Maine AllCare

Dedicated to promoting universal, high quality and affordable health care for the people of Maine

Imagining Universal Healthcare,

publicly financed,

privately delivered.

Federal preferred, State if needed.

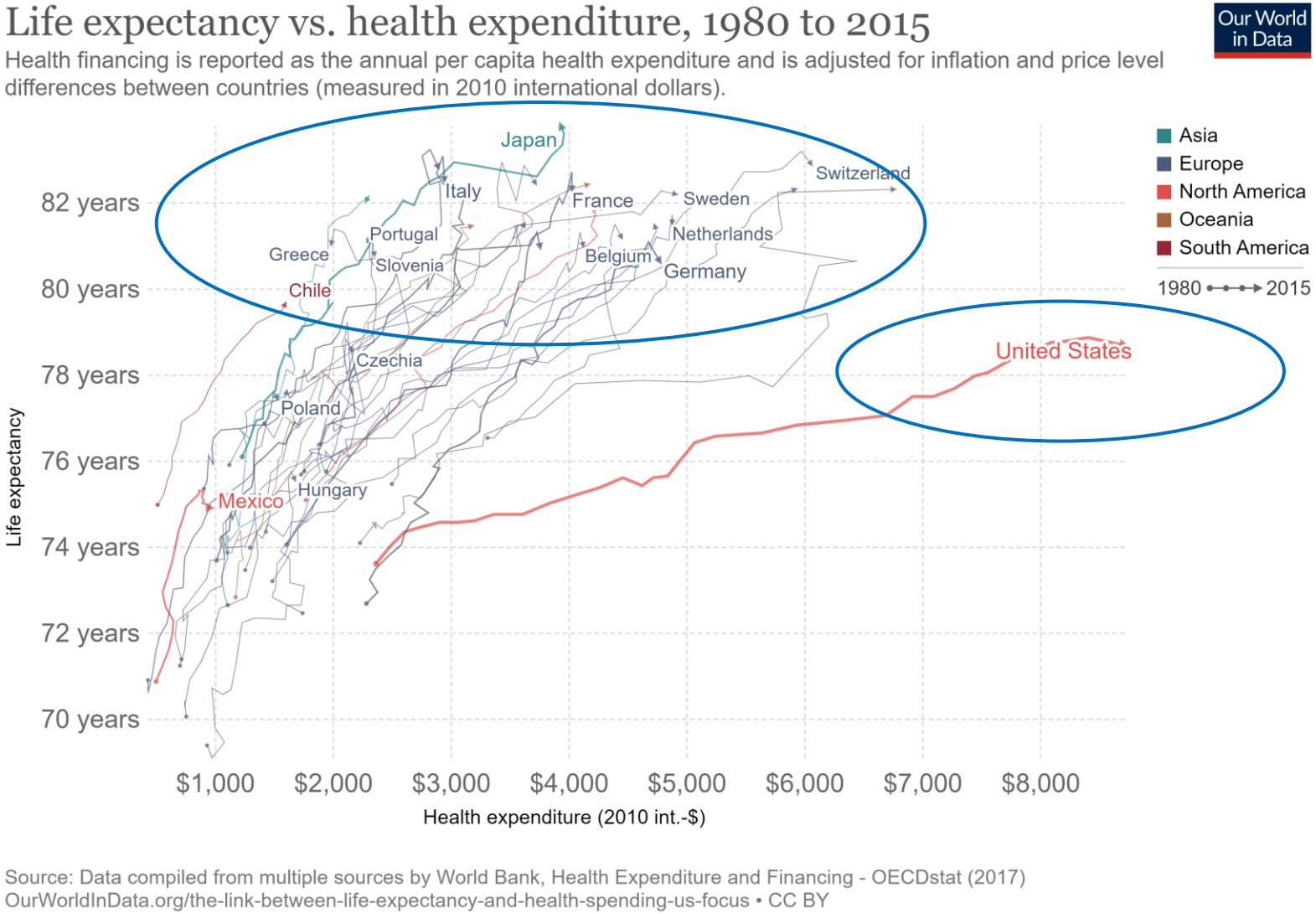
DISCLOSURE

- The presenter(s) has/have nothing to disclose with regard to commercial relationships.
- Henk Goorhuis, MD

https://maineallcare.org/

A state based universal health plan – what it could be.

