Plain Talk About Healthcare (2023)

Introduction

Innocentia Pureheart—governor of Rhode Island and surprise winner of the Republican party's nomination for the 2024 presidential election—was getting desperate. The debate with Uncle Joe on health care was coming up in a few weeks and Seymour Angles, her super-savvy campaign manager, was losing patience with her: "You were nominated on your manifest record of bringing innovative thinking to government and your commitment to bringing universal health care to every American, but your health policy thinking sounds to me like a hodge-podge of warmed-over proposals from the established health care bureaucracy and a host of special interests. If you can't go beyond that you're dead in the water."

She'd heard enough. "Seymour, I don't need lectures, I need ideas. I agree: Talking to the so- called experts has been an exercise in conventional wisdom spiced with defeatist incrementalism, and a dash of pandering to powerful constituencies or, on the other hand, wholesale expansions with burdensome new taxes. Isn't there anyone out there with some new ideas?"

Seymour, as usual, was ready "Well, John MacArthur—you know, the former head of the Harvard Business School—sent me a paper by some guy he knows that makes a lot of sense to me. The problem is he's not part of the health care wonk society."

"That's probably why it makes sense."

"You've got a point. Want me to get you a copy?"

"Sure, but if you think it's worthwhile, let's also see if we can get him in here for a face to face. I'd like to cross-examine him. What's his name?"

"Wyatt Knight."

Posing the Questions

Two days later Innocentia greeted her guest. "Hello Wyatt. Thanks for coming by on such short notice."

"You're welcome, Governor. My pleasure."

"Are you a Republican or a Democrat?"

"Can't make up my mind. But I think we need to do something about healthcare or risk damaging the country's economy and social structure."

"Well, we can agree on that, but how do you fix it? Where do you start? Seymour briefed me on your paper and your thoughts about single-payer, but I'd like to hear it from the horse's mouth. That's a polarizing issue and worth spending some time on.

Wyatt dove right in.

"I agree it's a very polarizing issue but before we get to it, we have to agree on what problems we're trying to solve."

"Sounds reasonable. Go ahead."

"I'd like to begin with a brief history of how we got where we are; it's reminiscent of the myth of the frog in the saucepan full of water who fails to sense the temperature is going up and ends up cooked. We knew that healthcare was changing but failed to recognize the consequences and took a piecemeal approach to adapting. As a result, we have a mixed bag of private and public insurance, various access points to seek care, and a myriad of subsidies and cross subsidies that was put together piece by piece to deal with specific problems but with insufficient attention to how the pieces fit together. So, we really don't have a healthcare system at all. What we have is almost impossible to fully comprehend and, as a result, almost impossible to intelligently reform or systematically improve. We're close to a figurative boiling point comparable to the literal one that had such disastrous consequences for the frog.

"Our current approach started to evolve over seventy years ago when the country and the practice of medicine were in very different places. In the good old days when healthcare was simpler and the options for treatment were limited the primary relationship was between the doctor and the patient. If a person felt ill, he or she saw a doctor, he did what he could, and the patient paid his bill. In a way it was the 'perfect' relationship: simple and straightforward. The average annual per capita expenditure on health care was $146 per person in 1960 so it worked pretty well. In was $12,914 in 2021and and is projected to hit 20% 0f GDP by about 2028."

Inno interjected. "The per capita was only $146 in 1960. Well, that's a bit of a surprise. It's hard to believe. But I've heard all that stuff about growth in national expenditures. And so, in fifty years half the economy will be in health care. It can't happen. So, skip the general background. What do we do now to make sure it doesn't?"

"Excuse me, Governor Pureheart, I know you want to jump to the single-payer issue, but I think the key to getting out of this mess is posing the right questions. And to do that we've got to understand and agree on the underlying causes of the problems before we start discussing possible solutions. So, bear with me a little. Cut me a little slack."

"Look Wyatt, I'm not an amateur and I've spent a lot of time speaking to a lot of people about these problems and thinking deeply about them, so I know the background, the statistics, the seriousness of the problem. I know our current approach is unsustainable and I'm all too familiar with the political realities. Let's get to the point as quickly as possible."

"Fair enough. Then why don't we start with you telling me how you see the problem and let's see if we can agree on the underlying causes and pose the questions in ways that they can be dealt with."

"Well, aren't you the clever one? Turning the tables on me like that."

At this point Seymour jumped in. "Go ahead, Inno. Call his bluff."

"Okay, Wyatt. The conventional wisdom, which I think is probably correct in this case, is that the three dimensions of the problem are costs, access, and the quality of the care delivered. You've already made point one. Costs are dangerously close to spiraling out of control and the premiums of private insurance are certainly beyond the reach of much of our population. So, I guess the obvious questions are how do we stop the spiral? And how can we get our entire population insured? But I guess we need to go a little deeper into underlying causes before we can pose the right questions."

Seymour came back again: "Yeah, so Wyatt, what's driving the spiraling costs."

Wyatt was ready. "This is a good news/bad news story and there's lots of good news. One of the main factors driving spiraling costs has been the enormous progress our healthcare providers have made in understanding disease and applying science and technology to combat it. Our medical professionals and healthcare facilities are world class. We're also the world leader in biopharmaceuticals.

"On the other hand, the bad news comes in two doses. First, the broad and continually proliferating arrays of effective treatment modalities that physicians have at their disposal keep getting more and more expensive to deliver. Also, increasing life expectancy has a geometric effect on health care costs because the average costs of keeping a person healthy increase with age. So, we need to figure out how to manage the introduction of new and ever more expensive technology and how to take care of an increasingly older population. Moreover, these phenomena are exacerbated by the fact that our self-indulgent lifestyles have led to an ever-increasing incidence of chronic diseases (e.g., diabetes, coronary heart disease, cancer), which are expensive to treat at any age, but tend to become more prevalent, more serious and more expensive to treat as one grows older.

"The second dimension of the bad news story is that we have imprisoned ourselves in a system of insurance-based healthcare financing that has produced mind-numbing complexity, a host of middlemen, enormous unproductive bureaucracies, a lack of transparency and increased inefficiencies and costs for the people and institutions that actually deliver healthcare. A recent New York Time Guest Essay reported that a majority of healthcare professionals were disillusioned and discouraged by the complexity of our financing systems. And a recent AP-NORC opinion poll indicated that as much as 80% of the population are "moderately concerned" that they won't be able to get the care they need when the time comes."

Innocentia was getting more engaged.

"Well, Wyatt, the way you've parsed the underlying causes of the spiraling cost problem, the unintended consequence of our superb record in creating ever more powerful medical technologies and our self-indulgent lifestyles, is pretty widely recognized and makes a lot of sense to me. But I'm more intrigued by your comment that we've embraced a complex system of financing that seems to be at the heart of the matter. Tell me more. Start with your view on the complexity of our financing system and its implications and your solution for simplifying it then we'll get to the solution and the politics."

Once again Wyatt was ready.

"Well Governor, you asked me early on "how can we get the rest of the population insured?". That's the wrong question. The right question is how we can ensure that all Americans have access to our world class providers. Healthcare insurance is the problem not the solution."

"What do you mean, Wyatt, for most Americans access is synonymous with insurance."

