Minnesota Academy of Family Physicians
House of Delegates
April 9, 2014

Single Payer Task Force Report
Submitted by Richard Horecka, M.D., Chair

The task force was created in response to the following resolutions passed by the 2013 House of Delegates:

> *BE IT RESOLVED that the MAFP form an ad hoc task force, including medical students and residents, to study state-based single payer systems especially as they would apply in Minnesota and present an informed view of the findings to the 2014 House of Delegates*
>
> *BE IT FURTHER RESOLVED that the 2014 House of Delegates consider an MAFP position, or set of principles, regarding a Minnesota single-payer system.*

We have identified nine key questions important to the discussion of Single Payer in Minnesota.

A. *Why discuss this now?*
B. *What are the benchmarks that any reform plan should aspire to?*
C. *What is a Single-Payer system?*
D. *What problems does our current system face and which would a Single-Payer system address?*
E. *What are the problems of our health system that Single-Payer would not address?*
F. *What constraints does a Single-Payer system face?*
G. *What might a Single-Payer system look like in Minnesota?*
H. *What might be the financial impact of a Single-Payer system in Minnesota?*
I. *How could Single-Payer address AAFP's Principles of Health Reform?*

A. WHY DISCUSS THIS NOW?

This is a time of great changes and reform within the Minnesota and national health care systems because of the Affordable Care Act, Health Exchanges, Health Care Homes, Accountable Care Organizations, Meaningful Use of Electronic Medical Records, and the Triple Aim of Quality, Cost-Effectiveness, and Patient Satisfaction. However, we are still looking for a financing system that supports universal coverage at a reasonable cost (See #1, 2, 7, and 8 of the AAFP's "Principles for the Reform of the US Health Care System," shown below). We believe that Family Physicians and our Academy of Family Physicians have an important role to play in the dialogue about health care reform and universal coverage. We further believe that the possibility of a state based single payer-style reform

will soon become a prominent discussion topic in Minnesota. We offer this paper on a Single Payer Financing System in the spirit of better equipping Family Physicians and our Academy to participate and lead in the health care reform efforts.

B. WHAT ARE THE BENCHMARKS OF REFORM THAT ANY PLAN SHOULD ASPIRE TO?

This report uses the Principles of Health Reform established by the American Academy of Family Physicians and ten other leading physician organizations as a benchmark. These principles are as follows:

1. Health care coverage for all is needed to ensure quality of care and to improve the health status of Americans.
2. The health care system in the U.S. must provide appropriate health care to all people within the U.S. borders, without unreasonable financial barriers to care.
3. Individuals and families must have catastrophic health coverage to provide protection from financial ruin.
4. Improvement of health care quality and safety must be the goal of all health interventions, so that we can assure optimal outcomes for the resources expended.
5. In reforming the health care system, we as a society must respect the ethical imperative of providing healthcare to individuals, responsible stewardship of community resources, and the importance of personal health responsibility.
6. Access to and financing for appropriate health services must be a shared public/private cooperative effort, and a system, which will allow individuals/employers to purchase additional services or insurance.
7. Cost management by all stakeholders, consistent with achieving quality health care, is critical to attaining a workable, affordable and sustainable health care system.
8. Less complicated administrative systems are essential to reduce costs, create a more efficient health care system, and maximize funding for health care services.
9. Sufficient funds must be available for research (basic, clinical, translational and health services), medical education, and comprehensive health information technology infrastructure and implementation.
10. Sufficient funds must be available for public health and other essential medical services to include, but not be limited to, preventive services, trauma care and mental health services.
11. Comprehensive medical liability reform is essential to ensure access to quality health care.

C. WHAT IS SINGLE-PAYER?

"Single-payer" (SP) describes a method of financing health care; it does not specify a health care delivery mechanism. It is designed to promote health care access to all, to improve quality, and to moderate costs. There are many different kinds of single payer

systems used by different systems and countries. In a traditional SP system, one agency collects all health care fees and pays out all health care costs. This agency does NOT have to be the government. It could be a private company, a public fund with decentralized management to regional bodies, or a public enterprise, to name a few. (http://www.pnhp.org/PDF_files/SinglePayer-FiftyPlayers_TomBodenheimer.pdf). In general, the providers of health care (doctors, hospitals, pharmacies) can be private or public in a SP system.