Value in Healthcare – who has it?



As a comparison to peer countries, universal healthcare systems can be cost effective if they contain these six general principles:

1. One payer, that collects premiums and that pays providers of care directly, with no sub-contracting of funding to competing risk-bearing entities (no complexity with financial middle-men).
2. Budgets for institutional providers of care, including hospitals, nursing homes, and community health care organizations.
3. A simplified, standardized, negotiated fee schedule for individual (and mostly independent) providers.
4. Negotiated prices for drugs and durable medical equipment.
5. No relation of coverage to employment.
6. Minimal OOP cost at Point of Service

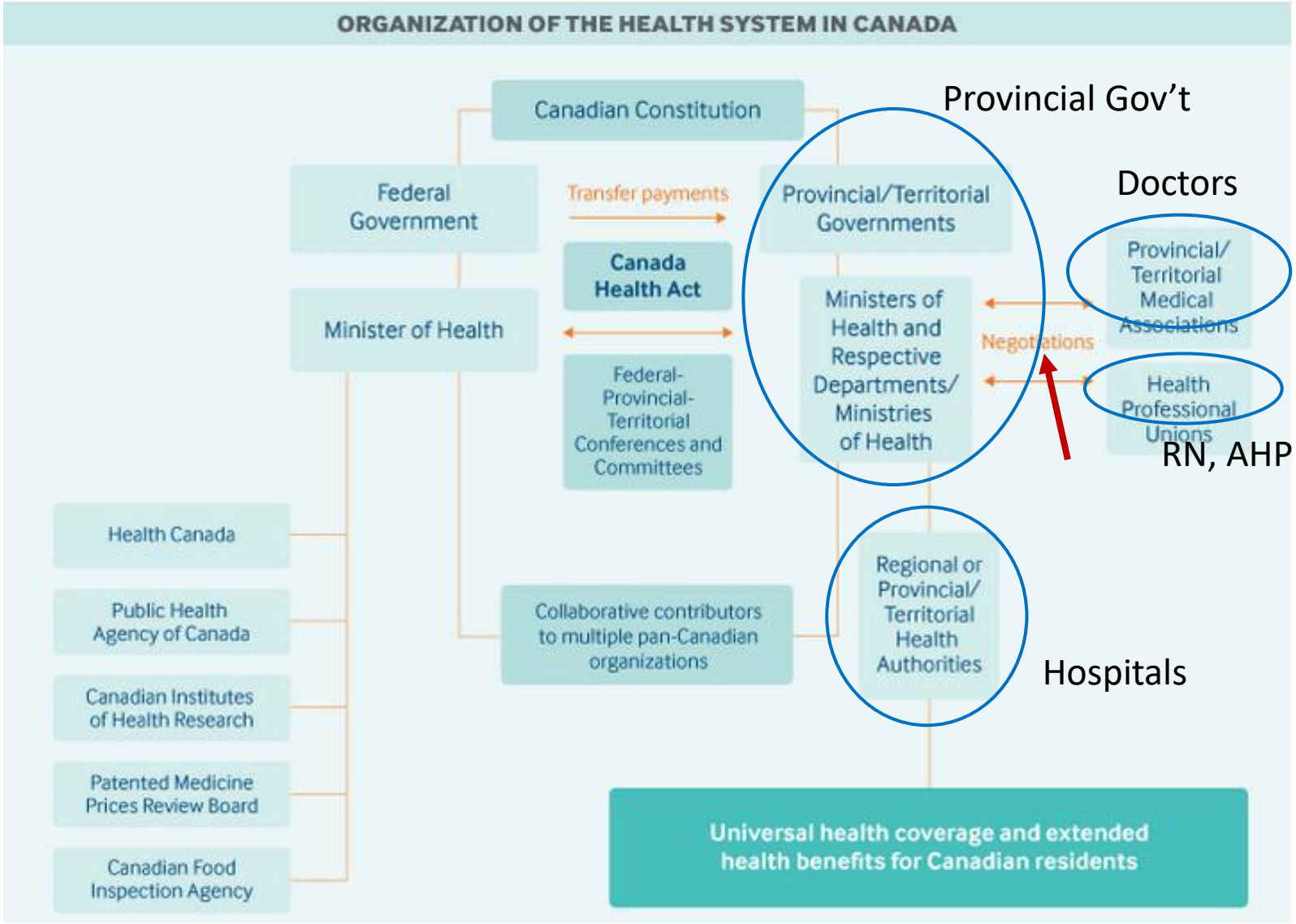
Comparing Systems

Government Owned	European regulated and nationalized, or a maximized public option	Single government administered and financed "Unified Payer"
- US VA system -United Kingdom -owns everything, -employs everyone	-Germany, France, -Switzerland, Netherlands may have multiple financial intermediaries, but -none is allowed to profit from healthcare products -so is a gov't regulated marketplace, - gov't negotiates/sets all prices and is the backstop and high-risk pool, -hospitals spending is capitated, -providers predominately FFS	-US MediCare -Canada (Provincial) -Taiwan, Israel -(since mid 1990's nation-wide) - a single tax supported payer. -private delivery -as previous column

Canada Provincial health – an example for a USA state.

-in 1867 Canadian constitution tasked the Provinces with healthcare
-1956's Saskatchewan "organized" a Provincial payment system
-1984 "Canadian Healthcare Act" sets national standards and committed regular Federal fiscal contributions.
-funding currently is 70% from inside the Province, 30% Federal

Simplicity is the Key!
-in enrollment
-in premium collection
-in payment to providers



What does it cost to get a bill out the door vs. our competitors?

USA = $220

EXHIBIT 3

Billing and insurance-related costs in six countries, by activity category, derived from a time-driven activity-based costing study, 2018–20

Who is paying for this inefficiency?

Canada = $6

SOURCE Authors' calculations based on data collected for the study from Australia, Canada, Germany, the Netherlands, and Singapore. US data (for 2017) are from Tseng P, et al. Administrative costs associated with physician billing and insurance-related activities at an academic health care system (see note 5 in text). **NOTES** Values are 2020 purchasing power parity–adjusted US dollars. Bills from Australia, Germany, and the US represent inpatient surgical bills; those from Singapore represent combined surgical and nonsurgical