"Exactly! And that's the heart of the problem; we've equated access to insurance and that has led us down a very slippery slope."

The Problems of Choice, Complexity and Middlemen

"Let me try to explain in general terms with a little bit more of the history and then we can get down to the specifics. Simply stated it goes like this.

"When employers started using insurance as a path for access to healthcare to avoid price controls on wages going back to the end of World War II and even before, they began interposing middlemen between the patients and the physicians, hospitals, and the pharmaceutical companies who actually deliver the care. The insurance companies then started to treat healthcare insurance as a consumer product providing an increasing range of choices to their customers. For example, before redesigning their website in 2017, a major on-line vendor of health insurance plans advertised on its opening page that a purchaser could "choose from over 13,000 plans from over 600 suppliers". Similarly in 2016, the Medicare Advantage program included about 3,500 plan options."

"Slow down, Wyatt. I thought choice was essential to permit people to choose the product that best suits them."

"That's true, Governor, when you're talking about classical consumer products like, for example, automobiles where you have the opportunity to choose from a wide range of manufacturers, models and features that you want and can afford. The more you pay the better the product you expect to receive. At first glance, providing a wide range of choice seems to be a sensible way to permit individuals to select a program that offers coverage at a mix of premiums and out of pocket costs that they believe they can best afford. That's the classic definition of a consumer product. However, the Affordable Care Act specified ten Essential Benefits that must be included in insurance coverage and the vast majority of policies now provide for them. These Benefits account for almost all diseases and other medical problems a person can encounter. So, when you choose the type of insurance coverage you want, you're actually choosing features that primarily differ between different mixes of high premiums and low out of pocket costs not by which diseases are covered . Compared to classical consumer products the choices in healthcare insurance are empty; they are primarily between premiums (pay now) or out of pocket costs (pay later when you receive the care).

"Health care is very different; it's not a traditional consumer product. A person with appendicitis doesn't choose whether or not they need to have their appendix taken out. The physician does. Nor does the patient decide whether they want a Cadillac or beat-up old clunker version of an appendectomy. There's standard of care procedure which the physician will follow. You don't have a choice about when you are going to develop a disease or other health problem."

As I mentioned, when one considers that the vast majority of healthcare insurance policies cover the Essential Benefits defined in the ObamaCare legislation, this extraordinarily complex segmentation of the market seems quite unnecessary; it became primarily about not what illnesses are covered but only who pays when.

"OK, Wyatt, I think I'm beginning to see the dangers of equating healthcare to healthcare insurance; please continue."

"I will, but just to reinforce your concern about the dangers; for many people in our mid- to lower- income groups healthcare insurance simply sets up a future decision on whether to pay the out of pocket costs when they actually need the care. So, in effect, healthcare insurance is a way to ration care based on ability to pay. It's an obstacle to universal access not a way to achieve it."

"Um, I've never thought of it that way, but I see your point; it's very regressive."

"It is and we'll speak more about that a bit later. But let's move on to a more complete discussion of the costs of complexity. The overabundance of choice coupled with prior authorization has led to a spider web of complexity that spreads to every provider of healthcare, the physicians, the hospitals, the biopharmaceutical companies and so on. This complexity causes an enormous amount of unproductive administration, and, because of the attendant lack of transparency, facilitates substantial waste and overutilization. None of this should be surprising since the insurance companies are not motivated to reduce complexity because they are primarily regulated by the Medical Cost Ratio which simply requires them to pass through between 80 and 85% of their premiums to the providers. In other words, the more complex the system, the higher the premiums and the more money the insurance companies make."

"Well Wyatt that's an interesting hypothesis but how much money do the insurance companies and middlemen actually cost. After all, if the insurance companies have to pass 80 to 85 % of the premiums they collect through to the providers, they only take out a little over $180 billion for their expenses and profits. That's a lot of money but in 2021 our total spending on healthcare was $4.3 Trillion. I don't get it."

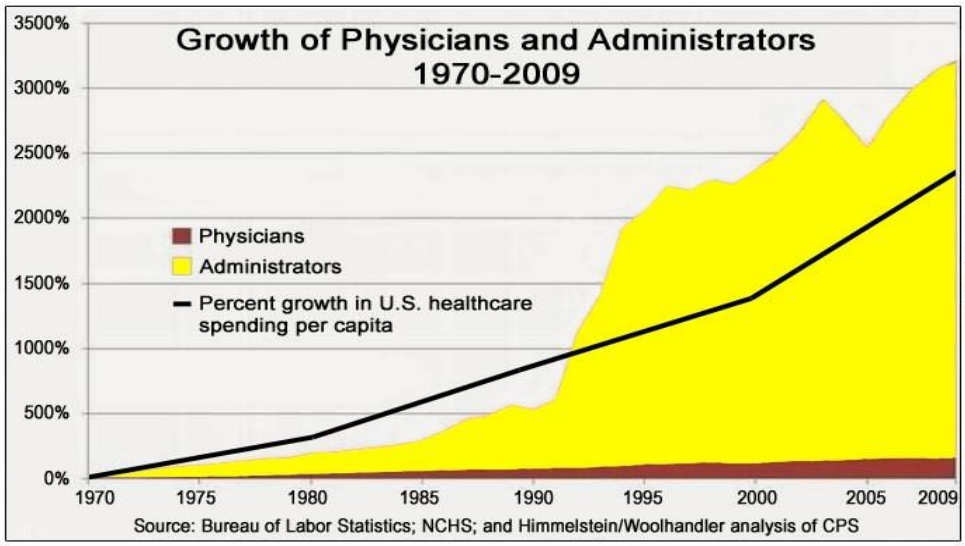
"Governor, as I hinted at a few moments ago the costs of this complexity go far beyond the insurance companies and reach into every nook and cranny of the economy

"A detailed and comprehensive study by the National Library 0f Medicine(NLM) in 2014 estimated that billing and insurance (BIR) costs in US health care totaled approximately $471 billon in 2012. This includes $70 billion in physician practices, $74 billion in hospitals, $94 billion in settings providing other health services and supplies, $198 billion in private insurers, and $35 billion in public insurers. Moreover, this does not include the substantial time, energy, and money devoted to managing insurance by individual households or patients. Compared to simplified financing, the NLM report estimated that $375 billion, or 80%, of the BIR costs of our multi-payer system, could be eliminated. This was roughly equivalent to 15% of total spending on healthcare. Fifteen percent of 2021 spending would amount to $645 billion. Moreover, this complexity and the lack of transparency it engenders makes systematic reductions in operating costs near impossible. It also provides a fertile ground for fraud and overutilization."

"Wyatt, that data seems a little out of date. Are you sure it's still representative of the complexity?"

"Governor, one can argue about the details at the margin but the fact that an insurance-based system is inherently more expensive to operate than a direct subsidy system is indisputably correct and of central importance. It has administrative costs proportional to the amount of healthcare delivered, **plus** the costs of a complex insurance and reimbursement structure and the other middlemen it spawns. On the other hand, a single payer system has administrative costs proportional only to the amount of health care actually delivered. Moreover, the US has the most complicated and expensive middleman structure in the world, so those numbers are in the ballpark.

