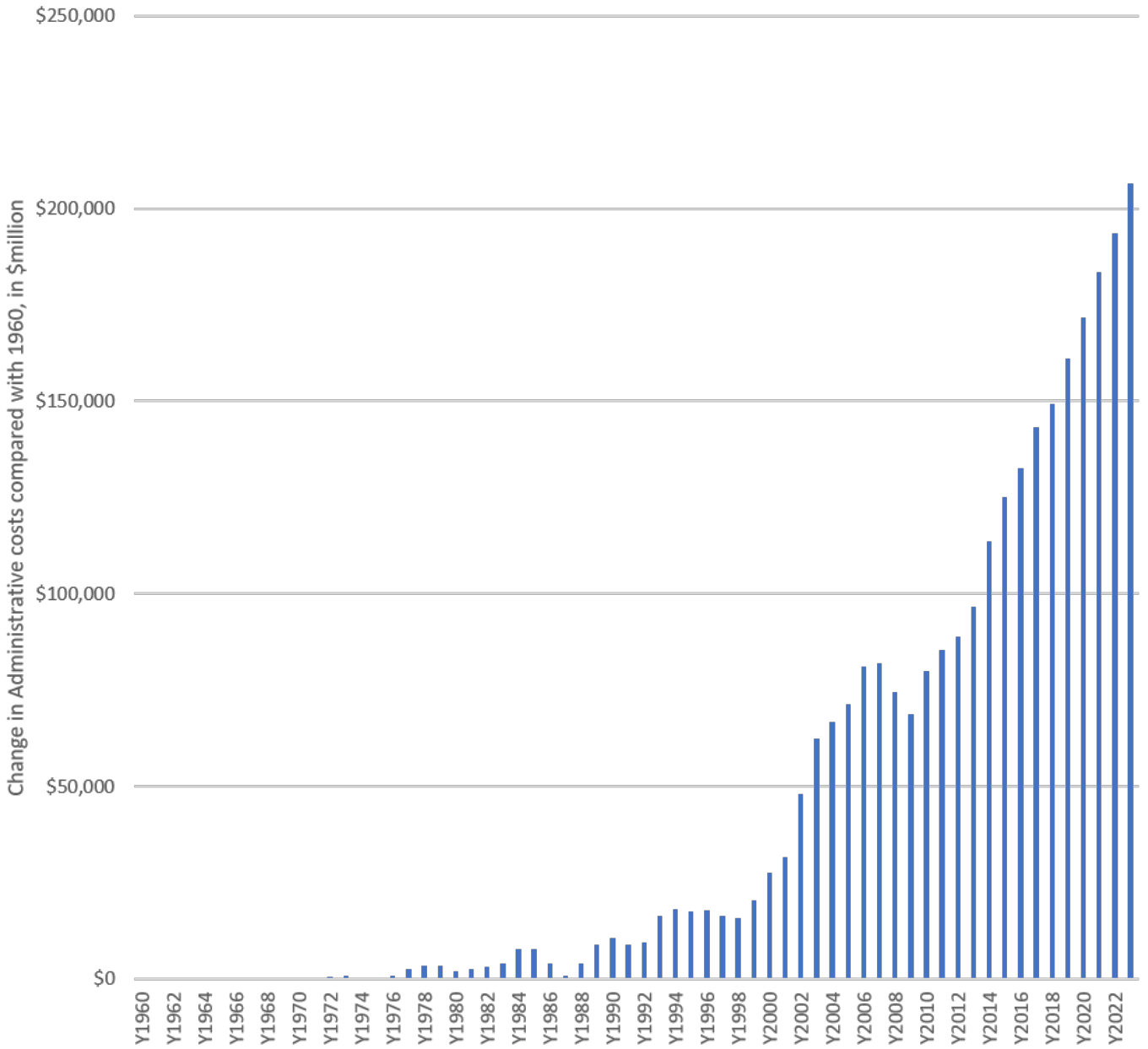
Administration is partly to blame but prices also matter

If US used as much healthcare as Canada, our spending would be 25% of US GDP, not 18%



Rising burden of insurance administration

if our administrative burden was the same as in 1960, we would be spending over $200 billion less



Rising administrative costs account for about one third of the increase in healthcare share of GDP

