The importance of equitably including Medicare in a universal health program in Oregon

12/14/22 – Charlie Swanson & Debby Schwartz, for Health Care for All Oregon-Action

In 2019, Oregon legislators had the foresight to enact SB 770, which established a Task Force to explore how Oregon could implement a single-payer system, a system that is equitable, affordable, and comprehensive. Because of delays related to COVID 19 and other issues, the legislature renewed their support of this effort with SB 428 in 2021, which extended the timeline of the Task Force. We thank the legislature for this important investment.

The success of the effort towards an equitable and cost-effective universal health care system now depends on important next steps:

1. Establishment of a governance board with appropriate legislation in the 2023 session;
2. Supporting the Task Force recommendations of continuing the planning process with sufficient funding to do the job well;
3. Recognition, at least by the governance board, of problems with one of the possible options suggested by the report relating to Medicare inclusion;

The universal plan should equitably include Medicare-eligible Oregonians, because not doing so

1. Will create inequities that will cause harm to seniors, people with disabilities, and rural Oregonians;
2. Will lead to high administrative costs, wasting taxpayer money, and may make it cost-prohibitive; and
3. Will not garner necessary support from a sufficient number of Oregonians.

We will deal with each of these issues in more detail below. Before doing so, we will present a little background information.

The Final Report and Recommendations of the Oregon's Joint Task Force on Universal Health Care includes the following statements regarding Medicare on pp. 2 and 21:

> *People who qualify for Medicare will be covered by the Plan to the extent that the federal government will allow.*

It is unclear whether existing federal law will allow Medicare to be appropriately included in a state universal health program. The Task Force Report acknowledges this on pp. 5-6:

> *At present, there is no clear way for a state to fully administer Medicare funds within its single-payer program, although some rules may be waived for demonstrations with innovative payment systems.*

Because of this lack of clarity in federal law, the Task Force Report includes several options for Medicare to be included. One of the options for including Medicare recipients outlined in the

Task Force Report is a wraparound, but as indicated in Table 2 on p. 23 of the Report, provider reimbursement would be *"outside of single-payer purview."* This sort of "inclusion" will lead to unacceptable inequities and higher costs for the whole system. This paper deals primarily with the problems of the wraparound option.

SB 770 contains in section 3 (Purpose) a statement that is the most basic reason why Medicare needs to be equitably included in a decent system. It essentially says a well-functioning system is responsive to the needs and expectations of the residents of this state by (among other things)

> *Removing any financial incentive for a health care practitioner to provide care to one patient rather than another.*

If federal law does not currently allow appropriate inclusion of Medicare in a state system, Oregon should fight to change federal law. Importantly, Oregon should not implement a system that will make access to care by Medicare-eligible Oregonians more difficult, because not only would it be unfair, it would not be able to garner enough support to pass, as we will explain in more detail below.

1. Not equitably including Medicare will cause harm to seniors, people with disabilities, and rural Oregonians

Medicare recipients, primarily seniors and people with disabilities, are among those most likely to need substantial health care services.[1] In 2016, Medicare reimbursed large hospitals at 48% of the rate from commercial insurers.[2] These hospitals are required to treat Medicare patients, and more than 1/3 of their revenue comes from Medicare. For other providers, the differential is less but still significant enough that with no requirement to treat, traditional Medicare beneficiaries often have trouble finding willing providers, and those on Medicare Advantage often have limited provider networks.

Suppose Oregon were to implement a system that included all residents except those eligible for Medicare, who would remain with their Medicare coverage. Reimbursement rates for those not on Medicare would be equalized between private insurance, Medicaid, and would cover those currently uninsured, yet this rate would still be substantially higher than the Medicare reimbursement rate. Non hospital providers would enjoy the administrative simplicity of a single-payer with higher reimbursement rates than they would get with Medicare. With the tight supply of providers in Oregon, too many may choose the administrative simplicity of dealing with only one payer with higher reimbursement rates, and find a sufficient supply of

[1] On p. 101, the Task Force report presents that in 2026, Medicare recipients are projected to represent 18.7% of the population with 35.7% of the healthcare expenditures (if reimbursement rates were uniform).

[2] Table 5 of p. 19 of https://www.oregonlegislature.gov/committees/jhccr/Reports/SB%20419%20-%20Task%20Force%20Final%20Report.pdf.

patients without having to deal with the hassle of another payer (Medicare). This would tend to make it even more difficult for Medicare recipients to find willing providers.

Equity in healthcare resources requires society to have control over major capital expenditures. Market forces have led to substantial inequities in healthcare resources, with deficits in many areas of rural Oregon. It will likely require a number of years of society control over capital expenditures to ameliorate the situation. If Medicare is not equitably included in the system, it will not be possible to reasonably use global budgets to pay hospitals. Global budgets allow appropriate separation of operating and capital budgets, so local communities, rather than private hospital systems, can control capital expenditures in a way that aligns with community needs and desires. The Task Force report rightly acknowledges the importance of regional entities having substantial input on capital expenditures.