"Consider also that the ratio of administrators to doctors has exploded since 1970 and has reached ten to 1. That's right; ten people in purely administrative roles for each and every doctor. Here's a chart that will give you an idea of how onerous administration has become.



"The data is reliable and indicative enough to size the problem even if it's dated. And what is also indisputable is that the private healthcare insurance business has ballooned to over a trillion dollars in revenue and unfortunately, it does as much harm as it does good.

"OK, Wyatt, I take your point on the need for precision and you've pretty much convinced me that complexity and its widespread impact on administrative costs are a major problem. But what do you mean when you say the health insurance does as much harm as it does good."

"There are a number of problems. First, for most people it puts primary emphasis on premium cost and deemphasizes the additional out-of-pocket costs of paying for care when it is actually delivered. Second, an

individual's access to hospital care is independent of their insurance situation by federal mandate. Third, our safety nets such as emergency rooms and neighborhood clinics provide outpatient access to all comers albeit not as conveniently as consulting a personal physician. Fourth, the requirements for cash outlays for necessary routine or chronic care often cause lower income or, in some cases, middle income patients, who generally choose a low-cost premium, high cost out of pocket option to forego treatment when they're short on cash at the time of need. This frequently leads to more serious illnesses and, ultimately, much higher expense to treat them; and, unfortunately, when people do choose to pay the out of pocket costs either for outpatient or inpatient care it all too often leads to financial problems or in many cases to medical bankruptcy. So, as you observed a few minutes ago our approach to providing access is highly regressive. Finally, and perhaps most important, the total costs to our healthcare system of complexity in insurance, which far outweigh the benefits, have been largely ignored when considering reform.

"The more you tell me, Wyatt, the less I think we can simply reform this hodge-podge. I'm beginning to wonder whether have to start over; at least for the financing."

" We're on the same page on that; single-payer can be viewed as starting over on the financing. But there's more to the story, and you should have as complete a picture of the middlemen and the complexity they cause as possible. So, before we leave the subject, we should touch on the other major middlemen in healthcare, the Pharmacy Benefit Managers or PBMs."

"Wyatt, I'm well aware of the debates going on in Congress and Vermont and many other states about the role they play in constructing formularies, setting prices and defining copays. The biopharma companies claim that the PBMs add substantial costs and add little value while the PBMs claim they negotiate better prices across the board. But it's all pretty murky with a lot of finger-pointing. Maybe you can clarify this one for me."

"It's murky all right. One of the problems in really grasping the nature of the debate is that the PBMs are very secretive about disclosing their economics particularly when discussing the disposition of the rebates they negotiate with the manufacturers. And on the other side, the biopharma companies operate in a rarified atmosphere of research and development with difficult to understand economics which require on average about a $2.5 Billion investment for each new drug introduced and from ten to fifteen years for it to reach the market. Although spending on prescription drugs was only about 12 to 13 percent of total healthcare spending in 2021, they play a disproportionate role in treating chronic disease. Roughly 50% of American adults suffer from at least one chronic disease and about 30% have 2 or more. Estimates of the percentage of the costs of treating chronic care as a portion of the total cost of care actually delivered reach as high as 83% . So, the resolution of the disputes will have an important bearing not only on the future of drug prices but also on our ability to control chronic disease. Suffice it to say that PBMs are the second most important middlemen in the healthcare space with total annual revenues of about $500 billion in 2021 and unquestionably constitute a substantial portion of the prices of drugs. For me the question is simply whether there is a better way of setting drug prices that will result in a better balance between costs to the payer and the investments in R&D required to develop more effective medications. I have some ideas, but I think they're better discussed when we get to discussing solutions.

"OK, Wyatt I think I'm beginning to get a deeper understanding of the costs of complexity."

"Inno, before we move on, there's a whole other dimension of complexity in the way we manage subsidized government programs. There's no good reason why Medicaid is partially financed by the federal government and partly by the States who are also responsible for how it's administered. Moreover, the approach differs from state-to-state and many of them delegate responsibility to the county level. In addition, each state has responsibility for regulating the insurance companies operating in their state: just more unnecessary complexity. It's a very good example of how we got where we are through political compromise rather than a hard-nosed assessment of the most efficient and effective way to organize our efforts. On the other hand, Medicare and Medicaid are successful programs and administration costs in are roughly one-fifth of those of

private insurance. This is a natural consequence of both Medicare and Medicaid being essentially single-payer systems so the good news is that their success demonstrates that single-payer will work in the United States. Moreover, absorbing them into the ultimate single-payer system will be relatively straightforward because they're almost there.

The politics will be more challenging."

The Total Cost of Complexity

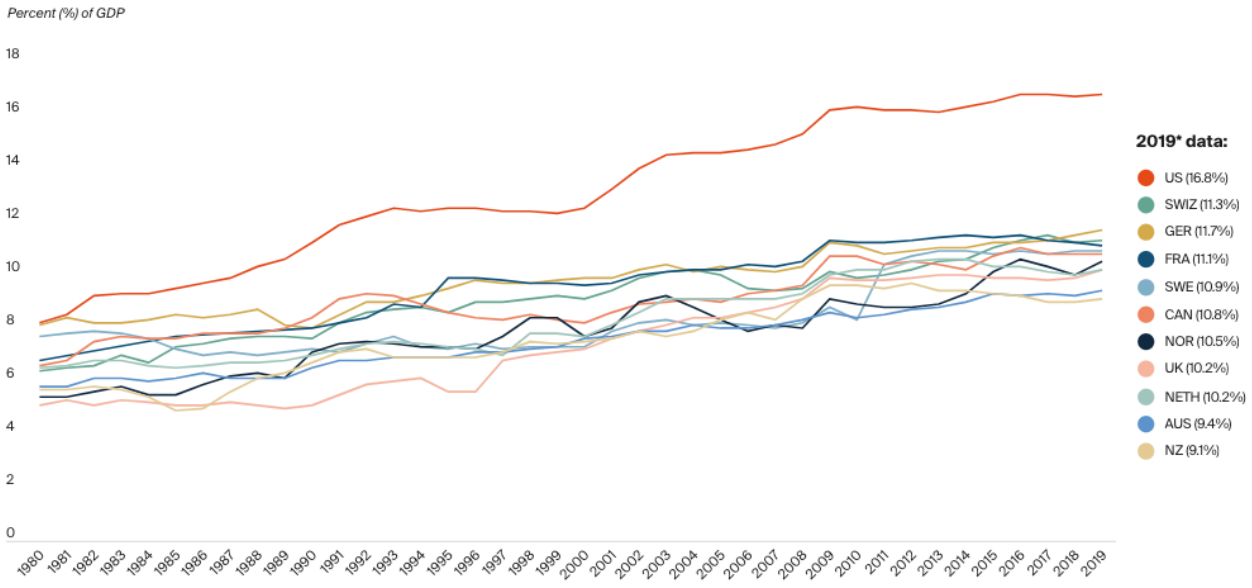
"When you add up the cost of complexity in choice, the non-BIR related costs of the insurers, the costs of the Pharmacy Benefit Managers and other middlemen, the foregone tax revenues from Employer-based insurance and the reductions in fraud and overutilization facilitated by the complexity you easily exceed one trillion dollars or about one third of current total spending on health care. No other developed country has to deal with any of this unproductive complexity or its attendant costs.