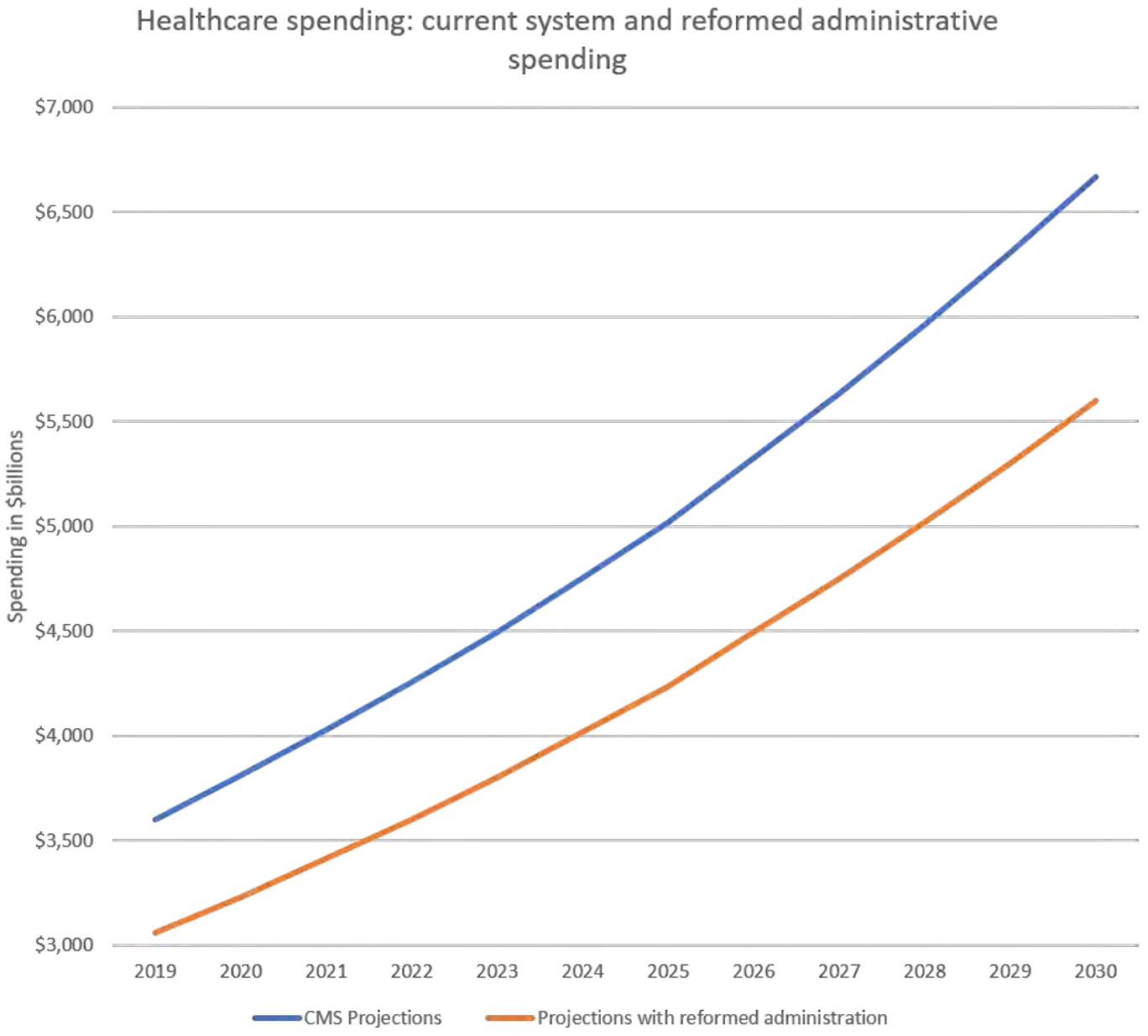
Most of the rest is rising prices

Controlling health care administration costs will help to bend the cost curve. But we also need to look at prices.

	Increase 1960-2018
Increase in Healthcare as share of GDP	13.49%
Increase in Health insurance admin as share of GDP	3.93%
Insurance admin share of healthcare increase in GDP	29%
Estimated increase in BIR share of GDP	0.69%
Insurance admin plus BIR share of healthcare increase in GDP	34%

Stopping the growth in administrative costs would bend the cost curve

$500 billion in savings in first year.
$1 trillion after 10 years



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Review of Single Payer

Harold Pollack
University of Chicago

The bear that caught the car: The political and policy challenges of health reform.

Harold Pollack
haroldp@uchicago.edu

Roadmap of presentation

- Uncertain political political and policy landscape of health reform as of ~~January 2014~~, ~~October 2014~~, ~~January 2015~~, ~~October 2015~~, ~~January 2016~~, ~~June 2016~~, ~~October 2016~~, ~~January 2017~~, ~~March 2017~~, ~~July 2017~~, ~~October 2017~~,~~January 2018~~, ~~June 2018~~, ~~November 2018~~, ~~January 2019~~, May 2019
- Unfair charges against single payer.
- Unfair expectations of single payer.
- Some suggestions for what happens over the next hill.

