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Navigating the Road Toward Healthcare Reform: Single-Payer Pros & Cons

Dr. Birnholz: Cries for healthcare reform have reached a fevered pitch, as proponents and objectors square off on a contentious election year cycle. While most in the medical profession readily agree that day-to-day practice is not going well as things currently stand, the road toward greater healthcare access, delivery, and cost coverage is highly uncertain right now. So, does a single payer, or a privatized model, or something in between stand the better chance of improving patient care? Who's going to steer that model away from disaster? And what's it going to take from all of us to see it through? These and other pie-in-the sky public health policy considerations to come on today's program.

You're listening to *Voices from American Medicine*. I'm Dr. Matt Birnholz and joining me to shed some new light on the healthcare reform debate is Dr. Kenneth Thorpe, the Robert W. Woodruff Professor and Chair of the Department of Health Policy and Management in the Rollins School of Public Health of Emory University. He also serves as the Executive Director of Emory's Institute of Advanced Policy Solutions and Director of the Institute's Center for Entitlement Reform. Dr. Thorpe was Deputy Assistant Secretary for Health Policy in the US Department of Health and Human Services from 1993 to 1995, where he coordinated all financial estimates and program impacts of President Clinton's healthcare reform proposals for the White House. Dr. Thorpe, welcome to you.

Dr. Thorpe: Thanks for having me.

Dr. Birnholz: So, just to set the stage here for a moment, it's absolutely impossible not to acknowledge just how polarized the political climate has become, and healthcare reform is hovering out there as this sort of figure head for how people align politically in general. Can you just talk to this issue and how you, as a leading figure in public health policy research, tweet out the healthcare debates from the broader political divisiveness going on.

Dr. Thorpe: Well, I think you're right, you know, there is a range of proposals, particularly on the democratic side, that span from really fixing the Affordable Care Act, making the subsidies broader in order to get more people insured and finding ways through taking out high-cost cases and so on to reduce health insurance premiums. So the advantage of that is that we have the infrastructure in place that we can build on, and certainly with some major changes in the affordable care act, we can dramatically reduce the number of uninsured and continue to reduce the growth in healthcare spending. So, that's one version. The complete other extreme would be the complete elimination of private health insurance – the single-payer approach. You know, the advantage there would be obviously everybody is covered. They wouldn't pay premiums. You would pay nothing out of pocket. The challenge is it's just so dramatically disruptive. Our estimates show that over the next decade, you'd have to raise 32-trillion dollars in new taxes in order to fund it, and yes, people would save on premiums and out of pocket, but my calculations show that 71% of people with private health insurance today would pay more in new taxes than they'd save in reduced premiums and out of pocket. So, I think, politically, that's unrealistic. This approach was tried in Vermont a couple of years ago, in 2010 and 2011, and they found the same thing, that the tax increases were just so overwhelming that even in a state like Vermont, which is very progressive, just couldn't get the legislation enacted. So, they looked at how can we build on reforming the current system that we have.

Dr. Birnholz: Right, and this is an important point because, in a way, to clear the air here, I imagine many who don't know you or haven't interfaced with you or seen some of your research, would assume, based on your background helping to guide the Clinton's administration's health reform proposals, that you're a Medicare-for-all devotee, that everything in that corner is, sort of, let's just get it to single payer, but much of your research has raised these important questions on whether public funding for single payer is even financially plausible. And, if I'm not mistaken, you looked into finding that 70% or so of working, privately insured Americans would actually end up paying much more for health insurance under that single-payer system than they do today. Can you comment on that a

little bit more?

Dr. Thorpe: Sure. In order to fund a 32-trillion dollar tax increase over the next decade, you'd have to raise payroll taxes, income taxes, some combination of the two – and there's other tax instruments you can use, obviously, but those are our two major taxing instruments – by about 20 percentage points, which is an enormous increase. And so, if you just look at that type of a tax increase and look at how much people would pay under these new taxes compared to how much they would save by paying no premiums, zero out of pocket, 71% of people with private health insurance today would pay more in new taxes than they'd save in not paying out-of-pockets. So, a lot of people would be very surprised, obviously, because it's being sold as it's a win-win, you know, it's free to everybody, but it's not free to everybody. You've got to pay for it.

Dr. Birnholz: Right, and this does bring up that familiar issue of ideals versus reality. But either way, there is a price tag on any approach and it has to come from somewhere, so who's going to be picking up that single-payer tab and how much will or should they be paying?

