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INSIGHTS AND INNOVATION FOR COMMUNITY HOSPITALS AND PROVIDERS

Is Single Payer "A Pig in a Poke"?

by Jim Burnette, President/CEO, HospitalMD

We hear a lot of debate about "single-payer health systems" ("SPS") as a remedy for the high cost of healthcare, and to ensure that everyone has access to healthcare. SPS has become a political euphemism for "Medicare for all", "universal health care", "nationalized healthcare", or other expressions that imply that the federal government should be the only payer. The "simple" argument for SPS is that everyone is entitled to a specific standard level of healthcare that can be assured only by the government as a single payer subsidizing a significant portion of the cost. A SPS further guarantees that everyone has equal access without regard to pre-existing, current, or future health conditions. Regardless of your preferences of expressions, the meaning is the same. SPS in any form is a "pig in a poke".

"A pig in a poke" is a Southern colloquialism that refers to something that is bought or sold without the buyer knowing its true nature or value; and especially when buying without inspecting the item beforehand.

A more contemporary expression would be "dumbing down" the buyer. The seller is offering something that sounds attractive, but is actually something entirely different—less value and/or greater cost. The expression may sound benign, and the image may appear amusing, but the image describes the paradox of what would likely be even more exorbitant costs (and the likeli-

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hood of less access and service level as I illustrate later) under the disguise of reducing costs.

STS proposals generally provide that **individuals enrolled for benefits are entitled to have payment made...to an eligible provider... for a list of covered services".** These proposals sound appealing, but the devil is in the details. What do these provisions really mean?

Actually, this proposal could be said to represent several "pigs in one poke". So what are the "pigs"? First, the words are vague and can mean anything the author wants them to mean. Second, the cost of services to the beneficiary can be made politically acceptable (i.e., minimized to the beneficiary) by shifting the balance of the cost to the government thereby hiding it in the massive, perpetual federal budget. This "shift" of cost to the government also means that all tax payers pay collectively for health care for excessive utilization; and expensive care for people with significant costly conditions due in many cases to poor choices and poor life styles.

Next, the ambiguous and politically unattractive elements of the STS often represent what I would describe as the "iceberg". This is the effect of often massive, unknown, and unpredictable sums of money that we commit today that are paid down the road that can be shifted to a camouflage of social (emotional) benefits that are difficult to argue against except for the high cost. I would even use the "ice berg" analogy to describe the current Medicare entitlement.

We have worked hard to introduce more effective treatments and technology to reduce the cost of many health care events in order to reduce the future cost of Medicare, only to have ignored (or did not know at the time) the "baby boom" which has resulted in utilization that is likely to "sink" the Medicare Trust Fund. Guess what. Tax payers will pay for this, like it or not. This in itself is a "pig".

One might assume that with only one payer (STS), all providers would have no choice except to accept the fees offered by the STS. Fortunately, providers in the US are licensed individually and are legally autonomous, which permits them to be professionally and financially independent. They can chose to participate or not. And independent providers may set their own fee schedules outside of any insurance plan if the rates in the fee schedule are not less than fees paid by a government payer.

Scientific advances and technological breakthroughs have followed an exponential trajectory for the better over the years. But the economic model has changed little at its core.

SO, HOW DID WE GET HERE?

It is interesting how great breakthroughs evolve over the years. What was great promise with

such progressive outcomes often lead to unintended consequences unless we consider carefully and objectively the evolution itself. This is the case with the evolution from primitive medicine to great improvements...and here we are today. Our scientific advances and technological breakthroughs have followed an exponential trajectory for the better over the years. But the economic model changed little at its core. And here we are with a dilemma that seems unsurmountable.

Beginning in the 1850s and 1860s, we discovered that many diseases were caused by specific microorganisms, and the most powerful idea in the history of medicine was born—the germ theory of disease. This knowledge of microorganisms was the fundamental technology from which advances grew exponentially. In 1891, the death rate for American children in the first year of life was 125.1 per 1,000. By 1925, a little over 30 years, it had been reduced to 15.8 per 1,000, and the life expectancy of Americans as a whole began a dramatic rise.