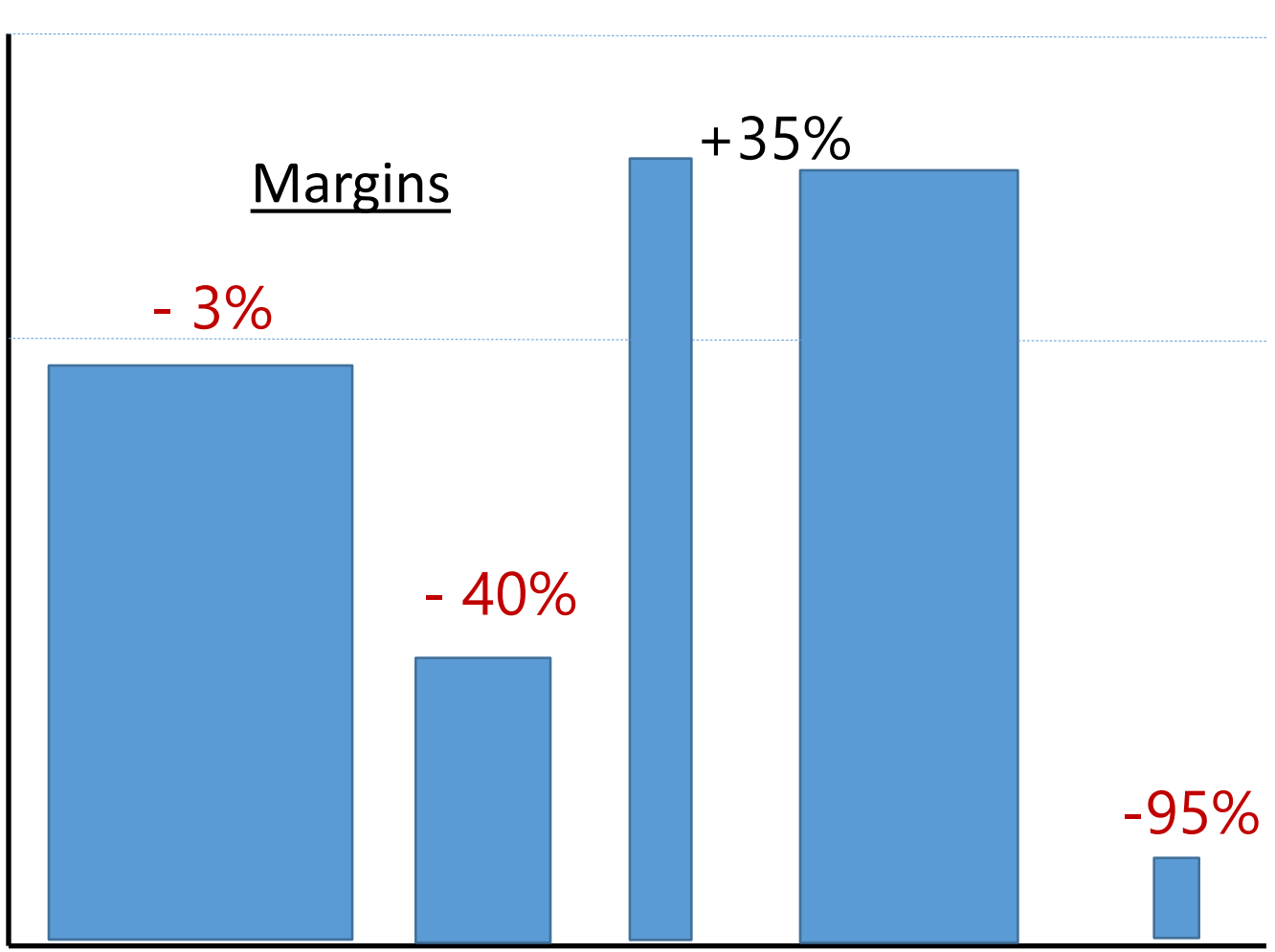
CONSIDERING HEALTH SPENDING

By Barak D. Richman, Robert S. Kaplan, Japees Kohli, Dennis Purcell, Mahek Shah, Igna Bonfrer, Brian Golden, Rosemary Hannam, Will Mitchell, Daniel Cehic, Garry Crispin, and Kevin A. Schulman

Billing And Insurance-Related Administrative Costs: A Cross-National Analysis

https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00241

USA has complicated funding – multiple payers



US Healthcare Institutional Funding–

Charges, Costs, Collections, Margins & Payer Mix

Mix	45%	15%	8%	27%	5%

Tax sponsored = 68%

-author composite-
Altman S.; & California Healthcare Foundation 2014

SBUHCA (State Based Universal HealthCare Act) is a Federal law that would ease and clarify the waiver process that a state would need to ask CMS for permission to explore "innovative state approaches" for healthcare coverage – as mentioned in the original ACA legislation from 2010.

-SBUHCA would also create safe harbors for a state plan, that would coexist with employer health insurance plans, from overlaping ERISA laws in any specific state.

- SBUHCA allows a state to maintain the full current Federal funding.
- a state plan in the USA will never be a "single' payer as Federal plans (i.e. Medicare, VA, IHS) would not be in the state coverage, and private plans would continue to exist. SBUHCA will help clarify these boundaries.

