June 15, 2019

Dear Regina,

Welcome to BioMarketing Insight's monthly newsletter.

Last month, I covered "Future Trends in Remote Monitoring Medical Devices." If you missed last month's article, click here to read it. This month we'll cover "Is a Single-Payer System or "Medicare-for-All" the Answer?"

Read on to learn more about this topic and other current news. The next newsletter will be published on July 15th, 2019.

We encourage you to share this newsletter with your colleagues by using the social media icons below, or by simply forwarding this newsletter or use the link below. Should you or your colleagues want to join my mailing list, click on the link below.

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Sincerely,
Regina Au
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BioMarketing Insight

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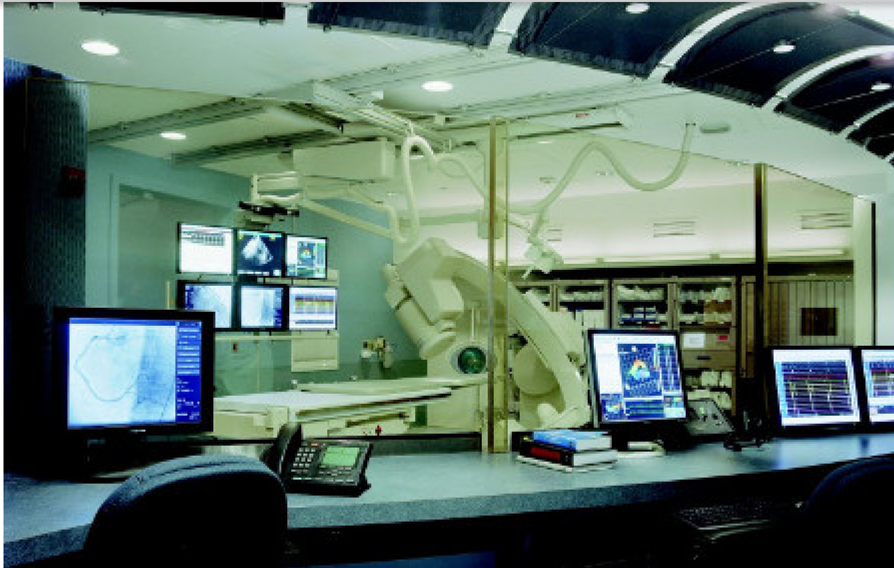

Developing a Product? Commercializing a Product?

If you are developing a product and have not conducted the business due diligence to determine commercial viability or success, contact me for an appointment. For successful commercial adoption of your product or looking to grow your business, contact me for an appointment.

For more information on our services, click on the links below:

Product Development
Market Development
Marketing Strategies

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Microbiome
Therapeutics
US

Save the Date: Microbiome Therapeutics Conference,
September 10-12, 2019 - Boston Convention & Exhibition Center

I am pleased to announce that I will be speaking at the Microbiome Conference on "Important Early Considerations to Developing a Successful Commercial Strategy," Wednesday, September 11, 2019. For more information, click here.

BioProcess International

Save the Date: BioProcess International Conference, September 9-12, 2019 - Boston Convention & Exhibition Center

I am pleased to announce that I will be speaking at the BioProcess Conference on "The Cost of Speed – How Preclinical Shortcuts Impact Molecule Value and Tech Transfer", Thursday, September 12th. For more information and to register, click here.

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LiveWorx Conference - June 10-13, 2019 - Boston Convention and Exhibition Center

I am pleased to announce that I presented at the LiveWorx Conference on "Future Trends In Remote Monitoring Medical Device" on Tuesday, June 11, 2019. There were more than 7,000 attendees and the conference offered 12 industry tracks, 4 Keynote speakers, 4 Livetalk speakers, 16 Track Spotlight speakers and more than 240+ breakout sessions. For more information click here.

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3D Medical Printing Potential

I am pleased to announce that my article on 3D Medical Printing, Printing Potential has been published in the April 2019 issue of *Innovations in Pharmaceutical Technology* (IPT). This article reviews where 3D printing is the most beneficial and why. To read the article, click here.

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Updates in Solving the Mystery of Alzheimer's Disease Pathology

I am pleased to announce that my article entitled "Updates in Solving the Mystery of

timeline of biomarker abnormalities leading to cognitive impairment" and the involvement of both beta amyloid clearance and plaque, and tau clearance and tau-mediated neuronal injury and dysfunction. To read the article, click here.

