In health care, if there is agreement on one issue, it is that the system does not work nearly as well as it should.

Cost, quality and insurance coverage remain problems to be solved in the United States, which spends far more per person on health services than any other country in the world.

The Affordable Care Act during the Obama administration put in motion significant changes with a philosophy that government should play a larger role. Republicans in Congress and the White House failed earlier this year to pass their American Health Care Act, but still hope to eliminate key provisions of Obamacare and reduce Medicaid funding to the states.

Four prominent health care leaders in Western New York sat down this week to talk about the uncertainty in a discussion organized by the University at Buffalo School of Management. They examined what’s working, what isn’t, the challenges moving forward and the prospects for even greater change – a single payer health system similar to Canada’s.

Chaos is not the environment we want to live in, so we strive for certainty and stability. We have to ground ourselves in what is important to our patients and community, and what is important to our system. So, we focus on several things, the first of which is quality – patient safety, outcomes, patient experience and efficiency. We can focus on those things because providing value to the community and patients will ultimately win the day. What happens in Washington, or with legislation in Albany, those things will impact us, but it will have much less impact if we can provide the quality that our patients and community deserve.

– Dr. David P. Hughes is executive vice president and chief medical officer of the Kaleida Health hospital system.

Doctors were not divided at all on the American Health Care Act. I don’t care what side of the aisle you prefer. It was a terrible bill that would have hurt people dreadfully and not accomplished very much.

The Affordable Care Act clearly improved coverage. No doubt about it. But what I have heard repeatedly and what doctors worry about is that patients come for care and then don’t pay their co-pay or they have not met their deductible so the doc does not get paid. But the thing is the Affordable Care Act did not do this. It accelerated a situation that was already here. We had high deductible plans prior to the ACA.

– Dr. Nancy H. Nielsen is senior associate dean for health policy and a clinical professor at the University at Buffalo Jacobs School of Medicine and Biomedical Sciences. She is also a past president of the American Medical Association.

There is a lot of noise in Washington and ultimately it is about who is going to pay – the government, individuals? We try to look past the noise, and go back to the idea of the triple aim – better quality, better experience, affordability. That is what has driven us.
While attention is focused on the Affordable Care Act, another major piece of legislation is lesser talked about. That’s MACRA (Medicare Access and CHIP Reauthorization Act), a completely bipartisan action that redefines how Medicare pays for services now and sets the stage for how all health services will be paid for in the future. It moves us away from paying for activity or volume, and instead paying for results or value. We believe this is a really important direction for the country to move in, particularly as we move into a more transparent age when more information is available to providers and consumers.

—*Dr. Michael W. Cropp is president and chief executive officer of Independent Health.*

The only certainty we have at the moment is uncertainty. We all expected a significant change after the election. Now, as late as last week, we hear there is a new proposal brewing, but have no idea what it looks like at this time.

We are focusing on how we can continue to improve quality and cost reduction. This goes beyond duplicate testing and unnecessary treatment. We need to challenge ourselves as a community well beyond health care to take a more active role in other issues, such as palliative care and life care. There are strong initiatives in Western New York but have long way to go in changing the norms of society. We also need to eliminate unnecessary emergency room visits by providing more care to people in primary care offices, in their homes and in alternative settings. We are starting to see some impact due to multiple initiatives.

—*Dr. Michael J. Edbauer is chief clinical officer of the Catholic Health hospital system, and president and chief executive officer of Catholic Medical Partners, which represents the more than 1,000 doctors affiliated with the system.*

Could U.S. move to single-payer system?

*A single-payer system would be like Medicare for all, in which a single government entity handles health coverage instead of insurance companies, but care remains provided largely by private doctors and hospitals. The panelists discussed why some doctors have come around to the idea.*

**Edbauer:** Not due to anyone’s fault, when you look at the true administrative cost of health care, it is staggeringly high. There are costs at the level of the payer, whether the government or the insurance company. There is an administrative cost in hospital systems, at the physician’s office and every other person who touches a patient. Part of that is due to the fact that we have complicated processes, multiple ways of being paid, and all this goes to the question of whether a single payer, regardless of who the payer is, would help streamline and bring down some of the costs.

**Nielsen:** I was at the New York state medical society meeting (recently) and was stunned. There were resolutions and extensive debate on a single-payer system. I never thought in my lifetime that I would hear that at our state medical society. But I’ll tell you that if the chaos continues and people are hurt, that is where we are going.

I never did support it but am beginning to re-look at it – even if they may take away my AMA past presidency (said jokingly).

**Cropp:** A single payer system could work. I shudder to think the government could do it based on fee-for-service Medicare and the VA, and based on the need for greater accountability. Yet we do need to have administrative simplification. Right now, economic forces just don’t work in health care. We need
to find a model that enables economic forces to work – on the pharmaceutical side, the provider side, and the payer side.

Edbauer: We’ve seen a real change at the grassroots level. We used to hear doctors say they’ll quit practicing before they accept single payer. Now, out of frustration, they’re saying it is what we need. Hospitals are beginning to lean in that direction, as well, primarily because of the administrative costs and the complexity. The complexity of the billing and payment structure leaves most consumers quite dissatisfied with their overall experience, and it’s understandable. Everyone has probably seen when you get a hospital statement or a doctors statement – what’s paid by the insurance company and what’s your responsibility.

Sometimes the first statement is different from the final one – charges versus what they accept as payment. The doctors office is trying to figure out how much they have to collect from this person, do they have co-pays, or deductibles, and does the doctor have to collect that money. Or did you have an appointment somewhere else and paid your deductible there, and now a doctor’s office has to issue a refund. None of that has anything to do with delivering health care. It is not making you healthier. Out of necessity we are going to have to seriously look at single payer. Does it have to be the government? Not necessarily. But there has to be some standardization across the country or at least in each market.

Should block grants be used to fund Medicaid?

In Medicaid, states, counties and the federal government now combine funds to provide coverage to everyone who qualifies. Republicans want to cap federal spending in certain ways, one of them known as block granting, and, in return, allow states to impose enrollment limits or reduce eligibility levels.

Hughes: Block grant funding for Medicaid in New York would be devastating for hospital systems.

Edbauer: If there is less money coming in from the feds, you can either raise your taxes, reduce eligibility, reduce benefits or reduce what you pay the people who provide the care. Any one of those scenarios, other than raising taxes, all end up with running the risk of more people going to the emergency room for their primary care. And New York would be one of the states most negatively impacted.

Nielsen: Nearly half of Medicaid spending is for people in nursing homes. What are we going to do when this is block granted? We in this country have not figured out how to handle long-term care. If you are going to change it, you better have something in place that is not going to hurt people.

Why have medications costs skyrocketed?

Many drug prices are soaring, especially for specialty drugs for complex conditions, and there have been more instances of price-gouging by some manufacturers, including for generics that are supposed to be low cost.

Nielsen: Other countries negotiate the price of drugs. Congress has not allowed that. If you wonder why, all you have to do is look at the contributions to members of Congress in election campaigns. Now we are a poster child for ridiculousness, such as with the price of the EpiPen. There are so many other examples. We did not get any significant reduction in pharmaceutical prices when we had a Democratic president and a Democratic Congress. And we are not going to get it under this president and this
Congress, despite what you heard on the campaign trail. People are helpless. Insurers are held hostage by the cost of life-saving pharmaceuticals, as well as simple medications that have been around for years.