Unfair charges leveled at Single Payer

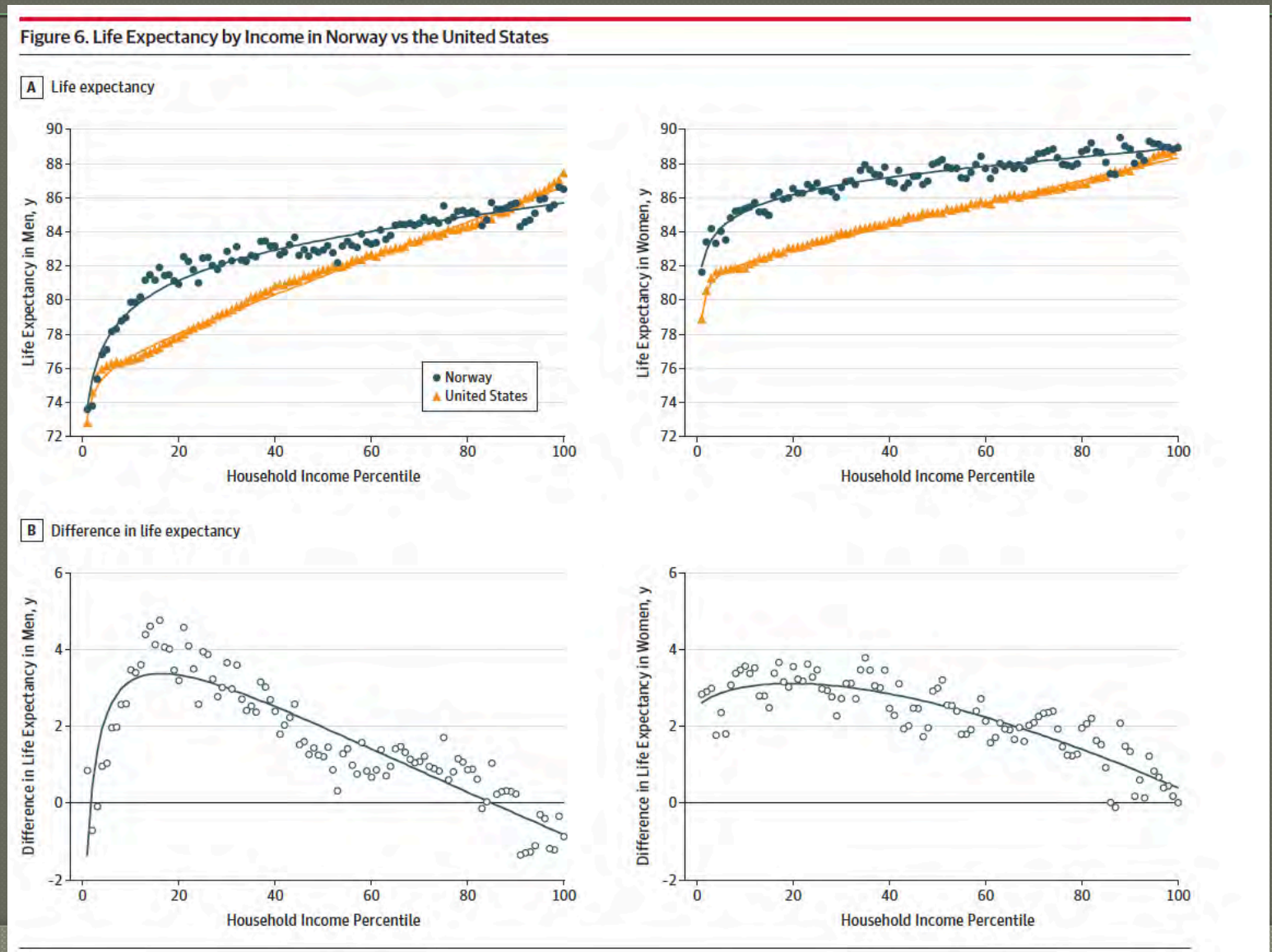
- Single payer can't work
- Single payer can't discipline the health care marketplace
- At its best, the American health care system is the best in the world. Don't damage that.

This place exists

It's the prices stupid…

- US system relies on fragmented payers to discipline the system.
  - Insurers lack market power, public standing, and legitimacy to perform this role.
  - Public payers susceptible to their own pressures on this front, though they do better.
- The best Western European healthcare rivals ours (e.g. Norway analysis).