2. Not equitably including Medicare will lead to high administrative costs, wasting taxpayer money, and may make it cost-prohibitive

The most credible study comparing of hospital administrative costs in various nations, written by an international team of health policy experts,[3] found universal systems had lower administrative costs than those in the U.S., and systems using global budgets for hospitals had substantially lower costs than other universal systems that did not use global budgets. Hospital administrative costs in the U.S. account for 25% of expenditures (private communication from the authors indicates Oregon hospital administrative expenditures were 26% when they examined them), while in universal systems where hospitals are paid with a global budget administrative expenditures were 12% of total costs. From the paper

[3] Health Policy expert authors David U. Himmelstein, internist, professor at the School of Public Health and Hunter College, City University of New York, lecturer at Harvard Medical School; Miraya Jun, was a research officer at the London School of Economics and Political Science; Reinhard Busse, professor of health care management at the Technische Universität Berlin-World Health Organization Collaborating Centre for Health Systems Research and Management; Karine Chevreul, deputy director of the Paris Health Services and Health Economics Research Unit at the Assistance Publique-Hôpitaux de Paris; Alexander Geissler, senior research fellow in health care management at the Technische Universität Berlin; Patrick Jeurissen, head of the Celsus Academy on Sustainable Healthcare, Nijmegen Medical Centre, Radboud University, in Nijmegen, the Netherlands; Sarah Thomson, associate professor in the Department of Social Policy, London School of Economics, and a senior research associate at the European Observatory on Health Systems and Policies, in London; Marie-Amelie Vinet, health economist at the Paris Health Services and Health Economics Research Unit at the Assistance Publique-Hôpitaux de Paris; Steffie Woolhandler, internist, a professor at the School of Public Health and Hunter College, CUNY, and a lecturer at Harvard Medical School.
https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.1327.

The combination of direct government grants for capital with separate global operating budgets—as in Scotland and Canada—was associated with the lowest administrative costs.

Per patient billing increases administrative expenditures, as does multiple payers. In order to be most administratively efficient, Medicare would need to allow Oregon not to require per patient billing, and to lump Medicare payments with all of the other payments to a hospital.

Relative to the status quo, an Oregon single-payer system using global budgets for hospitals with separate operating and capital budgets could be expected to lower hospital administrative costs by up to $2.3 billion.[4] In the previous section, we noted that global budgets, with separate operational and capital budgets, are also necessary for sufficient equity in healthcare resources.

A decent system will shift from premiums and payments by those needing healthcare, to taxes collected from those with income to pay such taxes. Fairness to taxpayers, as well as necessary support from a sufficient number of taxpayers, requires not wasting money on unnecessary administrative complexity, and international experience indicates a single payer with hospital budgets is the most cost-effective method.

3. A system that does not equitably include Medicare will not be able to garner necessary support from a sufficient number of Oregonians

It is hard to imagine a healthcare plan getting voter support without decent support among seniors. If seniors and the disabled who are Medicare-eligible understand providers will get less for treating them than for treating essentially anyone else, they will not, and should not, support the plan.

Not including Medicare would create a system that is not single-payer. Providers would see substantial numbers of patients with one set of rules and reimbursement rates, and a different substantial group with another set of rules and reimbursement rates. Providers would have a financial incentive to treat some patients rather than others. Besides the inequities created, this would increase the administrative complexity, and thus the costs and the taxes necessary to fund the system.

If the federal government does not allow it, why bother?

A quick answer to this question is federal law can change. There has been a proposal in Congress for quite some time to change federal law in a way that would reasonably allow a

[4] The paper of reference 3 shows in systems paying hospitals with global budgets, hospital administrative costs are about 12%, compared to 25% in the U.S. (and Oregon). Hospital expenditures are 1/3 of total health care expenditures. Using the 2026 projected value for healthcare expenditures in Oregon, the difference in hospital administrative costs could result in as much as $2.3 billion in savings. (25%-13%) x 1/3 x $54 billion = $2.3 billion

single-payer plan to include Medicare and those otherwise covered by insurance prohibited from state regulation by ERISA (which the Task Force discussed as the State Based Universal Health Care Act – SBUHCA). Probably the best way to build support for passage of such a bill is for states to propose systems that require such legislation. If states refrain from passing bills that need SBUHCA-like legislation, we can be pretty sure Congress will not act.

If we were to manage to elect a somewhat reasonable Congress, we can envision an even better outcome. Suppose a number of states have enacted plans that would be most cost-effective if SBUHCA-like legislation were law. Congress would realize even more cost-effective and equitable than these separate state single-payer plans would be a national plan – improved and expanded Medicare for All.

Our expectation is that it is unlikely either SBUHCA-like legislation or improved and expanded Medicare for All will pass unless a number of states enact cost-effective single-payer plans that include their Medicare and ERISA populations, at least in the near future.

As the state wrestles with how to meet its healthcare obligation in the short term, it is crucial lawmakers keep the long term goal in mind. The plan outlined by the Joint Task Force on Universal Health Care is not yet ready for implementation, needing the legislature to set up a well-funded governing board to complete the planning and design process, as recommended by the Task Force. Whatever steps are taken in the short term should be designed with the recommendations of the Task Force and this paper in mind

Developing the sort of equitable, cost-effective, universal plan that meets the purpose, principles and values of SB 770 is the best way to build the public support that will be necessary to pass and implement a decent system. Not doing so will create a plan that is inequitable, especially for seniors, the disabled, and rural Oregonians, and also is not cost-effective. We can do better!