Dr. Thorpe: I mean you can certainly structure the new taxes in any way you want, but the most powerful tax instruments we have are income and payroll taxes. And you can structure it so that higher income individuals pay more. No question about that. But just limiting it to higher income individuals is not going to raise 32-trillion dollars over 10 years. So, at the end of the day, the middle class is gonna end up having to pay some higher taxes. And some will fare better; they'll pay less in taxes than they currently are paying, save more in not paying premiums, but a lot of them are gonna pay more in taxes compared to how much they save on no premiums and no out-of-pocket. The single-payer plans basically slow the growth in healthcare spending by eliminating administrative costs. Those are called jobs. So, there'd be about a million and a half jobs lost in administration, and arbitrarily capping what we pay healthcare providers. But that doesn't solve the underlying problem of what's driving the growth in healthcare spending. The big driver is this persistent growth in the number of Americans that have a chronic disease. So, in Medicare, about 70% of the growth in Medicare spending is due to an increase in the prevalence of chronic disease in the Medicare program. In private insurance, it's closer to 55-60%. So, to me, any cost solution has got to go to the underlying problem, which is issues around chronic illness, prevention, earlier detection, and better management of it, rather than just simply setting arbitrary payment rates.

Dr. Birnholz: For those just tuning in, you're listening to *Voices from American Medicine* on Reach MD. I'm Dr. Matt Birnholz and with me today to discuss the merits and challenges of single-payer healthcare in a polarized political landscape is Dr. Kenneth Thorpe from Emory University.
So, Dr. Thorpe, let's come back to the clinical side. One of the biggest objections against Medicare for all is that when all is said and done, the system will ultimately demand that clinicians handle much higher patient volumes for much less reimbursement. We hear that argument time and time again from those on the frontlines. But before we dive into some of the downstream impacts of that issue, what's your general take on this objection?

Dr. Thorpe: Well, I think that's right. Certainly providers are going to be paid a lot less under a program like this, so hospitals, in particular, would face, you know, 15-16% reduction in revenues. Their administrative costs would be lower, but still, overall, their average profitability would go way down to about, -9 to about -10%, and physicians would be in the same boat, getting paid dramatically less but being expected to see more and more patients. That type of disruption, to me, is not necessary to go to the ultimate goals that I think most democrats want to move towards, which is universal coverage, a more efficient system, higher quality care.

Dr. Birnholz: Yeah, and if we continue playing out that scenario, we envision that federal funding from anywhere they can get the 32-trillion dollars eventually or quickly falls behind the demand for care, such as the increasing need for chronic care coverage, as you were discussing. Would that automatically mean a sharp reduction in supply, if we're following the whole supply-and-demand Economics 101 principles and everything that follows from that?

Dr. Thorpe: I think it's a solution that has really nothing to do with the overall problem in terms of solving not just health insurance, but improving the health of our population and having a mechanism that really directly attacks the cost drivers. The thing is there was broad bipartisan support to do some of these delivery system reforms that do a better job of keeping patients with multiple chronic conditions healthier – reducing their hospitalization rates, keeping them out of the clinic – prevention efforts we know can work to reduce the number of people with a chronic disease.

Dr. Birnholz: Right. And among some of those issues, there've been arguments from the conservative wing saying if we have more transparent pricing, if we drive generic drug costs down, which I believe both are shared arguments by the democrats as well, that these might make inroads in ways that diving in on a single-payer healthcare system might not. What are your thoughts on that?

Dr. Thorpe: Well certainly, price transparency is a really important issue. I think the challenge is that there are so many prices and what your health plan pays and what you actually pay differs from hospital to hospital and from, sometimes, physicians to physicians. So, it's a very complicated system that way. One of the advantages of a single payer is that it simplifies that type of a system. But I think

enhancing competition is a move in the right direction. But again, the types of solutions that are really gonna get to the underlying growth in healthcare costs really deal with these issues around the prevention, earlier detection, and better management of chronic disease.

Dr. Birnholz: And, Dr. Thorpe, do you think that there is a way for that to be done in a concerted approach that, sort of, harnesses the collective energies from multiple stakeholders that have a part to play in that healthcare improvement process? Is there a way to do this in a concerted plan that brings us to better objective milestones rather than kind of doing it piecemeal?