US vs. Norway
(h/t David Cutler)



But let's not get carried away

- Single payer more promising to discipline the system through bargaining power.
  - But single payer not immune to lobbying by hospitals, pharmaceutical manufacturers, patients, and others.
- Political chances:
  - How would a single-payer system come into being?
  - It would be a product of—not an alternative to—our pathological legislative structures and health care political economy.
  - Danger of over-promising

Republican dilemma: Legislative dominance & policy unpopularity

- GOP controlled Presidency, House, Senate, and Supreme Court.
  - Not to mention more than thirty governorships and legislative majorities, making GOP governors a critical and complicated constituency in health policy.
- GOP dominance over political levers didn't match limited popular/policy mandate.
- Rhetoric & preferred policies never matched feasible options.
- Failure to prepare stakeholders or public for what could feasibly be legislated.
- Limited policy leadership from unpopular administration.

Inner logic of failed GOP repeal efforts last year

- For 7 years, GOP campaigned on ACA repeal & replace, arguing that they could offer something cheaper & better.
- Great counterpunching strategy—until they unexpectedly won.
  - … And then politically self-immolated.
- GOP failure to provide a credible alternative ratified public consensus for pillars of ACA.

This just can't happen

(CBO analysis)

Plan value of GOP plan vs. ACA

Using the benchmark second lowest-cost silver plan with a 70% actuarial value, here's how the ACHA's age-based tax credits and elimination of cost-sharing subsidies would drop the value of plans for various age groups.

	Premium	Premium Tax Credit	Net Premium Paid	Actuarial Value**
Single Individual with an annual income of $26,500, 175% FPL**				
Current Law (ACA)				
21 years old	$5,100	$3,400	$1,700	87%
40 years old	$6,500	$4,800	$1,700	
64 year old	$15,300	$13,600	$1,700	
GOP Plan (ACHA)				
21 years old	$3,900	$2,450	$1,450	65%
40 years old	$6,050	$3,650	$2,400	
64 year old	$19,500	$4,900	$14,600	

Democrats face dilemmas too… Tinkering with ACA isn't enough

- ACA was an ideologically moderate, market-driven approach to universal coverage.
  - Approach works well in Western Europe.
  - We saw what happened here.
  - Cost control and complexity issues.
- Institutionally complicated and fragile.
  - Requires pragmatic bipartisan problem-solving.
  - Specifically what our polarized political institutions can't deliver, even if Republicans were interested in doing so.
  - Which they aren't.

Democrats face dilemmas too… Tinkering with ACA isn't enough

- ACA's glitches and political travails discredits policy compromise among Democrats, particularly core constituencies.
- Dangerous divide between center-left policy analysis and progressive activist communities who are the future of Democratic Party.
- Next Democratic initiative will be simpler and more ideologically radical.

Democrats face dilemmas too… Leap to M4A won't happen

- M4A popular among Democratic core voters and aspects poll well among broader public.
- Worthy aspiration and political framing, but huge problems.
- Lurch to single payer would likely self-immolate as details fill in.
  - Would be surprised if such measure got 30 Senate votes.
  - About 0% chance Congress will precipitously eliminate private coverage.
  - Some incremental on-ramp is essential to universal coverage, whatever one's view of single payer.

Democrats face dilemmas too… Single leap to M4A won't happen

- Revenue requirements of disciplined single-payer system roughly equivalent to doubling of federal income taxes.
  - Different forms of taxation such as VAT may be more efficient.
- Tens of millions of winners and losers.
- Serious squeeze of entire supply-side of medical care economy—the same constituencies that resisted far less radical public option plans.
  - Rural hospitals
  - Doctors, nurses
  - Drug companies
  - Everyone selling everything from Band Aids to wheelchairs.

Democrats haven't faced some challenges this effort will face

- Progressives sometimes present single-payer plans as an alternative to messy politics.
  - Federalism issues
  - Congressional dysfunction and collective action problems.
  - Compromises with key interest groups.
  - Mindless complexity and incremental kludges through the hidden welfare state.
  - Complex wiring of state-federal disability system.
- But any feasible single-payer plan would necessarily be the product of that same system, and must navigate every one of these issues.

Reckless predictions

- Medicare *available to all* but not *mandatory for all* likely to play a larger role, particularly to bolster and maybe supplant marketplaces.
- Liberals and progressives recognize the value of these efforts.
- Progressives and centrist wonks must work together on something
  - Everyone is proud to own,
  - Can actually be passed,
  - Can work even if Democrats lose a subsequent election.
- The clock is ticking.

