Should We Have a Single Payer System?

Marvin A. Konstam, MD

Disclosures:
• Not a big fan
US Health care system Choices

• System aspiration
  – Haves / have-nots vs. Universal coverage

• Healthcare expenditure
  – Laissez-faire vs. Bend the cost curve

• Payment structure
  – Fee-for-service vs. Fee for value / Shared risk / Population based

• System structure
  – Insurance middle-man vs. Integrated system

• Payment source
  – Government payments vs. Private sector
Bend the Cost Curve

Health Expenditure as % of GDP

By Country

[Graph showing health expenditure as a percentage of GDP from 1960 to 2019, with data points for each year.]
Universal Coverage

Racial / Ethnic Disparities

Percent Uninsured\(^1\) By Race / Ethnic Group 2017

<table>
<thead>
<tr>
<th>Race/Ethnic Group</th>
<th>Percent Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>10%</td>
</tr>
<tr>
<td>White</td>
<td>7%</td>
</tr>
<tr>
<td>Black</td>
<td>11%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>19%</td>
</tr>
<tr>
<td>Native American</td>
<td>22%</td>
</tr>
</tbody>
</table>

\(^1\) Non-elderly

https://www.kff.org/uninsured/state-indicator/rate-by-raceethnicity/?dataView=0&currentTimeframe=0&selectedDistributions=white--black--hispanic--asiannative-hawaiian-and-pacific-islander--american-indianalaska-native--multiple-races--total&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
Patient Protection and Affordable Care Act (PPACA)

Guaranteed issue / community rating
- Requires uniform premium, regardless of gender or pre-existing conditions.

Individual mandate
- In absence of employer health plan, Medicaid, Medicare: buy insurance or pay penalty.

Health insurance exchanges
- Offers a marketplace for comparison and purchase of insurance policies.

Subsidies
- Low income individuals and families (1-4X poverty level) to federal subsidies.

Medicaid expansion
- Eligibility to include all individuals and families up to 1.33X poverty level. (States opt out.)

Minimum standards
- Established for all policies, with ban of coverage caps.

Employer shared responsibility
- Firms with ≥50 employees not offering coverage will share subsidy burden.

Subsidy for very small business
- If they purchase insurance through an exchange.

Co-payments, co-insurance, and deductibles
- Eliminated for benefits considered preventive care.

Fee restructuring
- Allows transition of Medicare reimbursement from fee-for-service to bundled payments.

Universal Coverage

Figure 1: Number of Uninsured and Uninsured Rate Among the Nonelderly Population, 2008-2017

NOTE: Includes nonelderly individuals ages 0 to 64.

https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/; accessed 4/20/19
ACA Impact on Uninsured Rate by Category

Figure 2
Change in Uninsured Rate Among the Nonelderly Population by Selected Characteristics, 2013-2016

Poverty Level (% of FPL)

- < 100%
- 100-199%
- ≥ 200%

Race/Ethnicity

- White
- Black
- Hispanic
- Asian

Age Group

- Children (0-18)
- Nonelderly Adults (19-64)

NOTE: Includes nonelderly individuals ages 0 to 64. Asian includes Native Hawaiians and Other Pacific Islanders (NHOPIs).

https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/; accessed 4/20/19
Should the Federal Government be the Sole Driver?
CABG: Financial Margin / Case

<table>
<thead>
<tr>
<th>PAYER</th>
<th>NET MARGIN / CASE*</th>
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<tbody>
<tr>
<td>Commercial</td>
<td>$32,940</td>
</tr>
<tr>
<td>Medicare</td>
<td>($1,250)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>($1,140)</td>
</tr>
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</table>

*FY 2019, Oct-Feb
450 hospitals at risk for potential closure, Morgan Stanley analysis finds

- More than 15% of US hospitals have weak financial metrics or are at risk of potential closure.
- Morgan Stanley analyzed data from roughly 6,000 hospitals and found 600 of the hospitals were “weak”, based on criteria for margins for earnings..., occupancy and revenue, according to Bloomberg. The analysis revealed another 450 hospitals were at risk of potential closure, according to Business Insider.
- Texas, Oklahoma, Louisiana, Kansas, Tennessee and Pennsylvania had the highest concentration of hospitals in the “at risk” pool.
Observed 30-Day Risk-Adjusted Readmission Rate with HRRP

Observed 30-Day Risk-Adjusted Mortality Rate after Discharge with HRRP

Expected 30-Day Risk-Adjusted Mortality Rate after Discharge without HRRP

Fonarow GC, Konstam, MA, Yancy CW. JACC 2017;70:1931-4
The 30-day readmission metric, with its many flaws, and clear direction to reduce utilization and cost, but without focus on patient well-being, should serve as an alarm that we are heading in the wrong direction of allowing government policy makers, rather than patients to drive the design of clinical care metrics. Alternatively, the government can and should play an important role in facilitating an environment of integrated health care systems and market-based competition, within which consumers can drive the advancement of their own health.

Heart Failure Costs, Minority Populations, and Outcomes: Targeting Health Status, Not Utilization, to Bend the Cost-Effectiveness Curve. Konstam, MA JACC-HF

Rather than focusing on service utilization per se, interventions should be directed primarily toward improving health – as by providing disease management services and by addressing the underlying drivers of disease. If we follow this course, we will secondarily reduce utilization of costly services, while deriving the greatest value for our patients.
Integrated System?

Healthcare Today

Providers

Insurers

Consumers

Health Care Value
Vertical Integration

- System aligned to deliver VALUE
- No stepwise profit taking
- Designed to manage population health
- Competes with other such systems based on cost and consumer-determined quality
<table>
<thead>
<tr>
<th></th>
<th>Medicare for All</th>
<th>Obamacare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Distribution</strong></td>
<td>Universal, rapid</td>
<td>Universal, more gradual</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>Standardized; (?based on federal budget)</td>
<td>Standardized</td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
<td>No Exclusions</td>
<td>No Exclusions</td>
</tr>
<tr>
<td><strong>Consumer cost</strong></td>
<td>?None</td>
<td>Means based</td>
</tr>
<tr>
<td><strong>Tax increases</strong></td>
<td>Very high</td>
<td>Not that high</td>
</tr>
<tr>
<td><strong>Provider payments</strong></td>
<td>• Based on cost and quality;</td>
<td>• Based on cost and quality</td>
</tr>
<tr>
<td></td>
<td>• Driven by federal budget</td>
<td>• More market driven</td>
</tr>
<tr>
<td></td>
<td>• Bureaucratic; arbitrary</td>
<td></td>
</tr>
<tr>
<td><strong>Cost reduction/ Provider impact</strong></td>
<td>Shock and Awe</td>
<td>Softer landing</td>
</tr>
<tr>
<td><strong>“Quality” metrics</strong></td>
<td>• Bureaucratically driven</td>
<td>• More consumer-based</td>
</tr>
<tr>
<td></td>
<td>• Less consumer-based</td>
<td>• Less bureaucratic</td>
</tr>
</tbody>
</table>
A Recommendation

- Repair, strengthen, and build upon ACA
- Provide incentives to drive integrated delivery systems