When a country provides all of its health care through public hospitals and public doctors, the system is called "socialized medicine." This is the system in England and Sweden. Some countries, like Canada, have a SP financing system where physicians are predominantly in private practice, while hospitals are both public and private. It is worth reiterating that SP is NOT synonymous with "socialized medicine."

Studies and experience suggest that a SP system is one of the most efficient methods to support a unified system of care. (Source) In the United States, we have several systems that already function with centralized government funding and management:

- Medicare that covers seniors and some disabled: 49,435,610 people as of 2012
- Medicaid/CHIP covering people in poverty: 66,390,642 as of 2010
- Community Health Centers: 20 million (under the Bureau of Primary Care for migrant clinics, homeless health, and community clinics)
- VA -- Veterans Administration clinics: 10 million
- Indian Health Service: ~5 million
- TriCare: coverage for military personnel, military retirees, reserve corps

The United States has a fragmented health care system that arose piecemeal rather than by design. The patchwork complexity of our system is administratively wasteful and economically unsustainable. A unified system is administratively simpler, more equitable, has monopsony power to lower prices, addresses public health, and relieves employers from the unwanted responsibility of negotiating and managing health insurance.

A unified system means:

- One system that covers everyone.
- A uniform and comprehensive benefit set for everyone. Supplemental coverage for additional benefits would be available.
- A single network of all licensed health care providers.
- Patients are free to choose their doctor, clinic and hospital.
- Coverage is delinked from employment.
- A uniform and streamlined enrollment process.
- A single insurance pool to spread insurance risk.

- The financial/risk-bearing/administrative component is a nonprofit system. (Private insurers, if they exist, are not-for-profit and are tightly regulated.)
- Uniform pricing, payment rules, and payment methods.
- Financial incentives to promote primary care, coordinated care, prevention, and community health.

Adapted from "Beyond the Affordable Care Act: An Economic Analysis of a Universal System of Health Care for Minnesota" published by Growth & Justice (often referred to as the Lewin Report); March 2012

D. WHAT PROBLEMS DOES OUR CURRENT SYSTEM FACE AND WHICH WOULD A SINGLE-PAYER SYSTEM ADDRESS?

THE MINNESOTA CONNECTION: In February 2014, the Minnesota Department of Health and the University of Minnesota's School of Public Health State Health Access Data Assistance Center (SHADAC) released a report regarding health coverage for Minnesotans that surveyed more than 11,000 Minnesota households (http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2013.pdf. The report highlighted the problems of uninsured and underinsured in Minnesota. Please keep these data in mind as you read the following discussion. They reiterate that national problems often are mirrored here in MN.

- 445,000 Minnesotans (8.2%) were without health insurance last year (2013), including 80,000 children.
- 22.4% of Minnesotans under age 65 experienced financial burden from health care costs in the past 12 months.
- 18.9% of Minnesotans did not get needed medical care due to cost.
- 28% of insured Minnesotans reported problems with paying medical bills or getting needed health care because of health care costs.
- 57.8% of uninsured Minnesotans reported having problems with medical bills or getting needed health care due to cost.
- Minnesotans without health insurance were less confident (30.0% compared to 79.0%) in their ability to receive care, and less likely to have a usual source of care (54.6% compared to 89.5%) than those with health insurance.
- The percent of Minnesotans covered through their workplace declined again, to 55.2%. (It had been 62.6% in 2004)
- And of those with work coverage available, fewer reported signing up for coverage.
- Public coverage, which includes Medicare and Minnesota's state programs, such as Medical Assistance and MinnesotaCare, increased to 31.1% in 2013 from 28.5% in 2009.
- The share of the population that purchased individual coverage in the private market remained steady as well, at about 5%.
- Disparities in health insurance coverage by income, age, and race and ethnicity

continued to persist in 2013. Rates of un-insurance for Hispanic/Latino Minnesotans (34.8%), African-Americans (14.7%), Asians (13.2%) and American Indians (18 %) have seen no significant improvement since 2004.

- 80% of uninsured Minnesotans are eligible for either public programs (62%), and 18% for employer based programs.
- Only 36% of uninsured know about new options under the ACA.

