

Issues for Single Payer Legislation

1- Who is covered

Undocumented immigrants - yes; residency requirement - 60 days, except emergencies, pregnant women & children - longer for long term care eligibility

2- What's covered

Global statement (eg. all medically necessary and effective services) rather than list; mechanism to update (eg. board with representation of consumers and experts); what besides acute medical (long term care, mental health/substance abuse, rehabilitation); alternative medicine (medically necessary & effective).

3- Governance

Elected board vs. political appointees; ombudsman/Citizen Utility Board model

4- Hospital & Nursing Home Payment

Global budgets; separate operating and capital funds, unspent operating funds returned to NHP; capital allocated by regional planning agency; inpatient costs for HMO patients included in hospital budget not HMO budget; limits on executive compensation; capital purchased with philanthropic gifts cannot obligate NHP operating revenues unless capital project is pre-approved; ? require more democratic representation on hospital boards.

5- Physician/outpatient payment

Fee-For-Service - negotiated total FFS payment with binding fee schedule to reach negotiated total; cost control through fee reductions if target is exceeded or caps on individual doctors' billing; doctors cannot bill for services provided by PAs etc, though may receive global budgets to cover their salaries.

Institutions - HMOs, NHCs, group practices etc. would receive global budgets as for hospitals, with same restrictions on capital etc.

HMOs

Global budgets with regulations same as hospitals; disenrollment at any time; eliminate purely financial HMOs which are really insurance firms - HMOs that do not directly employ physicians on salary and own their own facilities to deliver care would be eliminated.

7- For-profit institutions

Existing equity evaluated and owners/shareholders paid depreciation plus a fixed return on equity; new for-profit investment proscribed;

8- Parallel private coverage & extra billing

Coverage that duplicates public plan prohibited; health providers who take any payment for covered services from any source other than the public plan may not receive any funds at all from the public plan.

10- Free standing labs, X-ray, MRI etc.

Globally budgeted with same restrictions as hospitals; for-profit investment as in 7.

10- Border crossing

Patients from other states treated in Mass hospitals billed on a simple per diem; Mass residents cared for in other states - hospitals paid per diem, other care paid at Mass. rates.

11- Mental Health/Substance Abuse

Global budgets for institutions/clinics; separate expenditure targets for each mental health profession licensed to bill FFS (eg. physicians, social workers, psychologists); ? how to better target services to need

12- Long Term care

Eligible after 1-2 year residency; regional board certifies need for services and allocates resources according to need; full range of home and institutional services paid from single budgetary pot; upgrade quality and worker's pay; eliminate institutional bias.

13- Resources & personnel for undeserved areas

Fee/pay incentives to locate in undeserved areas; capital investment targeted to undeserved areas.

14- Financing

Must be more progressive than present; taxes on unhealthy behaviors/products; initially partly mimic existing funding patterns.

15- VA system integration

Leave undisturbed at outset

16- Quality

Statistical monitoring systems, CQI approach vs. punishing incompetence, community-wide quality.

17- Medical education/specialty distribution

Graduate med ed funds used to lever hospitals to adjust mix of training programs; funding for experiments in non-hospital based primary care training; rational referral patterns encouraged to eliminating specialists' fee premiums when they see patients as their primary care physician rather than on referral from a primary care physician.