"Just to wrap up this part of our discussion, and as you may already know, the Commonwealth Fund has published its Mirror, Mirror report, a triennial ranking of the quality and cost of care in 11 developed countries, since 2004. The United States has finished dead last in terms of quality of care in every instance despite spending from 50% to 100% more as a percentage of GDP on healthcare; and Bloomberg and the World Health Organization have come to similar conclusions. Take a look at these two charts which summarize the results of from their 2021 Mirror, Mirror report.

Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**3**	**10**	**8**	**5**	**2**	**6**	**1**	**7**	**9**	**4**	**11**
Access to Care	8	9	7	3	1	5	2	6	10	4	11
Care Process	6	4	10	9	3	1	8	11	7	5	2
Administrative Efficiency	2	7	6	9	8	3	1	5	10	4	11
Equity	1	10	7	2	5	9	8	6	3	4	11
Health Care Outcomes	1	10	6	7	4	8	2	5	3	9	11

Health Care Spending as a Percentage of GDP, 1980–2019



"Well, Wyatt, right at the outset I mentioned I wanted to hear it direct from the horse's mouth but listening to that impassioned plea was more like drinking from the proverbial fire hose. But you've certainly given me plenty

of cause to doubt both the effectiveness and the efficiency of using healthcare insurance to provide access to health care. I agree these charts pretty much summarize the dismal state of healthcare in the United State. You've certainly given me some concrete and specific issues to think about and presented them in a way I've found to be comprehensible and provocative."

"You've also worn me out. Are you available to stay in town and continue tomorrow?"

"I am. I've cleared my calendar for just this eventuality."

"Seymour, cancel tomorrow afternoon's staff meeting and we'll reconvene at 3:00."

"Will do."

"Wyatt, I can't thank you enough; you've done a great job communicating your perspective on the widespread problems driven by complexity and middlemen.

"You're not bad at listening and communicating yourself, Governor."

Well, I think I have the drift of your thinking on the challenges and how they developed so let's dive into solutions tomorrow. I know from your paper that you favor-single payer as the only solution and I lean in that direction myself but some of my other advisors have real reservations. And Bernie and others have tried mightily to get it passed and were notably unsuccessful. What should I do differently?

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Pinpointing the Issues

When they reconvened at 3:00 as planned Inno moved to take control.

"Guys, I've been thinking about yesterday's discussion nonstop, and I believe that before we dive into the single-payer solution, we should come to some agreement on the issues I'll have to be convincing about when the debates with President Biden and the rest of the interested parties begin in earnest. Let me give you my thoughts to get us started. "

"First, I think I'll have to demonstrate that moving to single-payer will eliminate the great majority of the complexity and the unproductive costs that insurance - based access generates. Second, I'll have to show it can be done without compromising the ability of the providers to deliver high quality care. In fact, I believe I'll have to show that it will enhance their capacity and capability. Third, we'll have to show that we'll redress the inequities caused by out of pocket costs. Fourth, We'll have to outline how we intend to address the price of prescription drugs. Finally, we'll have to demonstrate that we can make an appropriately timed transition to the single-payer system with a manageable amount of disruption despite effectively shutting down a major industry with all that entails in terms of job loss.

'Wyatt, anything to add?"

"That's a great list to work with. However, I would like include in the transition discussion a few suggestions on how you communicate your healthcare policy platform in a way that differentiates you from Bernie and the others who've attempted to get single-payer done. In a way they've done us a favor by smoking out whence the biggest resistance will come and how the counter-arguments might be shaped. They've also raised the general level of consciousness and understanding of single-payer and the polls are showing that more people across the political spectrum are thinking more seriously about the potential benefits. You should be able to attract a more receptive audience and do a better job of making the case.

"OK, that's a positive way to think about it. I would certainly like to hear more about your ideas on how I should think about and position myself and my platform."

"Seymour?"

"No more from me. I think if we can get through that agenda before midnight, it will be a miracle. But we'll have a great start on a platform policy statement."

Inno came back. "Seymour, I think Wyatt has already addressed most of these issues and we should be able to come to a common understanding of how to deal with them pretty quickly. I just want to make sure we're covering all he bases. But you're right about the platform policy."

Dealing with the Issues

Inno continued. "OK, let me try to get us started. Wyatt's comparison of the administrative cost of our insurance-based system compared to those of a single-payer system was compelling. And his characterizations of the how the additional costs of BIR rattle throughout the economy, the questionable role the PBMs play and how the ratio of administrators to doctors had grown put the last nails in that coffin for me. The benefits of simplifying our financing of healthcare is as close to self-evident as you can get. We just have to be sure we don't inadvertently compromise any essential functions."

"Governor, I told you that you were very good at asking the right questions. There are only two essential functions that will need to be preserved. Both are residual functions of the interface between the insurers and the providers once the complexities of financing have been eliminated. One is setting the prices for the products and services of the providers including the biopharmaceutical companies; the other is ensuring the integrity of the greatly simplified reimbursement system. Once you reach that conclusion you have to wonder how we could have permitted the interface to become so complicated. It calls to mind the boiled frog myth.

"Pricing should be community rated much as Medicare is today. In fact, Medicare's prospective pricing scheme could be adapted to carry out the function for the single-payer system. It would be the primary and most important function of a new federal agency that you'll have to put in place to energize and oversee the transition and manage the system once it's up and running. The agency should be at a level comparable to the Federal Reserve to insulate it as much as possible from short term political interference. I've dubbed it the American Health Agency, AHA, for the moment. I'll explain how I see it in more depth when we get to the transition discussion since its effectiveness in carrying out its responsibilities will be the most important factor in successfully transitioning to single-payer.

Wyatt continued. "On the other hand, ensuring the integrity of the reimbursement process is well understood. The responsibility of executing it for the much simplified financing could either be contracted out as a residual role for one or a number of the insurance companies; or it could be handled by the federal government."

Seymour jumped in. "And will we still get the savings?"

"We will, the expenses driven by complexity of insurance-based financing will simply disappear. The savings we discussed yesterday will be in the ballpark. The easiest way to cut expenses is to just stop doing things that aren't necessary."

Inno reasserted herself. "Seymour, I think we're further along than you might think. Let's move on to whether and how single-payer could enhance the capability of the providers to deliver high quality care. Wyatt, you're thoughts?"

"Relieving the physicians and the people who support them of the burden of dealing with the complexities of the BIR system could produce as much as a 15% increase in capacity and go a long way to easing the shortage of physicians and other healthcare professionals. Equally important would be the concomitant increase in morale and the reduction in frustration of those same people when they could once again practice what they were trained to do without the constant distraction of administrative complexity. The potential pitfall, real or imagined, will be that the federal agency responsible for pricing, AHA, would try to impose Medicare/Medicaid levels of reimbursement which average only about 85 % of hospital costs.

That will give the hospitals pause. Today, they survive by negotiating higher reimbursement rates with the private insurers which, as I discussed yesterday, leads to higher premiums and higher profits for the insurers. Similarly, many physicians have responded by refusing to participate in Medicare and or are converting to concierge practices. It's just another example of a hidden cross subsidy that is characteristic of the chaotic state of healthcare in the United States. Again, I'll suggest how to deal with it during the transition discussion when we dig deeper into AHA and the subject of federal oversight and control of pricing."