THE PROBLEMS OF OUR CURRENT HEALTH CARE SYSTEM	**HOW MIGHT THEY BE ADDRESSED BY SINGLE PAYER?**
Uninsured. People without health insurance are more likely to delay care, have worse clinical outcomes, and die sooner. (Source) (Source) (Source) (Source) (Source) (Source) (Source) (Source).	Under a SP system, everyone would be covered and there would be no uninsured.
Underinsured. People are considered "underinsured" when, despite having some insurance, they must pay more than 10% of their annual income for health care costs through co-pays, deductibles, out of pocket payments. Underinsurance also may lead to poor access to care and can lead to the same problems as un-insurance: postponing treatment or prescriptions leading to poor health outcomes. Sometimes underinsured health care costs are so severe they can lead to bankruptcies. ● 62.1% of all bankruptcies in 2007 were medical, and three quarters had health insurance. (Source) (Source) (Source) (Source)	A SP financing system would finance one of several different types of insurance plans. It is important to note that if a SP system financed a weak plan, it would be problematic, whereas if it financed a thorough plan, everyone would have adequate health coverage and there would be no underinsurance.
Rising healthcare costs. ● Paying for those without insurance places a large financial burden on the public and private sector. ○ For example, in 2001, of the $34 to $38 billion in care delivered to uninsured persons that was not paid for by the uninsured themselves, the public sector is estimated to have financed up to 85 percent. (Source) ● For insured patients, some causes of	A SP system would reduce HC costs in several ways (we acknowledge several areas that would not be addressed by SP in the next section): ▪ Having one financing system would reduce administrative costs to hospitals and physicians (Source) (Source) (Source) ▪ A SP system would have greater bargaining power and therefore could negotiate favorable drug and equipment pricing as well as help to even out the discrepancies in pricing

rising healthcare costs are administrative expenses related to multiple insurers, physician time spent interacting with insurances and quality measures (Source 1, Source 2, Source 3), utilization issues, and increased prices for the same services and materials compared to other countries (http://www.ncbi.nlm.nih.gov/pubmed/23569056, http://www.bloombergview.com/articles/2014-01-08/what-liberals-don-t-get-about-single-payer).	for medical procedures toward a fair market price. ▪ Each provider of care would be held "accountable" for their portion of care (primary care providers, specialists, and hospitals) and held to evidence-based standards of care. A SP system would work toward building a unified healthcare network, allowing for streamlined quality improvement. ▪ Further, as one system, it could locate appropriate cost accountability with each part of the network: physicians, hospitals, pharmaceuticals, medical supply, nursing homes, IT. Minnesota Community Measures could continue to monitor quality markers. Funding could be directed to support providers in communities who have a higher burden of disease (e.g. nutrition and exercise/activity support services).
Quality. Our insurance system costs more than most and offers worse outcomes on measures like infant mortality, life expectancy, obesity rates, and healthy life expectancy at age 65. (Source 1, Source 2, Source3). Seven in ten deaths in the U.S. are related to preventable diseases such as obesity, diabetes, high blood pressure, heart disease, and cancer. 75 percent of our healthcare dollars are spent treating such diseases. However, only 3 percent of our health care dollars go toward prevention. (Source). A 2012 Institute of Medicine (IOM) report recommended that we increase federal funding for public health and prevention by $12 billion annually, a doubling of the FY 2009 federal investment in public health (both clinical and community – AKA secondary and primary prevention). (Source)	Prevention has been shown to be effective in stemming this tide: CVD (Source) and non-insulin dependent diabetes (Source) A SP system could make it easier to forward a system which promotes primary and secondary prevention. Again, this would be a situation where the benefits of SP would depend on the system it affords us. A good one will be great; a bad one would be terrible.
Health Disparities. In February 2014, the Minnesota Department of Health released a	A universal SP financing system would do much to promote health equity

report, *Advancing Health Equity in Minnesota*, http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020114.pdf that documented the health discrepancies that exist between different communities in Minnesota. And in affirming commitment to the principle of Health Equity for all our citizens, they proposed several efforts to promote health equity in Minnesota. They are as follows: Seven Recommendations to advance Health Equity in Minnesota (Feb 2014) 1: Advance health equity through a health in all policies approach across all sectors. 2: Continue investments in efforts that currently are working to advance health equity. 3: Provide statewide leadership for advancing health equity. 4: Strengthen community relationships and partnerships to advance health equity. 5: Redesign the Minnesota Department of Health grant-making to advance health equity. 6: Make health equity an emphasis throughout the Minnesota Department of Health 7: Strengthen the collection analysis and use of data to advance health equity.	through universal access, adequate funding of health programs that address health disparities, and a governing body that would be committed to and accountable for accomplishing health equity.
Consumers In our current system, the individual consumer faces several challenges. • Some employees feel trapped in their jobs because if they leave, they will lose their health insurance.1 • Changing coverage offers a whole host of new problems: changing networks, physicians, lapsed coverage, etc. • As we all may have experienced, signing up for health insurance can be a	While we feel that potential solutions offered by SP, we recognize that a SP system supporting a weak plan would create perhaps more problems than it would solve. ○ In a SP system, insurance would not be tied to employment, thus allowing employees to increase their job mobility. ○ In an SP system, there would be no changing in coverage or lapses. No networks, no