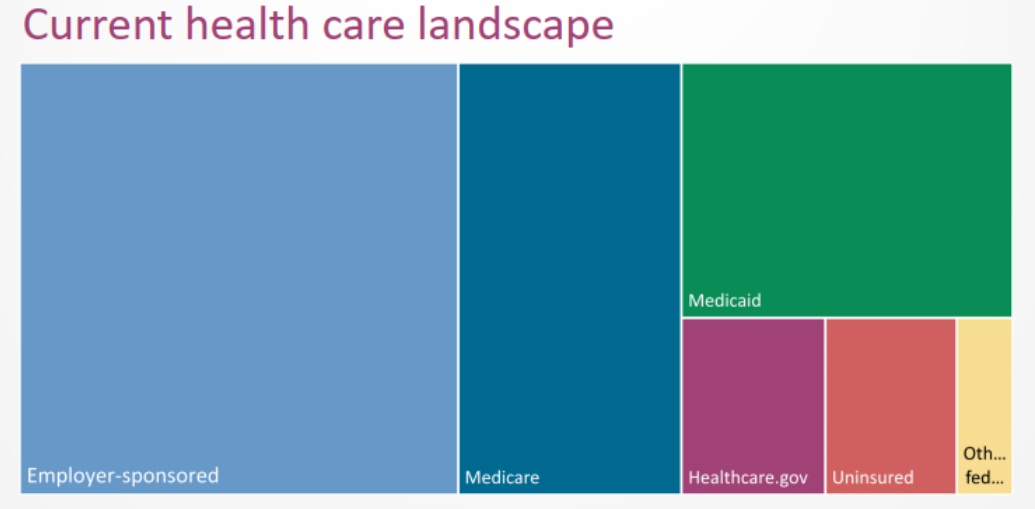
There is a Maine law, PL 391 from 2021, that if something like SBUHCA passes, it directs the Insurance commissioner to trigger the formation of a Board to develop a state coverage plan and form up the necessary Federal waivers and submit state legislation for the plan. Obviously a multistep process, but it would jump start the process. https://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP0773&item=3&snum=130

https://maineallcare.org/rep-ro-khanna-and-sen-ed-markey-reintroduce-the-state-based-universal-health-care-act/

https://static1.squarespace.com/static/651664ac711d096cd4761930/t/679356d0598f8f261f4544ad/1737709265396/What+is+SBUHCA+Charlie+Swanson+.docx-1.pdf

In regards to a state being able to form a state-based plan:

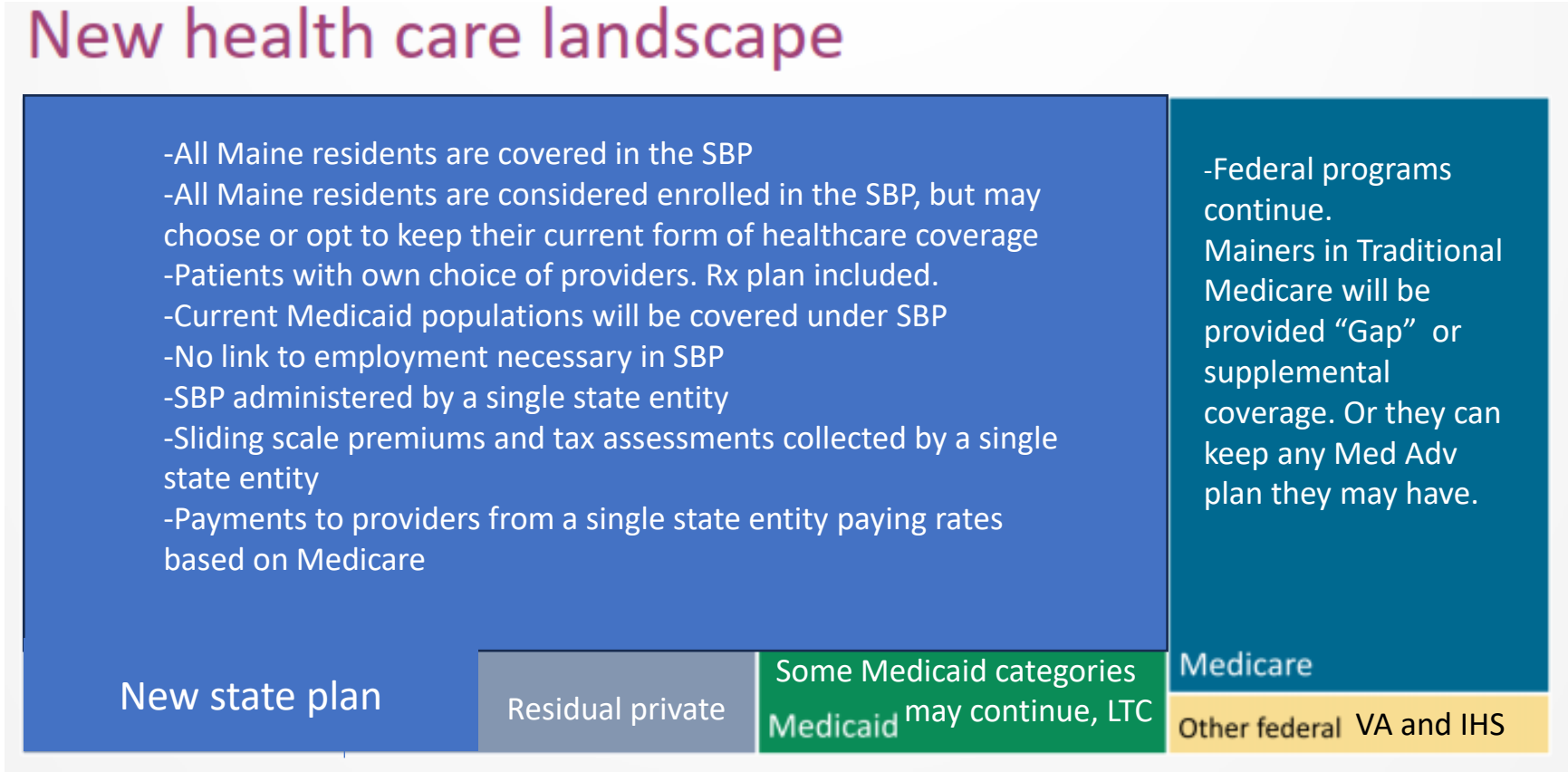
-the key is "simplicity" to the plan. If 1 million (NS or NB) Canadians in Provincial plans can administer a plan – then 1.3M Mainers can administratively run a state plan – if it is kept simple and straight forward. The financials are made in a straight forward manner and hospitals are financially stabilized.
-a state plan that auto-enrolled all residents (and assessed a premium/taxed for the funding), would soon become the dominate coverage option and payer.
- the state plan could provide wrap around coverage for Traditional Medicare or develop its own Advantage type options.
-in comparison, the idea of a state "public option" would be a state tax dollar funded premium sharing arrangement with marginal market share (i.e. Dirigo of the 2000's, ~50K enrollees max.) and will mimic and only take folks from ACA plans (i.e. plans that are Federally tax dollar premium supported). These plans don't have the "simplicity" paradigm, so don't and won't have enough savings to make a difference in premiums or coverage specifics.