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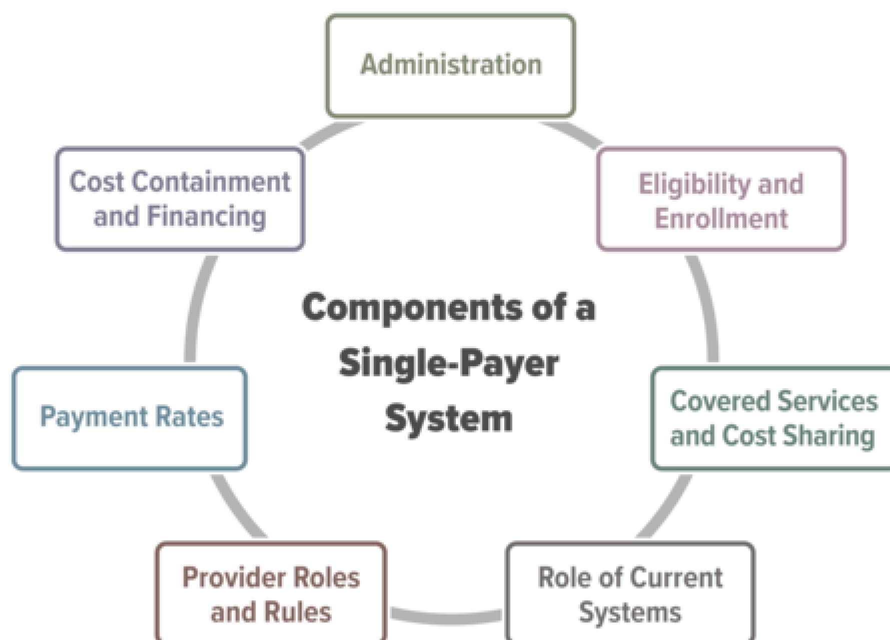
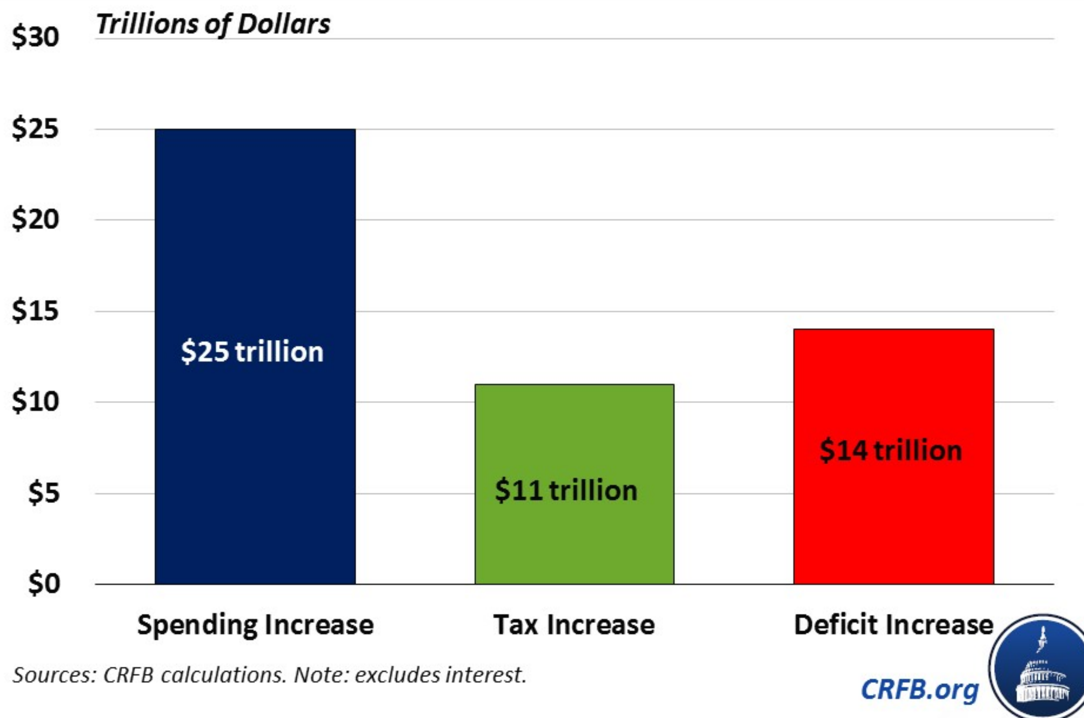


Is a Single- Payer System or "Medicare-for-All" the Answer?

Our current healthcare system is broken and needs to be fixed. But will a single-payer system resolve the problem because other country's single- payer systems look attractive from the outside and anything would be better than our current system?

Let's examine this proposed single-payer system proposed by Bernie Sanders closer. The Congressional Budget Office (CBO) issued a report on key considerations policymakers need to think about before they overhaul the U.S. healthcare system into a single-payer system which is very complex. There are five (5) takeaways reported by Paige Minemyer from FierceHealthcare and I will be commenting on each.

To read the full report from the CBO regarding Key Design Components and Considerations for Establishing a Single-Payer Health Care System, click here.



The CBO had one overarching concern:

To implement a single-payer system, a study by Mercatus Center at George Mason University, a nonprofit, a free-market-oriented research group estimated that the cost for "Medicare for All" proposals is between $32.6 trillion and $38.8 trillion over the first 10 years of implementation. That would account for somewhere between 11% and 13% of the GDP in 2020. The numbers in the graph above is from the Committee for a Responsible Federal Budget are different but it gives one an idea of the magnitude of the deficit.