[1] http://en.wikipedia.org/wiki/Job_lock

hassle. • Many Americans cut back on medications due to cost.[2] Others see the physician less than they should due to co-pays.	unwanted physician changes. o This would enhance the patient physician relationship. o Physicians could spend more time with patients because they would spend less time with insurance companies. This again would rely on a good plan and a good, low administration burden insurer. o In a SP system, sign up would be "one time" and portable. This makes for increased ease of use. o The benefit of a SP system is that everyone is on the same baseline plan. A SP financing system supporting a thorough plan offering broad coverage would provide full coverage for all services. Out of pocket expenses would be optimized (eliminated, minimized, whichever works best).
<u>Providers:</u> In our current system the individual provider faces many challenges. • Providers spend too much time talking to insurers.[3,4,5] This is partially due to prior authorizations, refusing coverage, and differing systems between various insurers. • As mentioned earlier, the many uninsured cost the system. If everyone is insured, all covered bills would be paid with a predictable amount and timetable as determined and publicized by the plan. • Health systems have to employ a plethora of medical billers to ensure	While we offer potential solutions offered by SP, we recognize that a SP system supporting a weak plan would create perhaps more problems than it would solve. o If the SP system is designed to minimize physician interaction with insurers, this would eliminate a very un-needed cost. o It would also eliminate a much un-needed time waste allowing for more time spent with patients thus potentially enhancing the doctor-patient relationship. o With a SP program, this

[2] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448534/

[3] http://www.google.com/url?q=http%3A%2F%2Fwww.commonwealthfund.org%2FPublications%2FIn-the-Literature%2F2009%2FMay%2FWhat-Does-It-Cost-Physician-Practices-to-Interact.aspx&sa=D&sntz=1&usg=AFQjCNEElVM7e_NuiGLNhvHcvde6BVBU5Q

[4] http://www.ncbi.nlm.nih.gov/pubmed/19443477

[5] http://www.ncbi.nlm.nih.gov/pubmed/21813866

repayment from the many different plans. The Medical Group Management Association recommends employing 0.61 billing staff per FTE provider.[6]	administrative expense could be drastically reduced. ○ Registration times could be reduced, if everyone has a standardized card that card could be used as registration.
Businesses and employers must decide whether to pay for employer-based health insurance or not, leaving them vulnerable to unpredictable changes in cost and sudden increases in premium based on "high risk employees"	○ In a SP system, all would be covered irrespective of their employment status. ○ In a SP system at least partially funded by employer contributions to a general fund, these costs would be predictable.

E. WHAT ARE THE PROBLEMS OF OUR HEALTH SYSTEM THAT SP WOULD NOT ADDRESS?

Many of the problems of current health system will continue to be the challenges of a SP system. These are therefore not so much arguments against SP but rather areas to continue working towards reform.

1. How to finance health education?
2. How to balance the number of primary care providers and the number of specialists?
3. How to promote relevant research, and hold drug companies responsible for honest relevant research?
4. How to deal humanely and prudently with end of life care?
5. How to promote malpractice reform?
6. How to curb overutilization? Methods would still need to be developed to encourage appropriate use of care by consumers and to counter "over expectation" and overuse of emergency rooms, MRI & CT scans, high tech procedures. Methods are needed to identify those physicians and hospitals that overuse high cost and high tech procedures.
7. How could we change fee structures to maximize quality and minimize costs? Health Care Home has recently shown increased quality measures and reduced cost http://www.health.state.mn.us/healthreform/homes/outcomes/documents/evaluationreports/evaluationhch20102012.pdf

[6] http://www.physicianspractice.com/qa/how-many-billers-do-i-need

F. WHAT CONSTRAINTS DOES A SP SYSTEM FACE?

In 2011, Vermont passed a SP system bill. In the July 2011 issue of *Health Affairs*, Hsiao et al described the constraints faced in passing the bill in the categories: Political, Legal, Fiscal, and Institutional and then describes how these points of contention were addressed.

