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To: Single Payer Activists

Re: Planned revisions of H.R. 676, the single payer bill in the House of Representatives

From: David U. Himmelstein, M.D. and Steffie Woolhandler, M.D., M.P.H.

We write to express both hope and concern regarding planned revisions to H.R. 676, the single payer bill in the House of Representatives that was closely modeled after PNHP's proposal for reform published in the JAMA. The bill has been a focus for single payer activism since its introduction in 2003.

As members of the Single Payer Caucus in the House of Representatives consider revising the bill, we urge them to add a provision that would protect reproductive rights that is included in the Senate's Medicare for all bill (S.1804), and to avoid adopting S.1804's problematic approaches to provider payment and for-profits providers' participation.

What activists can do: Contact your congressperson

If your Congressperson is a current co-sponsor of H.R. 676, call or email them to urge them to support the needed change to the bill indicated below, and to oppose weakening the bill by removing payment provisions that, while seemingly arcane, are critically important. You can reach the Capitol switchboard at 202-224-3121.

What to add: Reproductive Choice

At present, H.R. 676 is silent regarding the Hyde Amendment that forbids using federal funds to pay for abortion. We'd suggest adding the following provision that's included as section 701(b)(3) in S.1804:

"RESTRICTIONS SHALL NOT APPLY.—Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund."

What to keep: Healthy Payment Strategies

Don't change the provider payment mechanisms specified in the current draft of H.R. 676, particularly paying hospitals and other institutional providers global operating budgets which cannot be diverted to profits or new capital investments for expansion or modernization, with separate grants for such investments.

Global budgeting with separate, explicit capital allocation provides a “cost-neutral” payment framework, minimizing hospitals’ incentives to avoid (or seek out) particular patients or services, upcode, or inflate volumes by providing low-value care. Global budgets are also key to realizing

administrative cost savings within hospitals since they eliminate hospital billing and relieve clinicians of billing-related documentation.

Unfortunately, S.1804 adopts Medicare's current payment system that mandates wasteful per-patient billing, and rewards hospitals willing and able to game the complex payment incentives. Adopting Medicare's payment approach would sacrifice a large portion of potential administrative savings, and undermine health planning since business-savvy hospitals would continue to have the funds for new investment regardless of community needs, while unprofitable hospitals would spiral downward even if they provide vital services.

In particular, we caution against adopting Medicare's so-called value-based purchasing strategies that have triggered the explosive growth of ACOs. It is now widely acknowledged that ACOs have actually increased Medicare's costs, while fostering the takeover of hospitals and physicians' practices by giant corporations. Medicare's "pay-for-performance" incentives have triggered massive and expensive efforts to game the quality measures, but have not resulted in improved outcomes for patients. For instance, Medicare's readmission penalties appear to have caused hospitals to classify more overnight stays as "observation" stays, without actually decreasing readmissions, and may well have increased deaths among seniors with heart failure.

What to keep: A ban on payments to for-profit health care providers.

A raft of studies have concluded that for-profit providers (including hospital, dialysis centers, nursing homes, home care agencies, and hospices) provide inferior care at inflated prices. See, for instance here and here and here.