One of the most fundamental changes caused by the germ theory of disease, one not foreseen at all, was the spread of hospitals for treating the sick. But hospitals had a financial problem from the very beginning of scientific medicine. They are extremely labor intensive and expensive to operate. Most of their costs are relatively fixed, and not dependent on the number of patients being served. To help solve this problem, someone in the late 1920s had a bright idea: hospital insurance. Some 1,500 schoolteachers paid six dollars a year in premiums, and Baylor University Hospital agreed to provide up to 21 days of hospital care to any subscriber who needed it. (Remember HMOs?)

The driving purpose behind the idea was to improve the cash flow of the hospital, not improve healthcare. Thus the scheme had an immediate appeal to other medical institutions, and it quickly spread. But although these plans were called insurance, these hospital plans were unlike any other insurance policies. Previously, insurance had always been used to protect only against large, unforeseeable losses, and came with a deductible. But the first hospital plans didn't work that way. They paid all costs up to a certain limit. The reason, of course, is that they were instituted not by insurance companies, but by hospitals and were primarily designed to generate steady demand for hospital services and guarantee a regular cash flow. And that they did, and by that or any other measure, they were extremely successful.

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In the early days of hospital insurance, this fundamental defect was hardly noticeable. The original hospital insurance also contained the seeds of two other major economic dislocations. The first dislocation is that while people purchased hospital plans to be protected against unpredictable medical expenses, the plans only paid if the medical expenses were incurred in a hospital. As a result, cases that could be treated on an outpatient basis instead became much more likely to be treated in the hospital—the most expensive form of medical care.

The economic thinking behind "insurance" is financial protection against unforeseen risk. This equation is defined as "indemnity'. The

practical application of indemnify is that the insurance company pays for a loss and the customer decides how best to deal with it. The second dislocation was that hospital insurance did not provide indemnity coverage. Rather than indemnification, the insurance company provided service benefits. It paid the bill in full (usually) for services covered by the policy. As a result, there was little incentive to shop around. With someone else paying, patients quickly became relatively indifferent to the cost of medical care; and why not, the "bill was already paid in full". These dislocations perfectly suited the hospitals, which wanted to maximize the amount of services they provided and thereby maximize their cash flow.

We have known the unintended consequences for a long time. And we continue to "kick the can" down the road. As in the past, we are on a track that does not treat the cause of the flawed thinking. We continue to reduce the pain by treating the symptom which will make the matter worse.

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WHAT IS OUR CURRENT TRAJECTORY?

Every proposal should have a safety net. The safety net in this case is eligible providers. An "eligible" provider is one that agrees to provide the list of covered services and accept the payment offered by the STS. If one payer is the only option, would we not expect all providers to become eligible and take the fee offered? There is precedence for saying "no"; opting out. Reimbursement rates in many current Medicaid programs make finding a doctor difficult for this reason. This limitation in health care delivery capacity ("eligible" providers) even under our current mixed payer model has consequences. The "safety net" is to manipulate the price the STS pays for services.

A study in 2011 found that 66% of specialists did not, or would not, participate and accept Medicaid reimbursement, and thus did not treat these patients. This same study found that it took an average of three (3) weeks longer for a Medicaid beneficiary to make an appointment than those with private insurance. This, then, is a powerful barrier to access. Access is permitted, but not required. One former director of a state program called a Medicaid card a "hunting license" giving the Medicaid beneficiary a chance to "hunt for a doctor, but no access to one. We can look north of our border and to Great Britain to observe SPS in action. In a 2005, four Canadian justices noted that "access to waiting is not access to care". In this same case, the judges overturned Quebec's ban on private health insurance finding that the ban interfered with life and security because the government was

failing to deliver health care in a reasonable time.

The reality of SPS is "rationing" health care. A couple of years ago, an outbreak of winter flu created a national crisis resulting in Britain's health service to cancel tens of thousands of operations. ED resembled "Third World" conditions, and ambulances waited for hours to unload patients in emergent conditions because capacity had been reduced.

SOME ILLUSTRATIONS OF UNBRIDLED COST GROWTH IN THE US

Price & Utilization Growth

Price growth outpaced utilization growth in the 1980s and 1990s. Since 2000, utilization grew faster than price, and utilization has been energized in recent years due to growth in people covered under ACA.

Growth in per capita out-of-pocket expenditures

Out-of-pocket expenditures (in addition to premium cost) have grown steadily from an average of $601 in 1970 to $1,124 in 2017 (almost double).