Political

Businesses were most concerned about the continually rising costs and increased government control, providers were concerned about inadequate reimbursement and government control, and consumers were concerned about "rationing" and lack of input into decisions. Given that the measure passed, we know that the concerns of major players were addressed.

According to studies done in Canada, physician income would likely change very little. Those with a very rich payer mix might see a small drop in their income, while those who care for a large percentage of Medicaid patients will see an increase.

- The largest change might be shrinking of the differences in repayment between specialty and primary care physicians. (Source)
- No scientific studies have suggested that wait times would increase dramatically due to a SP system (a primary care workforce shortage is more likely to cause delays in care). (Source)

Regarding government control:

- The federal government programs currently serves 115 million Americans and are managed efficiently with high quality outcomes.
- We note that many rightfully worry about increased government control. We offer this thought: if you believe that something *might* be done poorly, is that a reason to not do it or a reason to make sure to do it well?

The SP financing system would be supervised by a body of elected and appointed members whose proceedings would be open and available to public participation and oversight.

- Currently, many of the most important decisions about health care are made in the offices of private insurers with no provider or consumer input.

Legal

Waivers are needed to redirect revenue from Federal programs of Medicare and Medicaid. Waivers would be needed from the Affordable Care Act that establishes the exchanges as the marketplace for individuals and small business. The "ERISA exemption" needs to be addressed because under ERISA (Employee Retirement Income Security Act), self-insured

corporations are exempt from state-regulated benefits.

- These issues are currently being ironed out in Vermont.
- It is worth noting that the Federal Government will allow for exemptions coming into effect in 2017 for health reform plans that offer better coverage than the ACA. Given this allowance, it stands to reason that the Federal Government will make allowances for these "better coverage plans" to succeed.

Fiscal

Many are worried, rightfully so, about where the funds would come from for a state-based SP. Vermont is currently working this out, and an excellent MN specific financing study is discussed in Section H below**.**

Total Cost:

- In Vermont, one of the requirements was reasonable and believable estimates of total cost (for consumers, business, and for the public/tax component).

Revenues:

- They also had to have a solid idea of where the revenue would come from. Granted, they are hammering out details now, but prior to passage, their plan was outlined. It included:
    - See above regarding Federal and state waivers which would capture Medicare and Medicaid dollars.
    - Consumer portion which will be either income or payroll tax.
    - Employer portion of the payroll tax.
    - Sin taxes

Support capacity

As seen in Vermont, proposals must address government capacity to run the health plan as well as plans to absorb or transfer the lost insurance jobs. Further, more primary care physicians will be needed because of retirement and expanded demand. It is currently estimated that we are short 90,000 primary physicians nationally.

- There are 167,900 non-physician workers employed in insurance companies, physician practices and hospitals in Minnesota. If a SP system is adopted, the number employed in this sector will fall by 42,800 workers. (Source)
- 20,000 workers in Minnesota are employed by health insurers. Employment for health insurers would be reduced by 16,700 workers, which reflects our estimate that total administrative savings would fall by 84 percent under the SP system. (Source)
    - An acceptable proposal would include retraining or job assistance for those displaced.

As mentioned above, a SP system would not inherently rectify the shortage of PCPs. However, it could be established with certain measures to promote the needed increase, starting with better distributed physician payments.

Other common critiques, criticism, concerns about SP financing system

A review of the health reform debate reveals several common concerns regarding a SP financing system. We encourage continued discussion of these concerns.

1. Cost controls would reduce reimbursement rates for physicians, hospitals, pharmacy, and equipment.
    - This may well be – depending on the system put in place. This depends not on the mechanism of SP but rather the type of plan it supports.
2. Cost controls would discourage investment in products and research.
3. Cost controls would be ineffective: Universal coverage is too expensive. Overuse by consumers will overinflate costs. The population is aging and chronic disease is on the rise, so we are expecting that health care costs will continue to increase.
4. Setting the "reimbursement rate" to providers is another form of fee-for-service, and will negate ability to gain cost reduction through mechanisms like accountable care organizations.
    - This also depends on what type of plan the SP system supports. Fee-for-service is not inherent to a SP system.
5. The governing bodies would take decision-making out of the hands of medical experts and "politicize" the decisions.
    - This depends on how well it is managed. Most plans include physicians and other "experts" on the advisory panels in order to circumvent this problem. This then is best termed a concern about mismanagement rather than SP itself.
6. Administrative savings are "one time only" in the beginning, when removing the costs of multiple insurance companies. After that, administrative cost savings are minimal.

