HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA®

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Briefs Focus

Could Single Payer Work in California?

Board Member Response Is Split

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Pursuing an industry consensus on "the best" payment methodology continued at the special April 2 HASC Board meeting with a discussion of single payer.

Three different payment concepts are on the Board's plate for consideration:

- *"Creating a Sustainable Health Care System"* presented by Duane at our March 12 Board meeting.
- *"Modern Pricing"* presented by Anne McLeod and Bob Hudson in a breakout session during the HASC annual meeting.
- *"Single Payer"* presented at the April 2 Board meeting.

Single payer is definitely on the liberal end of the political spectrum. It is financed through taxes on employers and employees, akin to "Medicare for all," and in doing so puts the government squarely in the driver's seat. (Some would say government is already in the driver's seat.) The only system further to the left is a "socialized medicine" health care system such as Great Britain's where the government owns the hospitals and employs the doctors.

Single payer is in selective use worldwide, most notably in Canada, and is not dead in the United States. The state of Vermont voted to establish a single payer system for its citizens by 2017. Single payer bills have passed the California Legislature – twice – before being vetoed by Governor Schwarzenegger. Because everyone in Sacramento is full speed ahead with ACA and Covered California, there is no bill in the state legislature at the present time.

In California we have a number of organizations advocating for single payer:

- Health Care for All – California (HCA): chapters throughout the state, including Santa Barbara, Ventura, Los Angeles and Orange.
- California One Care.com: an online organizing network.
- Physicians for a National Health Program: chapters in Northern and Southern California.

These groups sponsor legislation, advocate, analyze, and compare the different systems, and attempt to clarify the "socialized medicine" stigma associated with the single payer concept.

Who wants single payer?

- Unions, especially the CNA.
- AARP
- People disappointed with Obamacare (Obama didn't go far enough).

- Anyone who leans toward a western European socialist state.
- Folks angry at private health plan profits and coverage policies.
- Anyone who wants to regulate premiums (taxes in a single payer), hospital and doctor payments, and coverage/benefit policies.

Advocates emphasize social justice, equality, reducing the profit motive, administration simplification and public oversight. Advocates also claim there would be significant cost savings, a portion of which could go to increasing provider payments above current Medicare rates.

What is not so clear is the impact on hospitals, physicians, access, quality and controlling actual care costs. Detailed financial analytics are also missing, as well as a politically viable path to get there from here.

Single payer does not necessarily mean a single *payment amount* or a single *payment methodology*. Rather, single payer refers to a single entity (government) that collects taxes (offset by premiums) and pays providers. The classic single payer maintains a direct 1:1 relationship with providers with no intermediary involved (ex: Medicare FFS). When the fountainhead payer contracts with multiple intermediaries who in turn negotiate various price amounts and price methodologies (capitation, FFS, case rate, etc.) with providers, it is not truly single payer anymore.

Just like Medicare today, single payer could pay hospitals based on FFS, DRGs, bundled or capitation. Providers could negotiate the *payment method* that's best for them ***if*** that feature is written into legislative language. Previously proposed California legislation would pay hospitals based on an annual *global budget* derived by regional input.

Payment amounts could also be negotiated and could include carve-outs, stop-loss and supplemental payments for teaching/research, again ***if*** that is written into the legislation.

Single payer could be coupled with *any willing provider* in order to mitigate the narrow network phenomenon similar to what fee-for-service Medicare is now if it is enacted.

The previously proposed California legislation includes a factor for *capital expenditures* (facility and equipment) and a COLA for hospital employees. The capital budget control part is reminiscent of the C.O.N. days of the 1980s, which as we all know ultimately failed.

Perhaps the most fundamental issue is big government's takeover of health care financing and the elimination of virtually all vestiges of the private free market health insurance companies in America.

There may be an opt-out provision for individuals who want to buy private health insurance as long as it doesn't compete with the single payer plan, if there are any insurance companies still around to sell it. Wiping out the entire health plan industry, as entrenched into the American economy as it is, would be an undertaking by single payer advocates of monumental proportions.

Government has a long history of *overpromising and underfunding* health care. Who would be more accountable to the public? Government bureaucracies or private companies competing for business?

Could single payer work in California? Vermont is really liberal, really small (pop. 626,000), has a grand total of 15 hospitals, has very little racial or income diversity and has little competition among providers.

Vermont is like a petri dish of experimentation where mistakes can be contained. Mistakes in California would be like a nuclear explosion.