Basic design for the a State Based Plan

by
category and population

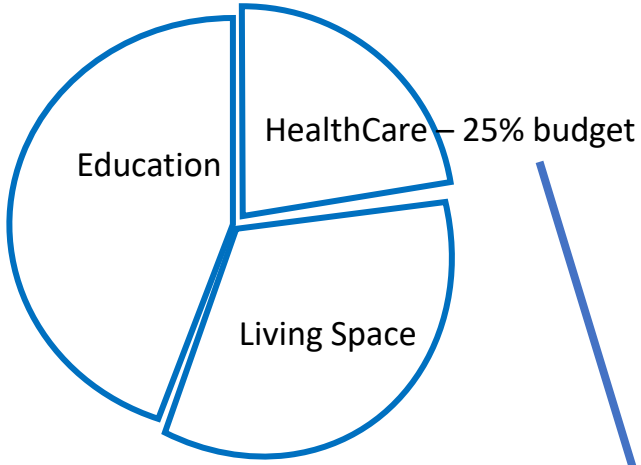
A state-based plan establishes the <u>institutional and fiscal state agency</u> that offers healthcare insurance coverage for all the residents of Maine.



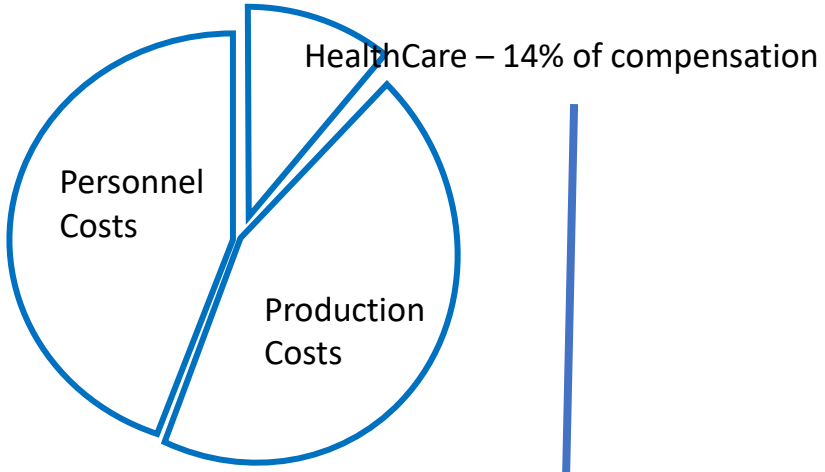
Imagining "value" for your business or your town.