G. WHAT COULD SP LOOK LIKE IN MINNESOTA?

We have a good model of what a SP financing system might look like in Minnesota, through the Minnesota Health Plan legislation introduced by Senator John Marty in 2009 and subsequent legislatures. Here is a link to current language of the bill as submitted in 2013:
https://www.revisor.mn.gov/bills/text.php?number=SF18&version=0&session=ls88&session_year=2013&session_number=0&format=pdf

Important components of this bill include:

- All Minnesotans would be covered with one time enrollment
- All basic health services would be covered.
- Patients would choose their providers.
- Governance would be through the Health Board of elected and appointed

members.
    - A public task force of consumers and experts would guide issues of quality.
    - A public fund would be set up to manage the finances (collect revenues and decide payments to providers and hospitals).

NOTE: The language in the bill is purposefully vague and lacks regulation or implementation language. This is an important reason physicians need to be involved in creation of this legislation, which will re-introduced in the 2015-16 Minnesota legislative session. The legislative process is convoluted and cumbersome, but physicians must be involved to ensure the best bill is put forward.

H. WHAT COULD THE FINANCIAL IMPACT OF A SINGLE-PAYER SYSTEM LOOK LIKE IN MINNESOTA?

SP system financing includes: total cost (and cost savings), sources of revenue, and payment. In 2012, The Lewin Group, a health care consulting firm owned by United HealthCare Group, presented a study of cost and cost savings for a SP financing system in Minnesota (Source). The study assumed several possible avenues of revenue (payroll, sin, and income taxes). Conclusion: a SP system would significantly lower state spending.

- Estimated statewide spending under ACA: $46.4 billion in 2014. This includes spending for benefits and administration covered by all payers under the ACA including governments, employers, and families. SP estimate: reduce total health spending by $4.1 billion, or 8.8 percent. Savings would come from bulk purchasing of drugs and equipment and administrative cost reduction, offsetting increased utilization and decreased cost-sharing. Of note, it assumes elimination of the provider tax.
- By 2023, total spending under the MDH projections will be reduced from $113.6 billion to $75.3 billion, by restricting spending growth to the rate of growth in state GDP. Total savings over the 2014 through 2023 period would be $189.5 billion.
- State general fund will see a net savings of $35.7 million in 2014.
- Employers: Nearly all firm sizes, with the exception of those with 10-24 employees, will see savings under single-payer:
    - Spending for currently insuring employers would fall by about $1,214 per worker. This estimate assumes employers must pay a payroll tax of 9.67 percent of earnings over $12,000 for an effective rate of 7.20 percent.
    - Note: this is NOT true for firms not offering health insurance before ACA. They will spend an average of $1963 more per worker (compared to zero).
- Households: Under the ACA, Minnesota residents will have premium payments and out-of-pocket spending for health services averaging about $4,382 per family in 2014.
    - We estimate spending for the median income families (~$59,000/yr) would

be reduced by $3,512 per family in 2014.

- Families with incomes of less than $150,000 per year will, on average, see savings.
- People with incomes between $150,000 and $250,000 on average will see a small increase in health spending averaging $240 per family.
- However, families with $250,000 or more in income would see an increase in health-related spending on a prorated basis.

I. IN SUMMARY: HOW WOULD SP IN MINNESOTA ADDRESS THE AAFP PRINCIPLES OF HEALTH CARE REFORM?

Principles for Reform of the U.S. Health Care System -established by ten of the leading physician associations, including AAFP.	**How Single Payer would Address Each of These**
1. Health care coverage for all is needed to ensure quality of care and to improve the health status of Americans.	Single payer and the Minnesota Health Plan would provide coverage for all Minnesotans.
2. The health care system in the U.S. must provide appropriate health care to all people within the U.S. borders, without unreasonable financial barriers to care.	SP and the MHP would offer the same level of quality care to all people regardless of their incomes.
3. Individuals and families must have catastrophic health coverage to provide protection from financial ruin.	SP and the MHP would cover catastrophic health coverage (and all other health services – primary care, acute care, and chronic care).
4. Improvement of health care quality and safety must be the goal of all health interventions, so that we can assure optimal outcomes for the resources expended.	The governing body* of the MHP system will set standards of quality and safety. And they can guide resources to support meeting those standards and thus address health disparities. *Governing bodies. The MHP proposes 3 governing bodies: The Minnesota Health Board is the general governing board. The "Office of Health Quality" guides issues of