Public spending has grown faster than private spending

In 1987, the public sector spending accounted for 32% of total spending; and 45% in 2017.

Administrative costs have risen over time

In 2017, administrative expenses as a % of total expenditures grew from 2.8% to 7.4%.

One would think that we would have stumbled upon a solution that made a dent in the cost of healthcare. Not so.

Health spending growth has grown more than all other economic growth

In 1970, total healthcare spending was 6.9% of GDP, and 17.9% in 2017.

CATCH 22

We have created a gigantic "Catch 22" over the years. It seems that there is no solution. Every variation of governmental policy, and every strategy tested for over 20 years has not solved this problem. Is it true that we can put a man on the moon but cannot solve this problem? One would think that after so many years, and after attempting such as significant number of presumed solutions we would have found the financial cure. One would think that after so many years and so many solution proposals that we would have randomly "stumbled" onto one solution that made even a tiny dent in the cost of healthcare. Not so.

This "Catch 22" itself is the result of trying to violate fundamental principles. But this principle, as simple and intuitive as it is, must be understood and not violated.

FUNDAMENTALS

You might ask how does one judge a SPS objectively that is so poorly defined and with so many uncertainties. There is good news. "Fundamental principles" (laws) are the intrinsic backbone of all systems and process models. Fundamental principles are simple and do not change with variation

in a model. These principles result in consistent outcomes regardless of the details. The details are simply the parameters that may vary and thus determine the magnitude and performance of the system or process.

Principles are analogous to mathematics formulas. The fundamental principle here is simple math, A + B = C. That is, the total of all elements of cost ("A" and "B") must equal the total revenue ("C"). Or said bluntly, someone has to pay. The mix of services provided, the qualifications for participation, the methods of delivery, performance, and the volume of services are the details. These details are the regulatory rules that we tinker with that ultimately result in outcomes.

In a commercial market model, the principle is assured by a natural equilibrium among the demand for the services, the supply of providers, and the price (price to providers, cost to patient or payer) of the services. In politics, the service entitlement becomes law and gives the government authority to spend however much it chooses to or can get away with. There is little transparency and accountability. Where there is no transparency and accountability, there is no mechanism to police or control the cost. Thus, there is no balance.

SO, WHAT SHOULD WE DO?

During the financial heydays, hospitals made so much money that it has changed our discipline and ideas of how to manage. We forgot that the hospital is a business. It was too difficult to collect unpaid accounts so we wrote them off and let people with the ability to pay walk away. We couldn't have lost money on our income statements if we tried. If we were short on cash, we simply increased our price (charges) or admitted more patients. We allowed patients to get by without paying their rightful share of the price in the name of charity. This behavior is not charity. There is a place for charity and if we let the market system follow the fundamental principles we could have given charity to everyone deserving charity.

The most fundamental of principles is that we need to connect the person receiving the care with the person that provides the care—the patient and the doctor.

So, what should be do? We must go back to basics. Let me repeat. Principles are analogous to mathematics formulas. The total of all elements of cost must equal the total revenue. Someone has to pay. And we have seen from history that our current form of "health insurance" is not insurance. It is a mix of principles consisting of part entitlement and part free market.

DOCTOR FUNDAMENTAL

The years of excess have come home to roost. We must define the problem correctly. We must go back to fundamental principles. The most fundamental of principles is that we need to connect the person receiving the care with the person that provides the care—the patient and the doctor the seller and the buyer. We must stop trying to sell a "pig in a poke".

We have even taken the doctor that provides care out of the

equation and now the doctor is part of the botched economic principle. Payers have succeeded in telling the doctor what is medically necessary, that they will pay for and what they will not. Payers come to believe they are in control. But don't forget, the doctor writes the order. When the doctor is arbitrarily encroached on by payers, the doctor will need more patient visits. The doctor is really in control, not the payer, and will make the level of income he feels is appropriate. In other words, he will make up for the payer's foolish ideas.

We must restore the trust that should exist between the "merchant" and the "customer". I believe these parties can correct these years of failure without much outside intervention. We might be surprised to find out that doctors will "do the right thing" if we deal with them directly and honestly.

And if we can't come to trust the doctor and let the market principles work naturally, let's not be duped by thinking that the payer controls revenue. Only a doctor can write an order. And not a dollar of revenue can be generated until a doctor writes an order.

