Our Profit-first Health Care System

Testimony to: Oregon Universal Health Care Task Force
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Hospital and staffing decisions and provider reimbursement are currently based on income from services provided. The resulting detrimental incentive is obvious. Our system is financially dependent on people being sick or injured. The folly of this has been clear for decades, but the pandemic has put a spotlight on it.

Since last February the pandemic has caused income-generating services to drop dramatically and high numbers of hospitals and providers to reduce or end services…at a time when those services were needed most.[1]

As thousands of Oregonians were ill and dying, insurance companies reported second-quarter earnings double that of a year ago and were paying out less for health care.

Ten years into the Affordable Care Act, health care remains too expensive and poorly accessible for over a third of our population, and the inequities persist unchanged. CCOs provided an improvement over other methods of delivering Medicaid services but do not and cannot correct the inherent costs and inequities within its profit-first health care milieu.

The value-based payment incentives used by Oregon's CCOs have been credited with improving outcomes and lowing costs. But to date:

a) There are no randomized controlled studies showing improved outcomes with VBP/P4P.
b) No improvement in large non-randomized studies.
c) Negative side effects are likely, e.g. increased CHF deaths.
d) The VA system with no VBP/P4P has better quality outcomes than do systems using VBP/P4P.
d) Quality scores tell more about patients than physicians. Compliance and rehospitalization rates are inextricably linked to and highly influenced by the environment to which the patient returns from the clinic or hospital.
e) The $12 B savings attributed to CCOs and VBP are overstated if they do not account for the subsidies given to Patient-Centered Medical Homes by payers and other third parties, nor account for expenditures by PCMHs themselves.

Proposed solutions:

1. Remove private insurance from any major role in the access of Oregonians to health care. Gently and quickly remove the elephant from the room. "Gently" means using tax funds to retrain administrative and clerical workers into roles of delivering care instead of denying care.

2. Move away from value-based payment for reasons stated above.

3. Global budgets for hospitals.

4. Time-based fee-for-service reimbursement. Provider reimbursements would reflect the years and level of provider training but would no longer be tied directly to the health care procedure rendered or to meeting arbitrary metrics.

A full rationale of time-based reimbursement is found in appended white paper authored by Stephen Kemble MD.[2]

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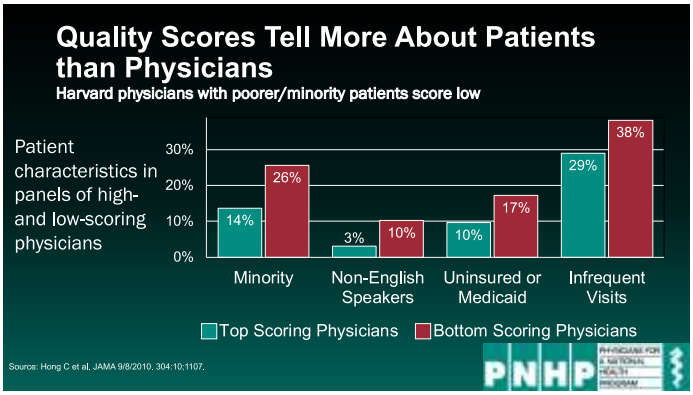
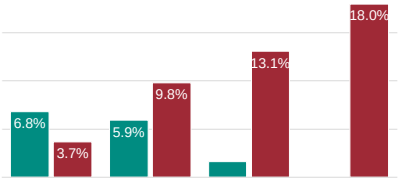
1. Eighty hospitals in the USA have closed this year. 80,000 nurses and health care workers were laid off or furloughed. 8,025 of the 138,707 private practice doctor's offices closed from 3/2020 to 6/2020.

2. A copy of the full report is on file with the Provider Reimbursement Technical Advisory Group and at https://drive.google.com/drive/folders/1blN9-ffpLE3iblqsbQ6qgZpCh_DdcA7_?usp=sharing)

Appendix A: Value-based Payments Ineffective and Harmful



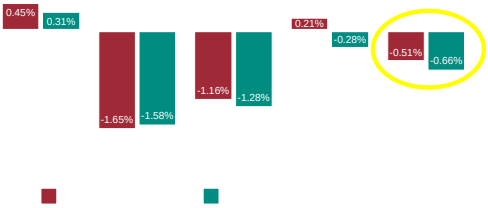


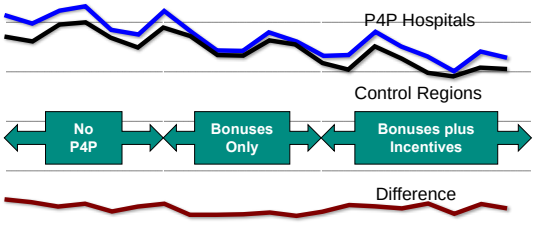
I do not think it's true

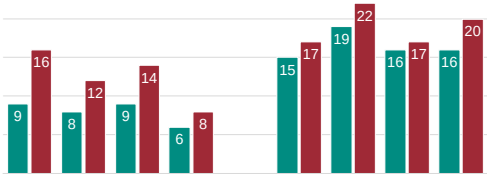
people respond to joy

it feels good to be a doctor, and better to be a better doctor.

we are playing with fire.
dissociate people from their work







Single-Payer Healthcare: Principles and Policies for Effective System Design

By Stephen Kemble and Kip Sullivan, *One Payer States* Policy Working Group

(A copy of the full report is on file with the Provider Reimbursement Technical Advisory Group and at https://drive.google.com/drive/folders/1blN9-ffpLE3iblqsbQ6qgZpCh_DdcA7_?usp=sharing)

November 8, 2020 Mid-Valley Health Care Advocates

The COVID-19 pandemic has exposed the severe flaws in financing health care through employment and state tax revenues, both of which have experienced sharp reductions due to the pandemic. This has stimulated renewed interest in single-payer healthcare financing, but proposals, at both the federal and state levels, rely on very different policies for paying for hospital care. Achieving savings from a single-payer proposal depends on getting the policy right. One Payer States (OPS) is a single-payer healthcare advocacy group, and this paper is a product of the OPS Policy Working Group.

1. Should single-payer proposals authorize competing risk-bearing organizations by any name (accountable care organizations, HMOs, integrated delivery systems)?

> No. American insurance companies and other risk-bearing entities have demonstrated that they compete by using strategies to capture a healthier than average risk pool (commonly referred to as "cherry-picking") and driving higher-risk individuals and populations out of their plan or network and onto the competition (often referred to as "lemon-dropping").

2. Since it is not possible to pay hospitals simultaneously with budgets and through risk- bearing entities, by which method should hospitals be paid?

1. Hospitals should be paid individually (not as members of chains),

2. Hospitals should be paid via budgets, not via payments per enrollee (premiums, capitation payments, shared-savings payments, or any other form of payment that shifts insurance risk off the single government insurer), and

3. Hospital budgets must be divided into capital and operating budgets.

Mid-Valley Health Care Advocates concurs with these findings and recommendations of the OPS Policy Work Group.

Sincerely,

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