	quality. And the "Minnesota Health Fund" will manage the finances.
5. *In reforming the health care system, we as a society must respect the ethical imperative of providing health care to individuals, responsible stewardship of community resources, and the importance of personal health responsibility.*	The above-mentioned governing bodies will gather all public input and decisions will be public and transparent.
6. *Access to and financing for appropriate health services must be a shared public/private cooperative effort, and a system which will allow individuals/employers to purchase additional services or insurance.*	The SP and MHP will distribute the cost of coverage with an employer tax and individual tax.
7. *Cost management by all stakeholders, consistent with achieving quality health care, is critical to attaining a workable, affordable and sustainable health care system.*	The Minnesota Health Board will publically address issues of affordability and then make the appropriate funding and service decisions. Corollary: a single payer health system will reduce the costs of the current delivery system and will better manage cost inflation.
8. *Less complicated administrative systems are essential to reduce costs, create a more efficient health care system, and maximize funding for health care services.*	A SP system offers maximum efficiency. The number of bureaucracies involved will be reduced to one. There are no "insurance" costs. Issues of capacity are centralized in the Minnesota Health Board. Issues of quality are centralized in the Office of Health Quality. Decisions will be public and transparent.
9. *Sufficient funds must be available for research (basic, clinical, translational and health services), medical education, and comprehensive health information technology infrastructure and implementation.*	As with our current funding streams, the funding for research, medical education, and HIT require contributions by the federal and state resources beyond the funding of health care services.

10. Sufficient funds must be available for public health and other essential medical services to include, but not be limited to, preventive services, trauma care and mental health services.	Under SP, the costs of clinical prevention, trauma care, and mental health will be covered for all members. The funding for adequate public health requires resources (city, county, state and federal) beyond the funding of health care services.
11. Comprehensive medical liability reform is essential to ensure access to quality health care.	A single payer system would support liability reform and could act as an important political force to accomplish liability reform.

Appendix 1. Frustrations in Daily Clinical Practice and how a SP system may impact them.

Frustration	Impact of SP System	Comments
Variable reimbursement levels for each patient.	A SP system would unify the reimbursement levels for all patients.	This would eliminate the "second-class citizens" of the healthcare sector (e.g. Medicaid patients).
Variable billing processes	A SP system would streamline all billing processes.	
Insurance eligibility verification • Excess staff time spent • Delayed patient check-in -> leads to a delay in rooming patient -> which leads to the physician getting behind schedule	All patients are eligible, eliminating the need to spend time confirming their eligibility. Will reduce delays in coverage determination for procedures or tests.	Allows for more patient-doctor interaction, enhancing the relationship and increasing the clinical efficiency of each visit.
Potentially inadequate insurance coverage • Concern that physicians push patients into debt situations from medications or procedures • Concern physicians may limit appropriate testing to avoid cost burden to patients.	All patients are eligible for insurance with a basic health plan.	Based on creation of basic health plans in the insurance exchanges, very reasonable to expect similar outcomes in the creation of a SP system
Formulary restrictions and changes.	All patients are eligible for insurance coverage with a single formulary.	Will the formulary be adequate? Likely yes because the limitations are often due to pharmaceutical-insurance. A SP system will change the incentives and power structure to allow for an adequate formulary.
Fragmented care due to various provider network eligibility	All patients are eligible for insurance without provider restriction.	

Patients are forced to leave their PCP due to changes in insurance coverage.	All patients are eligible for insurance without provider restriction. No insurance cancellation or changes.	
Excess paperwork: • Prior authorization formulary • Slightly different forms for each insurance company increases frustration and complexity of care coordination.	All patients are eligible for insurance coverage using a single formulary. This unified system will eliminate the need for different form templates and will reduce the complexity of care coordination.	
Unknown cost of services: • Lab tests • Immunizations • Recommended procedures	Many, but not all services, would likely have more transparent costs but full cost transparency may not exist.	France has full transparency so it can be done.
Insurance coverage decision-making.	More transparency in decision-making process for coverage decisions.	
Costs of quality measurement and reporting	Not likely to be improved, could be made worse.	In England, payment for quality metrics has benefited primary care physicians since there are so many more to get reimbursed.

Appendix 2: Single Payer Task Force Members

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