Why health system CEOs should support single payer

Understandably, hospital and health system execs have not supported the single payer approach to healthcare reform. This is because single payer has been defined by most policy analysts and the media as a government-run program, with the government calling all the shots. "Single payer" is often seen as a close relative of socialized medicine.

In sharp contrast, for me, single payer is a different idea that Walter McNerney and others promoted in the 1960s. We saw single payer as the most effective way to keep government from being excessively involved in day-to-day patient care decisions, even as the government necessarily had to become more involved in the financing of that care.

Our 1960s concept of single payer called for each hospital periodically to select a single payer, such as Blue Cross, as the intermediary between the hospital and the source of payment. That concept was built into the original Medicare legislation, with the result that operationalizing Medicare went much more smoothly than anyone had anticipated. Furthermore, as anticipated, direct involvement of the government in day-to-day clinical and management decisions has been kept to a minimum, even as governmental indirect financial and regulatory impact on institutional planning, strategy and management is necessarily pervasive.

I suggest that we move toward universal coverage by stages, first establishing a system requiring each provider to select a single payer from among competing third-party payers which meet government standards. Having this system in place and functioning would create the conditions for much less tension in moving to universal coverage.

With single payers for each provider, the stage will be set for decent universal coverage to follow one year later, financed through multiple sources of payment. A single payer for each provider is more important than a single source of payment into the system, and politically much less controversial. With multiple sources of payment, as in Massachusetts, required tax increases will be much smaller than with a single source of payment. In the long run, this version of a single payer plan even has real potential for tax decreases as healthcare costs are brought under control.

Single payer in the 1960s and beyond

In the 1960s, some of us could see that if most hospitals selected Blue Cross as their intermediary [more than 95 percent actually did], then the intermediary could "reimburse" monthly or weekly on the basis of negotiated global budgets for each hospital, rather than on case-by-case billings. The negotiation would involve achieving agreement on the key assumptions on which the budget is based.

The single payer approach would make most sense if all the sources of payment, including commercial insurance, HMOs, and uninsured families and individuals also agreed to pay through the same intermediary selected by the hospital. With payment based on negotiated prospective budgets rather than retrospective pricing of units of service, all of the case-by-case billing and utilization review bureaucracy could be shifted to more productive lines of work. The provider organization would know exactly how much money it would receive, as called for in its budget.

Hospitals and physicians could be held accountable through continuous analysis of both budget management and of the strategic and management decisions on which these budgets are based, as well as through retrospective analysis of group data on outcomes, rather than case-by-case analysis of clinical processes. Providers of care would no longer have to be concerned primarily about the financial implications of their decisions when caring for an individual patient. That concern is much more effectively channeled into systematic exploration of how to improve their overall management of their work and their working relationships.

Back in the '60s, some of us dreamed about the potential benefits of the reduction in costly red tape, combined with a payment arrangement that relied on increasingly effective strategic planning and budgeting and evaluation processes at each institution.

At that time, Blue Cross was handling almost all of the third-party contracted payments that go directly to the hospitals. Most commercial insurance was still paying for benefits directly to the subscriber unless the subscriber "assigned" the payment to the insurance company; few hospitals had contractual arrangements with any third-party payer except Blue Cross. Some insurance companies were able to negotiate discounts from retail charges, but none had cost-based contracts based on American Hospital Association-approved principles of payment that most Blue Cross plans and hospitals preferred.

If both the hospitals and the various sources of payment had outsourced their payment processes to Blue Cross as their intermediary, the nation would have had a single payer plan for each hospital, and the framework for a much more economical and systematic system of financing health and medical care, community by community.

Important developments during the next 50 years interfered with the translation of our exciting "single payer" dream into reality. Among the most important:

1. While the intermediary relationship was built into the new Medicare legislation, it was not built into the new Medicaid legislation. Medicaid was designed as a state-administered program, with most state government officials eager to manage the payment process themselves, rather than contracting with a third-party payer as the feds were doing with Medicare. Even when states did contract with a third party to do the actual paying, none incorporated the intermediary notion, with the hospital selecting its own intermediary from among approved third-party payers.
2. Most of the Blue Cross Plans and other approved intermediaries were not yet staffed up and prepared to play a dynamic intermediary role beyond bill paying, with potential impact on cost, accessibility and quality.
3. Eventually, Congress gave up on the intermediary role. In new legislation, they preserved the notion of third-party payers serving as agents for the government, but with no intermediary responsibilities and no intermediary structure. The third-party payers became simply agents for the government.

Today, it is clear that the nation's health system was not ready for single-payer healthcare reform 40 years ago. There is little evidence that the nation is ready for any healthcare reform involving the government as the single source of payment. But why not a key role for government as one of many sources of payment, but with broad oversight and regulation of a payment system based on health service goals and outcomes rather than the bottom line?

A 21st Century approach to single payer reform

Single payer will gain a great deal of public support if the emphasis shifts from a single government source of payment to a single payer for each provider. This approach responds to the heavy emphasis on choice and competition in this country's current culture by preserving both the prepayment marketplace for consumers and the third-party payer marketplace for providers. This approach demonstrates the value of a single payer where it really matters: in the governance and management of each provider organization at the community level.

The potential advantages of this single-payer approach to healthcare reform for hospital and health system CEO's are fairly obvious:

1. Eliminates the need for hospitals to prepare any bills for covered services.

2. Enables the organization to enter into a voluntary, collaborative relationship with the single payer organization to outsource all collection activities, including in-house interaction with patients and patient families about payment.
3. In collaboration with a single payer of its own choice, the organization regains control of its destiny, limited only by the willingness of the sources of payment to support the decisions of the single-payer organization.
4. Enables the organization to work collaboratively with and through the single-payer organization of its choice on developing an outcome orientation in the management not only of patient care but also in impacting on the care of target populations and communities.
5. Enables the organization to work collaboratively with and through the single-payer organization with respect to capital investment as well as ever more sophisticated and effective budgeting, management and evaluation tools for health service improvement.

The risks for hospital and health system CEOs are also fairly obvious:

1. The organization may discover that management is not able to develop a satisfactory long-term collaborative working relationship with any of the competing third-party payers capable of generating the needed money from the sources of payment.
2. The organization may discover that management is not able to develop effective working relationships with its clinicians, so necessary for constructing useful strategic assumptions for a reliable budget and so necessary for managing to operate effectively within budget constraints.
3. The organization may discover that the management team lacks the skills and teamwork to manage a budget effectively.

Because of the potential benefits of single payer for hospitals and health systems, CEOs are well advised to begin to explore methods of minimizing the risks and maximizing the benefits of having a single payer.