"OK, Wyatt, sounds like we'll have a lot to discuss when we get to the transition discussion. What about the question of the inequities in out of the pocket costs. How do we take the monkey off the back of the lower and middle income segment of the population and make sure out of pocket costs don't cause them to defer or refuse necessary care."

Well, the simplest solution is to emulate Bernie's approach and simply not require any copays or deductibles but that increases the likelihood of unacceptable overutilization. A more conservative approach would be to include a single modest copayment-like charge for routine and other outpatient services which are initiated by the patient but, instead of billing the patient, reporting the amount to the IRS as income. That would discourage overutilization but not be as much of a burden for the lower and middle income groups who are the ones most likely to defer or skip necessary care. It would also provide a source of federal income taxes to help finance the system. It's not perfect but I think it's workable.

Inno was smiling. "That's clever, Wyatt, you've sort of turned the out of pocket requirements upside down so they're progressive rather than regressive. I like it!"

She continued. "I guess that brings us to prescription drugs. Wyatt?"

" Most people are schizophrenic about prescription drugs. On the one hand, the Centers for Disease Control and Prevention, the CDC, reported that in 2018 more than half, 51.8%, of adults had at least 1 of 10 selected diagnosed chronic conditions and 27.2% of US adults had multiple chronic conditions. Prescription drugs are by far the most effective way to control these diseases and failure to adhere to the schedule for taking them has been estimated to result in about 70% more hospitalizations for the non – adherers. Nevertheless, the costs of prescription drug prices are one of the hottest topics in healthcare. Moreover, since they require regular payment, sometimes for a lifetime, they are front and center in people's minds. I have friends who are completely dependent on prescription drugs for their health and wellbeing complain about the "greedy" drug companies. That's what I mean about schizophrenia. "

"We discussed the conflict between the pharmaceutical companies and the PBMs and the well-publicized Congressional hearings on the subject yesterday. Also, the Inflation Recovery Act has empowered the federal government to negotiate Medicare prices for certain high use drugs directly with the drug companies and the number of drugs included is scheduled to increase over time. In other words, we're dealing with a moving target on prescription drugs. There is no doubt, however, that the PBM's are middlemen. Nor Is there any need to continue the extraordinarily complex and opaque process they use to negotiate prices with the manufacturers or produce benefit plans for large group purchasers. There's also the question of motivation; are the PBMs primarily motivated to control national expenditures on health care or to generate profits; at a minimum, there's a bit of cognitive dissonance there. The necessary function they provide is to negotiate prices. That

responsibility should go to AHA. I'll give you my thoughts on how AHA will handle those negotiations when we discuss the transition plan."

Inno took the floor. "Well, we've covered all the items in the list except for transition planning. Why don't we take a break and reconvene at 6:00. Wyatt, I took the precaution of booking a private room for dinner for the three of us at Wilaiwan's Kitchen. Are you up for that?

"Sounds great! See you at 6:00."

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Clarifying the Objectives

When they reconvened at 6:00 Inno took charge. "Well, we've certainly covered a lot of ground in the last two days. I think the transition plan will either make us or break us. Are you ready to discuss it, Wyatt."

"I am, Inno. But before I get started, we should make sure we agree on some of the key elements of single-payer that will make it indisputably better than our hybrid system: where we want this transition to take us. What's our objective. As you know my education is in electrical engineering and operations research and I spent the first ten years of my business career as a systems engineer. The first step in designing a system is to specify as exactly as you can what you want it to do. I have my ideas but you're the candidate so why don't you spell out in a few words what you believe the principal objectives of the transition to a single-payer system would be?

"You're pretty good at turning the tables, Wyatt."

"And you're pretty good at setting them once they're turned, so let's get started."

"Well, I guess my primary objective is to end up with universal access to high quality healthcare for all Americans."

"Any exceptions ? For example, should Congress be treated differently?"

"No, I don't think so."

"Should we allow people who can afford it to go outside the system."

"Uh, I think I'll have to give that more thought, but I don't see how you could prevent it."

"OK, Anything else?"

"Well, at the national level, it would be great if we could reverse the constant increases in the percent of GDP devoted to health care or at least slow it down or stabilize it.

"And at the level of individuals and households?"

"Well, we want to remove all the obstacles for people who need care, but we don't want to encourage overutilization. And we want to free people from their constant state of anxiety about paying for it, but I guess that's almost synonymous with universal access."

"How about setting prescription drug prices"

Well, as we discussed prescription drug pricing is in the news and the PBMs are under fire. As we agreed the discussions are murky, but the fact remains that middlemen are the enemy of single-payer. Fortunately, 90% of

prescription drugs are generics so there's clearly a competitive market to a certain degree so I'm leaning in the direction of a single formulary with complete reimbursement for the lowest cost alternative and an out of pocket equalizing charge for other drugs in the same category. As for the rest of the market I'd rather have that responsibility in the hands of people motivated by the national interest rather than profitability."

Wyatt responded. "Well, Inno you have been thinking about it and I like the direction of your thinking but getting the right balance between prices and pace of innovation will continue to be a vexing problem.

Wyatt continued. "What about the institutions and the professionals who actually deliver the care?"

"What is this? Twenty questions? A final exam?"

"Sort of."

"I'm beginning to feel like I'm back in third grade. Anyway. we obviously need the pricing of goods and services to be sufficient to keep our institutions financially healthy and our professionals well compensated and highly motivated. We also have to deal with the frustrations and dissatisfactions you pointed out earlier."

"How about transparency and understanding of how the system works?"

"Yeah, it's frustrating to work in an environment replete with requirements you don't understand and, as you pointed out earlier, it's almost impossible to systematically improve the effectiveness of an operation unless it's transparent and well understood."

"One last question and you're ready to graduate with flying colors. How does our current insurance-based approach match up against these objectives"

"I guess it doesn't really do very well on any of them."

"Exactly. Your statement of the objective and responses to my questions are a great description of where we want to go. They should also remove any doubts you might have about the necessity of moving to single-payer."

Building Support for Change

"OK Wyatt, I'm following your arguments about the problems with private insurance and middlemen. and you've sold me on the necessity for moving to a single-payer system. At the same time, I keep wondering why all my friends are as happy with their insurance as I am. And to most of them, single-payer is a four letter word."

"Governor, most people do believe that insurance is the best, or at least a good, way to get access to healthcare. It's certainly been heavily promoted that way. But that really only applies to those who can afford both the premiums and the out of pocket costs as we've discussed. More than 50% of the population is covered by employer-based insurance which is heavily subsidized by the tax preference which effectively allows employees to pay for their insurance with pretax dollars. But the great majority of those employed are in the 12% marginal tax bracket so most of the foregone taxes of over $300 billion benefit the higher income groups. Moreover, the people in the lower income groups can least afford the out-of-pocket costs and that explains their financial concerns and their anxiety about being able to get care when they need it as we discussed at the very beginning

"You, and I would guess, most of your friends are either covered by employer-sponsored private insurance or Medicare or both and they usually don't have to worry about paying out-of-pocket costs. They may be concerned about the fact that our spending on healthcare is approaching 20% of GDP but they don't see it as a problem for themselves personally. They're wrong, of course, because they're ignoring the impact is has on their personal

tax bills and the drag that all this wasteful spending and misuse of talented people is having on the economy. That's one of the problems with getting anything done. Our most influential people are not prepared to fight for change and the people who are being most poorly treated don't have the wherewithal to have a strong voice in the debate.