Do we need a radical change to achieve triple-aim goals? Can the current pluralistic, privately financed, employer-based system be incrementally improved to meet the needs of the nation?

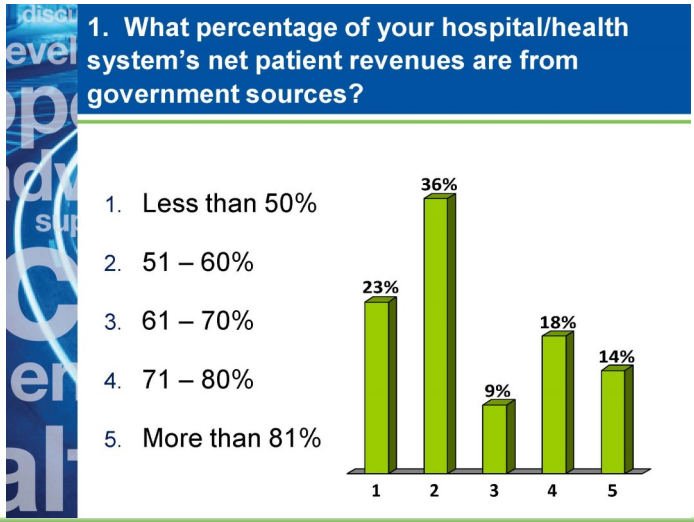
If the current pluralistic financing and payment system is to survive, it must do a better job of addressing quality, appropriateness, alignment of incentives and care continuity. It must reduce administrative costs and provide incentives to lower care costs. And it must reduce the cost shift so that government pays fairly and private insurance isn't priced out of the market. Are these goals achievable under Obamacare as it's currently structured?

Ironically, *Obamacare may be the best hope* in preserving the private, free-market health care system. If Obamacare fails, California may be headed for a single payer system faster than we now think possible.

Board Survey Results

The HASC Board discussed what single payer might and might not do for patients, hospitals and doctors. Discussion was stimulated by the use of online survey technology in place at the meeting. The Board was asked to respond to five questions, and the results are as follows:

1. What percentage of your hospital/health system's net patient revenues are from government sources?



Comment on Survey Results

The hospital's location is the single most significant variable in determining a hospital's patient mix and revenues from commercial vs. government sources. For a few hospitals, the variable is service mix, with children's hospitals being the best example. Also, large delegated-capitated physician groups and health plans which create narrow networks can effectively steer patients to hospitals located some distance away.

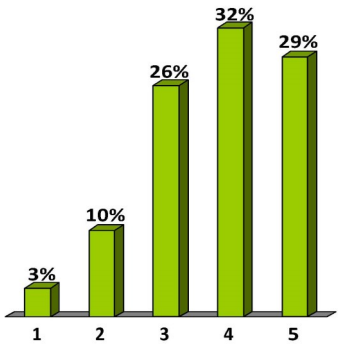
But for most general acute care hospitals, the old adage is true that health care is primarily delivered locally to the communities in close proximity to the hospital. Folks will travel outside their community for highly specialized and exotic services, but the emergency department of the community hospital is the access point for many patients.

This is not to say that a hospital can't thrive serving the inner city or a poor rural area of the state; but it is generally the case that hospitals in disadvantaged economic markets have a higher percentage of government pay patients and usually struggle financially more so than hospitals located in higher socio-economic communities.

The main policy questions are: Should where you happen to live affect your access to high quality, appropriate health care? Should we accept large gaps between the least healthy and the healthiest places to live? Is it fair that the financial health of a hospital should be so influenced by the socio-economic status of its community?

2. Will Obamacare succeed in addressing the triple-aim goals of better health, better healthcare and lower costs?

1. Yes
2. Probably
3. Unsure
4. Probably not
5. No



Comment on Survey Results

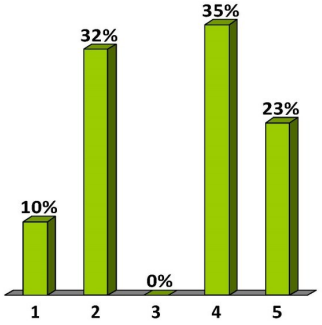
Board members expressed a healthy level of skepticism on the future of Obamacare at least in terms of triple-aim goals.

There is no doubt that under Obamacare more Americans will gain health care coverage. The doubt comes from whether or not coverage will translate to access, better health and lower costs. It is generally believed that costs will go up as pent-up demand surges. The cost spike could be a short term blip, analogous to the mouse going through the innards of the snake, or we could be faced with a new, higher cost plateau for America to deal with.