Thank you

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Expert Reactor

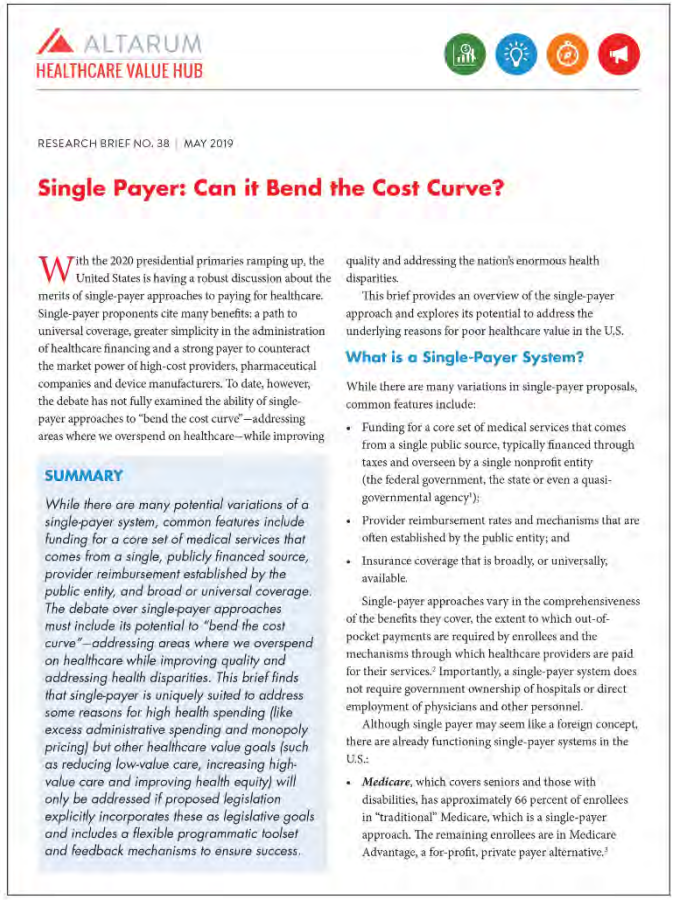
Eagan Kemp
Public Citizen

Questions for our Speakers?

- Use the chat box or to unmute, press *6
- Please do not put us on hold!

Hub Resources on Single Payer

Visit our webinar page for articles and reports from our speakers, plus:



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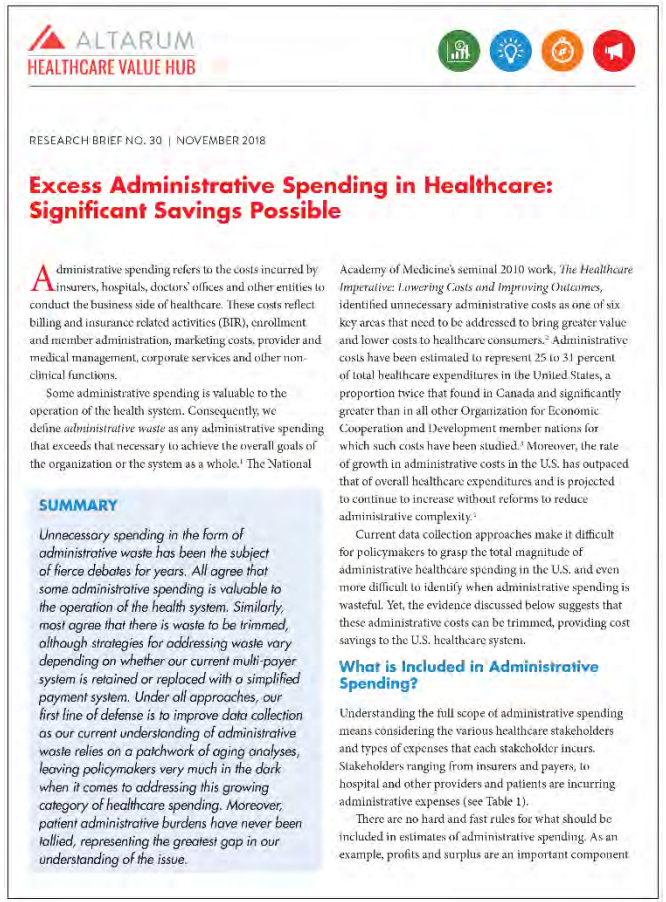
Single Payer



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Administrative Costs

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Thank you!

- Gerald Friedman, Harold Pollack, Eagan Kemp
- Robert Wood Johnson Foundation

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2:00-3:00 p.m. ET

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