"A more insightful way to think about private healthcare insurances and, to a lesser degree, Medicare and Medicaid is that it rations care based on ability to pay. That highlights some of the problems I've already mentioned and, of course, rationing care based on the ability to pay is the diametric opposite of the universal care that's a major element of your platform."

"I guess I can try those ideas with my friends, but they'll take some convincing

"Getting the more influential people in the country to see the benefits of moving to single-payer will be a walk in the park compared to contending with life or death resistance from the private insurance companies and their partners in crime, the Pharmacy Benefit Mangers. About 55% of the population is covered by employment-based private insurance and another 12% pay directly. And, unfortunately, the top 6 insurance companies control more than 60 % of the market for private insurance and the top three and their captive Pharmacy Benefit Managers also control about 80% of the market for prescription drugs."

"That seems like a formidable combination of power and influence, Wyatt."

"It certainly is but, as you know, the polls have moved in the direction of support for universal access and, in particular, to support for single-payer."

Inno let out a reflective sigh. " Well, it's nice to see something moving in the right direction."

"That presents you with a real opportunity to break the monopolistic control of our healthcare exercised by the insurance companies and the PBMs and return it to the healthcare providers. Tinkering with it won't work as prior efforts at reform have shown. And the wholesale expansion of services to be paid for by new taxes which Bernie tried to sell hasn't worked either."

"As we discussed before the break, the expansions of access that have worked and accomplished a very significant part of their objectives are Medicare and Medicaid both of which are versions of a single-payer system and are popular and growing in the number people of enrolled. As we discussed, neither is perfect but the results are a good counter argument against the assertion that government can't do anything right which is the mantra of many conservative opponents of single-payer. For example, the administrative costs of Medicare and of Medicaid amount to about 4 or 5% of total expenses while that number has been estimated to be as high as 20% for the private insurers. The government is doing something right.

"Our love affair with private healthcare insurance is at the heart of both our cost and access problems and the lack of transparency is a hindrance to ensuring the quality of care as well. We have to think about access to healthcare not as a good to be purchased like an automobile but as an essential feature of a well-functioning society. That's what every other developed country does.

"Inno, again. OK Wyatt, how would we get started? What should be our strategy for, first, getting me elected and then manag.ng the transition to single-payer? How do I go about convincing the voting public that I can deliver on my promise of equal access to health care for all Americans?"

Synthesizing a Strategy

Wyatt took a deep breath and responded. "OK. Since the meaning of a strategy is so often misconstrued let's start by use a definition of strategy that I coined in a former life."

"A strategy is an integrated set of actions aimed at achieving a clearly defined set of objectives"

"We'll focus on the phrases "integrated set of actions" and "a clearly defined set of objectives". Every aspect of your transition plan to single-payer has to spell out actions that are coordinated with and reinforce one another. That narrows the space for compromise but is essential to any well designed system which is what we need, and what we want. The approach we arrived at through piece-by-piece politically-driven compromises is what got us to where we are now. The answers you just gave to the question I asked are both a good summary of the key objectives and a good starting point for spelling out the actions required to achieve them.

"In many ways, once you get it established, AHA will be the linchpin for success of the single-payer system. It will have the responsibility for both specifying more concisely and concretely the objectives you just spelled out and energizing specific and carefully integrated action plans for achieving them. As I mentioned earlier this will require AHA to enjoy a level of independence and influence comparable to the Federal Reserve. Just as the Federal Reserve is responsible for keeping the financial system of the United States healthy and functioning at a high level of efficiency and effectiveness, AHA would be responsible for keeping the population of the United States healthy and productive by ensuring equal access to health care. We have to make the health of our people a national priority not something that depends so heavily on a person's ability to pay. Once the AHA is approved, organized and staffed, its first step will be defining a single, identical, comprehensive level of access that will be guaranteed for all Americans from the President to those below the poverty level. The Essential Benefits package spelled out in Obamacare will do fine as a start. It covers all major categories of healthcare including hospital and physician services and prescription drugs. In fact, the exact definition doesn't matter so much as long as its reasonably comprehensive because there will be continual adjustments as conditions change and experience is gained. This is a situation where it's better to be approximately right and adjust with experience rather than getting embroiled in an extended, politically driven debate."

"Well, Wyatt, The idea that keeping the population healthy should be a national priority is very compelling. Who can disagree with that? "

"When it's put like that, only a few. But if you asked ordinary people 'do you think that keeping you healthy, as an individual, is a government priority?', you'd get a majority of noes from the people who are "moderately concerned' that they won't be able to get the care when they need it. . And I think the evidence supports the noes."

Inno did a double take. "That's a very interesting observation, Wyatt. It converts the conceptual to the concrete. I have to think about that. Let's continue."

"What the transition plan will boil down to, no pun intended, is placing the responsibility for the two essential functions remaining after the elimination of the insurance companies and the PBMs, namely setting reimbursement rates and ensuring the integrity of the reimbursement system, in the hands of the AHA. It means eliminating an entire industry or group of industries. That can't and won't happen overnight. But there are some initial steps that will set a process in motion that will take you there over a number of years."

Inno again. "And I guess the AHA won't suffer from the cognitive dissonance of the insurance companies and the PBMs. They 'll have, as you mentioned 'a clearly defined set of objectives'. Any ideas on how it would be constituted and staffed.'"

"No, the AHA won't suffer from cognitive dissonance. As far as ideas about its organization and composition go, I've tried to avoid being overly specific about the makeup of the Board, but I think it should be bipartisan and include recognized leaders from the major professional groups representing the providers as well as consumer advocates. If you use the Federal Reserve model, there would be seven Governors and their terms would be for 14 years so that after the first 14 years a new governor would be appointed every two years which would, hopefully maintain is bipartisan makeup. While the Federal Reserve is a good conceptual model, you'll

have to think through the details from scratch and focus on including people with the capability to get the two essential tasks of pricing and administering reimbursement done well.

"I do have some thoughts, however, on how you should get the transition process started.

"Once you have the AHA approved and operating, you'll need some additional enabling legislation. The first provision would require all insurers, both private and government to provide the aforementioned identical Essential Benefit package as their base plan separately priced and administered. Those insurers who chose to do so woud be free to offer supplemental insurance but the market woud be limited because of the comprehensive scope of the Essential Benefits package. The identical package would be required in all base plans whether for an individual self-payer or a large group purchaser. This would force a downsizing of the private insurance companies driven by market forces; a natural consequence of eliminating the complexity of choice. It will also be mirrored in all providers throughout the healthcare system who would no longer have to navigate the complexity of our current BIR system. The downsizing and layoffs would be most dramatic in the insurers. However, because the inefficiencies on the provider side are so widely distributed throughout the entire economy, the layoffs in the providers would be quiet manageable and welcomed by them. And, as already noted, the physicians and other professionals would be delighted to be relieved of the administrivia of complexity.