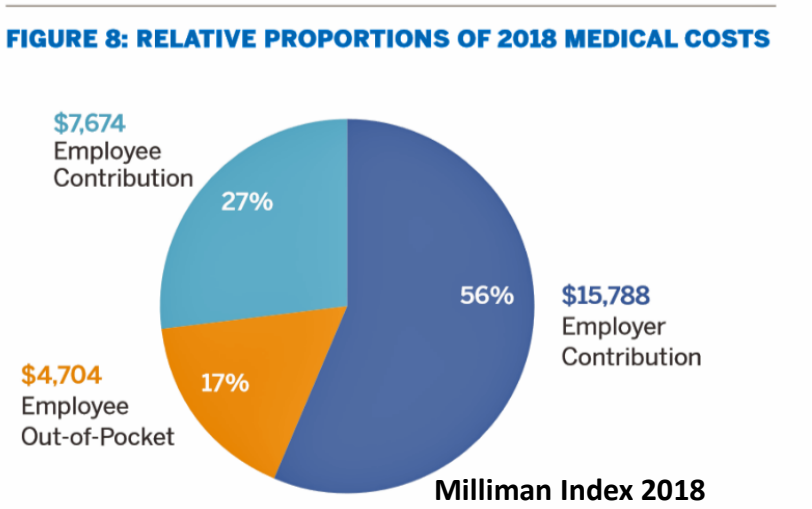
Let's get your business out of the healthcare business.