We did not ask the question of whether or not the Board believes that Obamacare is our best hope to preserving the multiple payer, pluralistic financed, privately delivered health care system. But if Obamacare fails, then what comes next?

3. How likely is it that single payer will be a legitimate contender for health system change by 2017?

1. Highly likely - Yes
2. Possibly
3. Unsure
4. Doubtful
5. Not likely - No



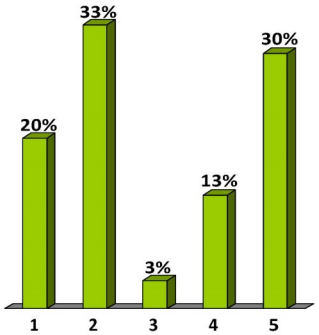
Comment on Survey Results

Question #2 led to question #3, whether or not single payer is looming in our future as the "next step." The question was not if single payer would be on top of us by 2017, the question was if single payer will get serious consideration. The Board was seriously split on the question.

One wonders if the same question was posed as 2020 and not 2017 if more would have forecasted single payer as a legitimate contender. On this question and the others as well, the Board directed staff to ask them the same questions next year, and the year after next … it will be interesting to see how this turns out!

4. Do you think your hospital/health system would be better off in a single payer system *at Medicare rates* than what is happening now?

1. Much better
2. Possibly better
3. Don't know
4. Probably worse
5. Definitely worse



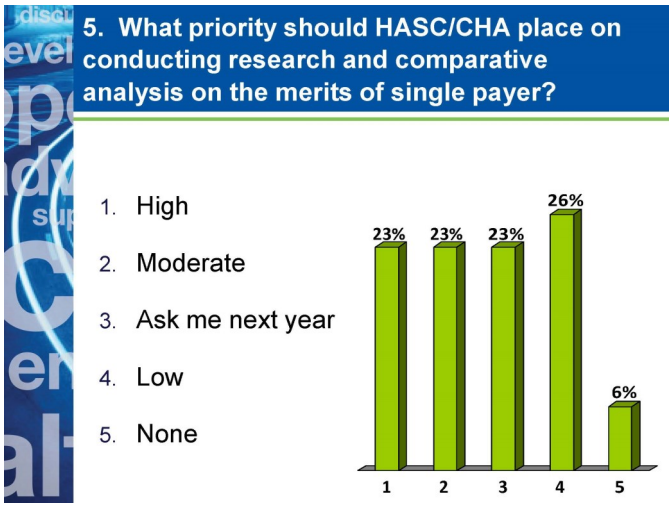
Comment on Survey Results

I wonder if the responses to questions #1 and #4 are related? We did not correlate location with whether or not a particular Board member thinks their hospital would be better off if everyone paid Medicare rates, but I suspect there would be a correlation. The theory being for some hospitals, if Medi-Cal rates were brought up to Medicare rates, it would more than offset the decreased revenue from commercial rates. For other hospitals, the same offset would not be a net gain.

The split in the responses suggests an important policy debate will be initiated in the not too distant future: should net income of hospitals be mechanically smoothed out through government manipulation/oversight of hospital payment?

Of course, we smooth out to some extent now through supplemental payments such as DSH, the hospital fee and area wage index.

But how far should we push revenue smoothing before we stumble down the rabbit hole to an "all-payer" system? Should all-payer be our desired endgame instead of the more radical single payer?



Comment on Survey Results

The response to this question is an ace example of living in tumultuous times.

Single payer is not our highest priority right now, that's for sure. We have more immediate concerns with ballot initiatives, legislation, on again/off again ACA regulations, payment cuts and market shifts. To get to the long term, one must survive the short term.

Nonetheless, nearly half of the Board not only appreciated that we took the time to more thoroughly explore a theoretical "armchair public policy," but believe we need to do more of that kind of blue sky thinking. Half the Board said "don't bother with it now," but let's keep it in the agenda parking lot for a future meeting.

In summary, we have a few years to produce desired health system results under more-or-less the same financing and payment systems currently in place. The systems will be tested as millions more Americans gain coverage through the exchanges, Medicaid and Medicare (as the population ages). If we can achieve triple aim goals without radical payment system reform, so much the better. Nonetheless, contingency planning is prudent and HASC/CHA will keep trying to peek around the corner as we fight the good fight of issues immediately in front of us.