"The second, perhaps concurrent, piece of legislation would call for all other government insurers including Medicaid to be consolidated into Medicare as well as all of the uninsured population. The States would have no role in the federal single-payer system. Taken together these two actions would bring you to very close to universal access both on the private and public side

"Slow down, Wyatt, won't including all the uninsured in Medicare be a serious financial burden."

"It will be less than one might think since our safety nets provide access to all comers and a substantial portion of the costs of major health care needs are already accounted for including all hospital costs. I haven't been able to find a precise answer to your question but another mitigating factor to consider is the cost of not providing care when needed certainly escalates the cost of treatment at a later date. The net costs are probably in the range of tens of billions of dollars but not enough to deter us from moving to single-payer.

"The third step, which could also be legislated concurrently, would be to assign the responsibility for setting reimbursement rates for all FDA approved drugs to the AHA effectively creating a single formulary managed by the AHA. That will eliminate the need for the Pharmacy Benefit Managers. The resulting simplicity and increase in transparency will also create the opportunity for systematically reducing costs throughout the system and reducing overutilization and fraud especially when one considers the rapid development of AI and its capacity to quickly identify discrepancies in the amount and type of care delivered.

"The final step in the transition will take place once all the private insurers, Medicare, Medicaid and the other government health systems are all operating with the Essential Benefits access package. At that point, AHA would oversee the final steps into a fully integrated single cohesive system. It will be a streamlined version of Medicare for All and Bernie's dream will have come to pass.

"This will take control of access out of the hands of the insurance companies and the PBMs whose primary motivation is to be as profitable as possible and place it int the hands of AHA whose only motivation is to provide universal access to high quality care at the least possible cost. Going back to the "perfect" healthcare system I described right at the beginning the direct relationship between the patient and the provider would be restored. The AHA would have only two operating responsibilities; establishing appropriate levels for reimbursement of the providers and ensuring that the care delivered was necessary and paying for it. In other words, AHA would become the sole intermediary between the single-payer and the provider. It's only other main function will be to negotiate a multi-year funding plan with the Congress and agreeing on the percentage of GDP that the nation can reasonably be devoted to healthcare. Adhering to a limit on spending will present a continual challenge as more effective and more expensive therapies are developed and the population continues

to age. That will present some difficult decisions that should be approached in an anticipatory rather than a reactionary way."

Inno spoke up. " OK, Wyatt, how do we make it fly. How do we avoid going down in flames like Bernie?"

"Making it fly will be your job, Governor; but let me try to explain how you might approach that daunting task."

"First, you should adopt a different philosophical stance than Bernie. His communications heavily emphasized that access to health care was a human right which is arguable at best and not surprisingly, lost the political ideologues on the right. Moreover, he expanded the range of services and planned to finance Medicare for All with additional taxes on both employers and individuals which offended not only conservatives but also many of our wealthiest and most influential people. You should avoid the humanitarian argument and approach your rationale from a more practical point of view emphasizing that, while universal access is a noble humanitarian objective, it isn't a right, it depends on having the necessary resources and deploying them appropriately. Keep referring to the very real enormous cost savings of transitioning to a streamlined single payer system and deferring increases in the range of services until your plan has proven its affordability. Keep repeating that a single-payer system based on the existing Essential Benefits range of services, but with limited copays and deductibles will produce a much healthier population at more affordable costs and could well provide room to decrease taxes. It would also produce major economic benefits both in increased productivity and because the rate of increase in the need for care, especially chronic care, would be decreased. Once the streamlined single-payer system is up and running the questions of how to expand the range of services can be addressed on a benefit/cost basis.

"Because a single-payer system accepts the health risk for all Americans it will end the insurance company/PBM monopoly once and for all by rendering it superfluous and the monopoly would become a niche industry concentrated on a very small market for private, supplemental insurance and, perhaps, play a role in the single-payer reimbursement process.

"Second, you have to clearly demonstrate that the reduced costs of simpler billing, insurance and reimbursement (BIR) processes in both the private and public sectors, the increased income from elimination of the tax preferences for Employer Sponsored Insurance, and the elimination of middlemen will far outweigh the costs of providing additional access. The income from discontinuing the tax preference will come immediately upon implementation and the savings from requiring all insurers to provide the same Essential Benefits package will begin to materialize as soon as the downsizing begins and move rapidly, especially in the administrative staffs of the providers.

"Third, you will have to emphasize that our current system is a major distraction for the providers that significantly increases costs, puts excessive demands on their time and reduces their capacity to provide care. It has also led to widespread dissatisfaction and discouragement for the professionals who deliver the care and the patients who receive it.

"Finally, you will have to demonstrate that the essentially total transparency into provider operations will facilitate a systematic approach to reducing costs and accelerate the introduction of innovative new evidence-based treatments as well.

"Remember simplicity is your friend."

Innocentia spent the next week preparing for her debate with Uncle Joe. As she got into it and became more and more comfortable with the healthcare segment of her platform, she had an idea; she'd hold a press conference and, hopefully, put Uncle Joe on the spot by getting out in front of him on single-payer and putting him on the defensive.

* * *

Innocentia Speaks Out on Health Care

Here's how she handled it.

"Thank you all for coming on such short notice. it's aways a pleasure to interact with the media and enjoy a little give and take on the issues.

"So much has been written and said about the mess our healthcare system is in and so many different solutions have been offered that one hesitates to add to the cacophony. So, I'm going to be short and sweet in my prepared statement and leave plenty of time for questions.

"First, the good news. The best health care in the world is delivered in the United States. The centers for innovation in pharmaceuticals, biotech, and medical equipment are in the United States. We are home to a dizzying array of world-class academic medical centers as well as many, many excellent community hospitals, doctors, and other health care providers. We know how to deliver outstanding medical care in this country; that's not where the problem is .

"Now, the bad news. First, we haven't figured out how to cope with the costs of increasingly expensive medical care including biopharmaceuticals. Second, the underlying assumptions that are driving the way we think about health care insurance are badly flawed and have led to misdirected government subsidies, large numbers of uninsured and underinsured people, mind-boggling complexity, and enormous bureaucracies. This complexity delivers little value and creates enormous unproductive costs both for the insurers as well as for the providers.

"In other words, there is a dramatic disconnect between the design and intent of our government's health care programs when compared to the real needs of our population and in light of the realities of high-powered, very expensive modern medicine. Tinkering with our current approach simply will not solve our problems. We need a fundamental redesign. We have to provide universal access for all Americans, and we have to do it without breaking the bank.

"My Administration will make ensuring access to healthcare for all a national priority comparable to ensuring the soundness of our financial systems and establish a new agency comparable to the Federal Reserve and insulated from the politicization of healthcare that has created the incomprehensible and ineffectual non-system that has gotten us into this mess. I've tentatively entitled the new agency the American Health Agency or, for short, AHA.

"Since I'm a Republican it may come as a surprise to some, if not all, of you that I'm going to charge AHA to move as quickly as possible to a single payer-system which has heretofore been liberal territory with the notable exception of President Biden who seems to be on the fence.

"I've concentrated very heavily on understanding the potential of a single-payer system and concluded that the benefits of moving to single-payer are enormous, the costs are substantially lower and the disruptions the transition will inevitably cause, though challenging for some, will be quite manageable.