Current Town/City Budgets



Current Business Healthcare Costs



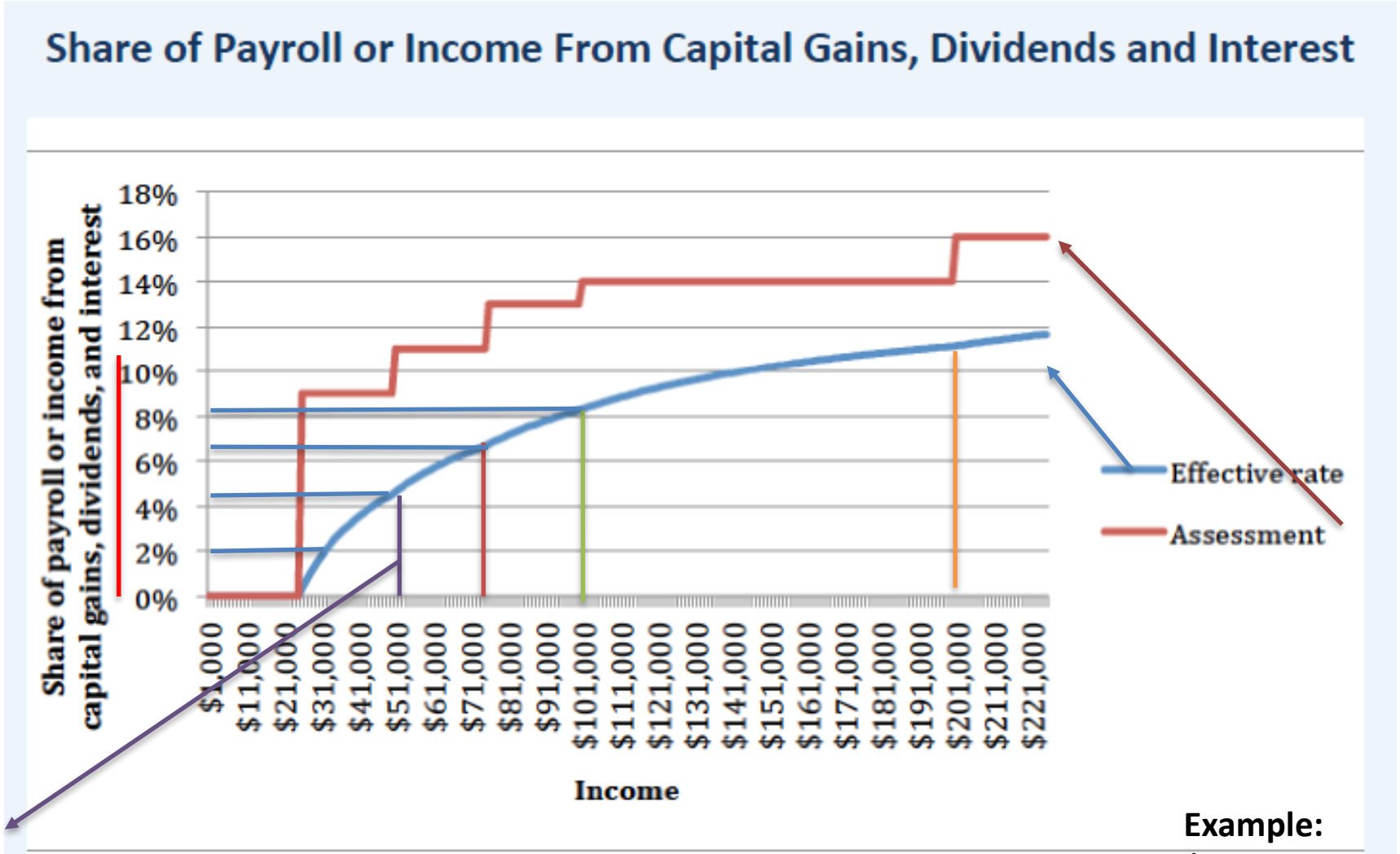


Milliman Index 2018

With Lower rates, and predictable rates,
Savings at all levels that,
Lessens the administrative burden for all
"what could you do with your time if you did not have this problem"

New York Health Act 2015- progressive percentages - 20% employee, 80% employer -initial $25K income exempt-

Many models of how to pay for it at a state level – here is one.



Economic Analysis of the New York Health Act p.31

Example:
$50,000 income- effective rate~5%
-healthcare premium tax of ~$2,250
Employer = $1,800/yr
Employee = $450/yr

Example:
$100,000 income- effective rate~8%
-healthcare premium tax of ~$8,000
Employer = $6,400/yr
Employee = $1,600/yr

Value – how to frame it in HC reform?

Value-Based Care - The current usage of this term is a cover for the continuing appropriation of healthcare dollars by fiscal intermediaries like insurance companies and their owners.

This phrase has been used in the last decade of healthcare system reform to try to pair cost control with quality patient care. It is a product of the faulty concept that "market forces'' will influence patient and provider behaviors in a positive way but fails to consider the ***distorting fiscal*** behavior of healthcare payers.

Based on the 1980s designs of "managed care", this paradigm **has still not shown to significantly affect net healthcare costs**—except to increase them via added administrative complexity and diversion of funds from actual patient care delivery to administrative bloat.

Do not be confused by the application of this term to clinically relevant “bedside” or patient value; it’s all about the money. Other countries have demonstrated “value”.

Why are we stuck?

Money

Power

Ideology

Big money in Mortgages 2008 pre-collapse

-Houses are a Big phenomena
-with Big and regular fees to skim
-and people will do anything to keep their houses.

Big money in Healthcare 2024

-Illness is a Big phenomena
-with Big and regular fees to skim off
-and people will do anything to keep their health.

-"Gov't sucks" -but, keep your hands off my Medicare
-gov't is the problem – R. Reagan
-if you give HC to them, do I get less?
-taxes will go up (and I don't believe you when you claim my net spending on HC will go down?)
-Europeans are dumb
-it ain't gonna change . . .

Publicly financed, universal coverage would….

- ✓Cover everyone
- ✓Reduce administrative burdens for hospitals, employers, providers and patients
- ✓Sever the link between employment and health insurance
- ✓Enhance patient choice
- ✓Enhance Quality
- ✓Be accountable to the public
- ✓Save money!