We must not forget that we cannot control the doctor nor the revenue he generates. If we distrust providers, they will do what they must to be rewarded for the incredible service they provide. If we foster with providers, I believe they will do the right thing.

Unless, we like buying "pigs in a poke".

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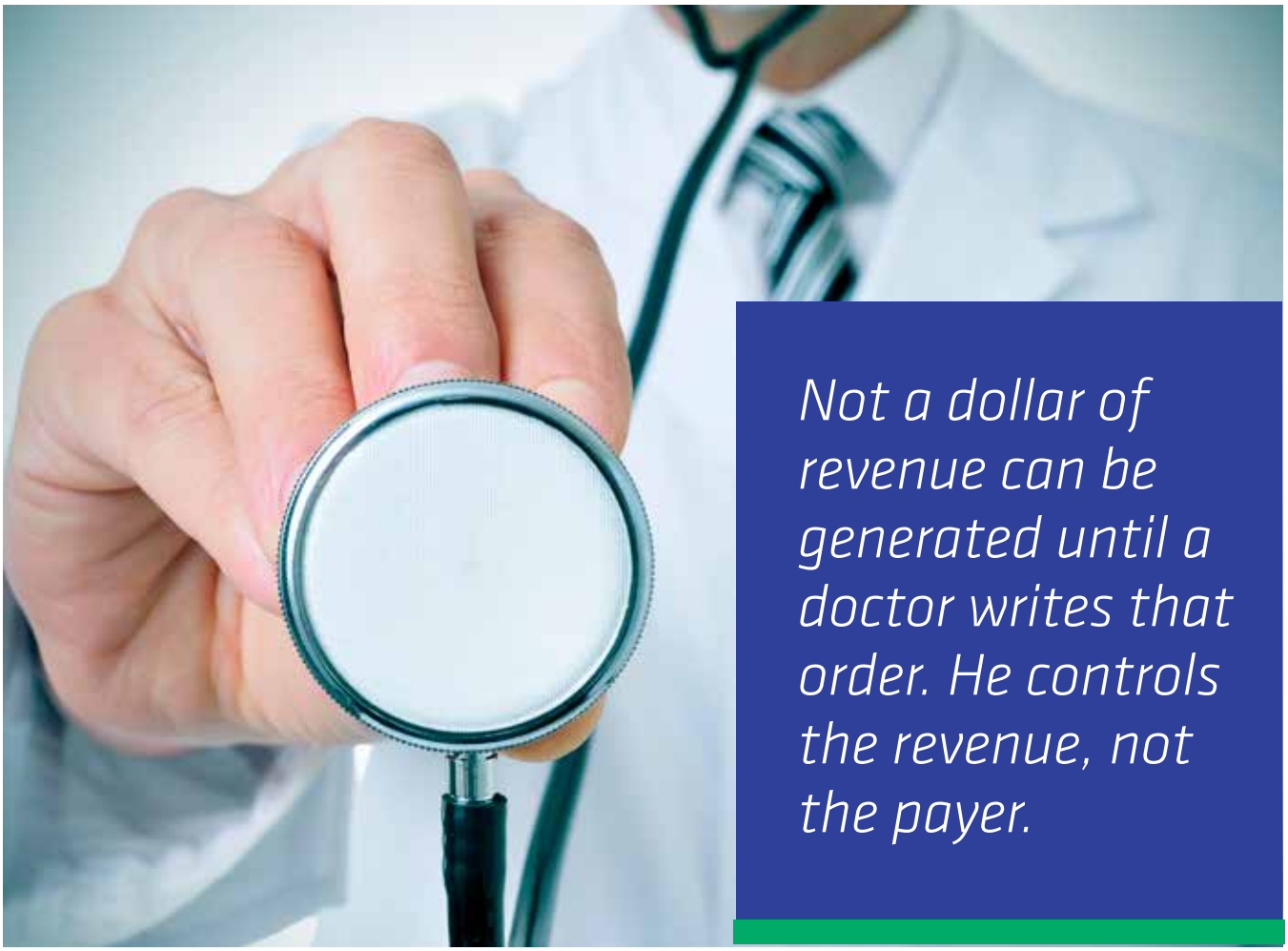

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