"Here's what I propose.

"AHA will be responsible for designing a federally financed single-payer health care system that will provide every American with identical access to necessary medical care as defined by the Essential Benefits mandate of Obamacare . The federal government will assume the risk of serious health problems and so there will be no need for insurance or insurance companies. Medicare and Medicaid are already single-payer systems, and they will be relatively easy to integrate . Once the risk is removed, the only remaining functions provided by the

insurers are to negotiate prices with the providers and to reimburse them when they ascertain that necessary care has been delivered. AHA will be responsible for ensuring these functions will be efficiently and effectively carried out. Similarly, prescription drug pricing will be the responsibility of AHA and the Pharmaceutical Benefit Managers which are now under such fire by both the Congress and a majority the States will become just another bad memory.

"The United States Healthcare System will become a system for the first time ever. It will consist of only three parts: AHA, the providers of health care e.g., the hospitals, physicians and other professional and the biopharma companies and one or more intermediaries responsible for ensuring the integrity of the reimbursement system. It will also be fully transparent and comprehensible to all American. It will be completely financed from general revenues, and I expect the move will result in substantially lower spending on healthcare and, accordingly, lower taxes

"I said I would be short and sweet and that's it. Seymour will distribute a more comprehensive and detailed description of and rationale for what I've just outlined at the conclusion of the conference complete with references to the sources of information and data that led me to my conclusions.

"We have plenty of time for questions and I'm sure there'll no shortage."

Inno Answers the Questions

There was a flurry of activity in the audience and a lot of reaching for cell phones as multiple hands rose to seek the floor.

Inno selected the first reporter. "Tom?"

"Governor, there has been some speculation that you were considering single-payer, but this announcement is a surprise, and you seem totally committed to it . It will be the most important piece of your platform. What prompted you to act so quickly?"

Inno was ready. "As I mentioned in my opening remarks, I believe ensuring the best possible health for all Americans should be a national priority and completely divorced from an individual's ability to pay. That means having access to our world-class healthcare providers becomes a responsibility of the federal government - the essence of a single-payer system. Once the risk has been removed there is no rationale for insurance. And when you remove the responsibility for assuming the risk that leaves only two tasks that are performed by the insurance companies and the PBMs: negotiating the prices, i.e., reimbursement rates, and ensuring the integrity of the reimbursement system. With an identical level of access for all Americans, both of these tasks become highly simplified and can be performed by a single federal agency. They will be carried out under the direction of the AHA and we'll cut over a trillion dollars from national spending on health care and take some pressure of the Medicare Trust . It's that simple.

"Dick?

"Governor, what about all the other intermediaries like, for example, HMOs and PPOs? Don't they provide a necessary function by providing access to different groups of providers?"

"Well, as you know they're just different types of insurance companies; they simply segment the market for access to providers based on ability to pay; exactly what we're trying to avoid. They become superfluous in a single-payer system."

"Harry?

"Will people still be able to use their own physicians; what will this do their access to providers? won't this be very disruptive to the patient, provider interface."

"On the contrary. The primary ways that the providers, the doctors, the hospitals, will be affected is they'll see a significant drop in their administrative expenses and have a more direct relationship with their patients. All aspects of our health care delivery system will also experience an increase in capacity. The only other difference is the providers will be reimbursed by the federal government directly."

"Matthew?"

"This may be good for patients and providers, but the insurance companies won't like it. This will essentially destroy the healthcare insurance industry. Doesn't that give you some concern? How do you plan to deal with the fallout from this announcement?"

"Well as a start I'll be looking in both directions before I cross a street. I certainly do have some concerns for the impact on investors and employees but, as President, the needs of the country trump the needs of all others. That having been said my team is completing a transition plan for a controlled downsizing to minimize disruption as much as possible. But there will be blood in the streets. Seymour's handout outlines our thinking on the transition. But for the moment my main concern is convincing the people of our nation of the wisdom, actually I believe the inevitability, of moving to a single-payer system and the polls have been showing a much better understanding of the need. I have Bernie to thank for that. And once I'm elected I'll have to work it through the Congress but first things first. I hope all of you will continue to probe me as the campaign goes on and keep your audiences fully informed of the wisdom of this decision."

"Mark?"

"How much will this actually reduce our spending? It better be monumental to justify the disruption."

"There are three main components. The first and easiest to estimate is that the tax preference for Employer-based insurance will disappear along with employer-based insurance. That's over a $300 billion dollar increase in income tax revenues for the federal government starting with enaction of the enabling legislation. We can expect the premium expense for the employers will be converted to wage increases for their employees so it will be a wash for the employers as far as deductible expenses although they should be able to make some cuts in their benefits staff. The wage increases will, of course, be a windfall for all the employees especially in the lower income tax brackets.

The savings from the reduction in the costs of complexity of the hybrid financing are much harder to estimate because of the complexity and the shortage of hard data. The last detailed estimate of the costs of reductions in the cost of billing, insurance and reimbursement was completed in 2014 and showed a reduction in about 15% of total spending on healthcare. Recognizing the dangers of extrapolation that would amount to about $645 billon in 2021. Then you have the elimination of the PBMs and the other middlemen that our current approach has spawned, the impact of increased transparency on the ability of the providers to systematically reduce costs including better control of overutilization and fraud. There's also some simplification of Medicare and Medicaid which will come along and will bring the total number to well over a trillion dollars or about a third of our total spending on healthcare. I think that's monumental.

"It's a win, win for everybody except the insurance companies and the other middlemen and, unfortunately, their investors and employees.

"Luke?"

"Well, everybody knows that our healthcare non-system is a mess but the amounts you just went through were a bombshell and, although I'm sure there'll be a lot of controversy, the way you categorized them has the ring of reality, imprecise as they may be. How did we get in this mess? Who was minding the store?"

"That's a great question and the material Seymour will provide you with in a few minutes will lay out a brief history. It puts one in mind of the myth of the frog that ends up in the boiling water. Our leaders knew that healthcare was changing and made some piecemeal changes, including some very large ones like Medicare and Medicaid. However, we never really fully grasped the fact that piecemeal changes weren't going to really deal with the problems and opportunities provided by the rapid changes in medical science and technology and, in particular, the tremendous increases in the costs of care and the increased needs of an aging population. Who was watching the store? We all were. There were some voices in the wilderness but too few of us were listening. I'm not going to point any fingers. We have to fix the problem. Forget trying to figure out who's to blame and how to punish them. it's a waste of time."

"We have time for one more question. John?"

"Governor, with all due respect, there are a lot of people out there, I'm one of them, who believe the government can't do anything right! How do you plan to deal with them."

"John, that's such a great question to end on that some people are likely to think it was a plant. There are two very relevant examples of the government doing something right, Medicare and Medicaid. Neither one is perfect; they're both ridden with compromises, but both are essentially single-payer systems and they've done great things for the people of the country. Sure, the Medicare trust is running out of money but that's a symptom of the lousy job we've done so far with managing our healthcare and exactly why we need to complete the job of transforming our healthcare into a streamlined single-payer system that's affordable. Remember that the perfect is the enemy of the good.

"We can do this."

Fred Gluck June 9, 2023