Dr. Thorpe: Well, I think so, yeah. I mean, one of the good parts of the Affordable Care Act is that it introduced the whole option of value-based purchasing, which is moving us away from fee-for-service payments, which is an uncoordinated, silo-based way of doing care towards care that's really trying to integrate our healthcare system, integrate acute-care services and post-acute care services, bundling payments. That's proven effective, particularly for improving orthopedic surgery outcomes, reducing spending there, better patient satisfaction, so we're making that transition right now and I think it's getting really broad bipartisan support to migrate away from fee-for-service and really focus more on changing the financial incentives in the system to do a better job of providing person-centered, patient-focused healthcare.

Dr. Birnholz: What stumbling blocks have you encountered from your unique vantage point on this when it comes to actually executing, rather than maintaining, a theoretical concept around switching from fee-for-service to value-based care?

Dr. Thorpe: Well, I think we're just at the beginning of this. So, if you take accountable care organizations, you know, which are really focusing on providing comprehensive care to a population of patients over the course of a year, most of the physicians and healthcare providers weren't used to that type of collaboration. And so in the first couple of years, it worked okay but not so good. Well, over time, as we've gotten more and more experienced with interacting with each other in how plans like that work, the number of HCOs that have reduced spending and improved outcome continue to increase. So, I think it's just a learning curve because we're making dramatic changes in how we deliver healthcare services in this country. We're really focusing on providing whole-person care, dealing with that patient with five or six chronic conditions rather than how we used to do it, which is carving them up into different disease states and treating diabetes and hypertension and pulmonary disease separately.

Dr. Birnholz: And on that idea of prioritizing chronic care services, understanding that an increasing patient population is dealing with chronic care and much of the costs of care are going into that sector, what do you think are the best steps forward to be able to keep up with the demand?

Dr. Thorpe: Well, I think Medicare can play a big role here. You know, roughly two-thirds of Medicare patients are still in the traditional fee-for-service Medicare program, and realistically, there's no care coordination provided in that program. So, I think there's a real opportunity, leadership-wise, for Medicare to step up and build into the fee-for-service Medicare program care coordination using healthcare teams. Many states have done this already. I think if Medicare made a move in that direction using multidisciplinary health teams, that would have an accelerating effect on having those health teams proliferate into the private health insurance sector as well.

Dr. Birnholz: Do you think that the states will have a stronger leadership say than the federal level? And I ask this because there's confusion around where Medicare stands or will stand in the next years, given that one side there is arguments to preserve, maintain, protect Medicare. On the other side, there are massive cuts to Medicare that are either planned or ongoing, such as an 800-million dollar cut that was discussed. Can you talk through that confusion and where you think Medicare is going to land?

Dr. Thorpe: Well, I think Medicare is certainly making some big changes. You know, they just recently introduced a new covered benefit called the Diabetes Prevention Program, which is a proven program that reduces the number of new cases of type 2 diabetes, saves money, and so on, so they are innovating, but the states aren't waiting. States are innovating in the Affordable Care Act right now. So, I think in the political gridlock we've seen where it's not clear where we're going to improve the Affordable Care Act nationally, a lot of states are getting waivers and working with Washington DC on these waivers to improve the exchanges in the Affordable Care Act health plans in their states. And they're largely doing it by introducing what are known as reinsurance programs, which take out high-cost expenses and reduce the premiums for everybody. So, there's a lot of state innovation that's happening in Medicaid around the health insurance exchanges in the Affordable Care Act.

Dr. Birnholz: Well, Dr. Thorpe, you've given us a lot to think about. I just want to see if you have parting comments you want to leave for our audience today?

Dr. Thorpe: Sure. In terms of me personally, you know, my goals are pretty clear. Certainly moving to universal coverage and getting everybody a health insurance plan, but doing it in a way that is not dramatically disruptive, that is realistic and doable, and then also focusing on the real underlying drivers of rising healthcare spending, which is this persistent growth in chronic disease. So, I think the solutions really aren't on the pricing side; they're really on the infrastructure. Building on the Affordable Care Act, to me, is the solution I'm getting the remaining 27 million people who are uninsured covered.

Dr. Birnholz: Well, those are great perspectives to think on as we watch these healthcare reform debates unfold over the coming days, weeks, and months. I very much want to thank my guest, Dr. Kenneth Thorpe, for joining me to share these new insights on the pros and cons of single-payer healthcare proposals as they stand today. It was great having you on the program, Dr. Thorpe.

Dr. Thorpe: Well, thanks for having me on. I appreciate it.

Dr. Birnholz: For ReachMD, I'm Dr. Matt Birnholz. To access this episode and others from *Voices from American Medicine*, visit ReachMD.com/voices, where you can be part of the knowledge. Thanks for listening.