According to Charles Blahous from Mercatus, he said "even if the country doubled the amount of income taxes, the results would still not cover the money needed to fund the change."
“Establishing a single-payer system would be a major undertaking that would involve substantial changes in the sources and extent of coverage, provider payment rates and financing methods of healthcare in the United States,” said the CBO.

Comment:
Who is going to pay for the implementation of this system? According to Fortune, in 2018 U.S. Health Care Costs was $3.65 Trillion and congress wants to spend 10x the current cost to implement a single-payer system over ten years or double the amount of healthcare expenditures every year for 10 years. Ultimately, it will be the tax payers as usual.

Changing from the current system to single-payer is overwhelmingly complex from a software perspective and getting people to change to a new system is difficult. More will

Consideration one: **There could be a role for private insurance—**or not

There has been numerous heated debates around how *Medicare for All* will affect private insurance companies since two-third of Americans are enrolled in a private plan and one-third in Medicare. Commercial plans could play one of three roles in a single-payer system, according to the report: as supplemental coverage, as an alternative plan or an “enhanced” plan to members in the government plan.

However, the private insurance would not be able to offer substitutive plans, because they could potentially offer broader provider networks or more generous benefits, which would draw people into them. A solution to this issue could be mandating that providers treat a minimum number of patients who are enrolled in a single-payer plan.

Rep. Tom Cole, R-Oklahoma at a legislative session said “*Medicare for All* really means Medicare for none.” It would robbed consumers of their choices, because it would end employer-based coverage.

Comment:
It will be a nightmare in switching two-thirds of the American population to a single-payer system from an administrative and paper work perspective and it's going to be slow because it has never been done before in the US. What are people suppose to do while they are in transition?

It is not clear as to the three roles that private insurance will pay in a single-payer system. If *Medicare for All* works similar to the current Medicare system, people will still need to purchase supplemental insurance since Medicare only picks up 80% of healthcare cost. In addition, Medicare only provides Part A&B and not Part D, prescription coverage. Part D is usually purchased through private insurance companies since the patient has to purchase supplemental insurance to cover the 20% that Medicare doesn't cover. Even with patients who have Part D covered through the Medicare Advantage program, they still need to purchase supplemental insurance for the 20% that Medicare doesn't cover.

Even with a single-payer system, there will still be inequality of healthcare coverage. The people who do not qualify for Medicaid if this still exist in the new system, may not be able to afford supplemental insurance for the 20% not covered by Medicare and they may also not be able to afford Part D. Those who can afford supplemental coverage and Part D will get better services and better coverage of medical care and prescription.

This will also shift the administrative burden on to the government for enrollment and processing all the claims and the insurance companies may have to lay off people since those administration jobs are gone or have been reduced.

In addition to Medicare and Medicaid, the federal government operates several other health programs targeting individual populations such as the Veterans Affairs health system, TRICARE and Indian Health Services.

“Those public programs were created to serve populations with special needs,” the CBO said. “Under a single-payer system, some components of those programs could continue to operate separately and provide benefits for services not covered by the single-payer health plan.”

Comment:

While the special needs people are taken care of if the government maintains those programs, what about the people who fall through the cracks? These people don't qualify for Medicaid nor any other government assistant program, yet they can't afford supplemental insurance, an alternative plan or an enhanced plan or Part D. These are the people we need to address if there is to be equality for all. These are the people who have to decide whether to pay for their medication or pay for food including people on Medicare because they can't afford to purchase supplemental insurance or Part D prescription coverage and have to pay for their medication out of pocket.

Doris Browne, M.D., immediate past president of the National Medical Association, talked about how necessary it is to creating equality in care. She talked about how minority groups are more likely to experience health inequities and have disproportionate amounts of chronic diseases.

Consideration three: **A simplified system could also mean simplified tech**

Taiwan’s government-run health system has a robust technology system that can monitor patients’ use of services and healthcare costs in near real-time, according to the report.

However, getting to a streamlined system like this in the U.S. would be bumpy, the CBO said. It would face many of the same challenges the health system is already up against today, such as straddling many federal and state agencies and addressing the needs of both rural and urban providers.

Comment:

A single-payer system is not simply to incorporate when one is starting from scratch or trying to incorporate a single-payer into our current software system is extremely difficult if anyone understand computers and software while still offer existing government programs for the special needs groups.

One can't compare Taiwan's government-run system as easy or robust since Taiwan has been using their current systems for decades and have perfected it over years to a well run system that they can monitor patients' usage of services and healthcare cost.

Two good examples of this would be when CMS decided to go from an ICD-9 system to an ICD 10 system, the implementation was pushed out for at least three year from the targeted deadline which at least three years from when they first started talking about the switch over.

Or when Obamacare mandated that everyone switch over to an EMRs system instead of paper. That was a total nightmare for everyone because there wasn't any guidance from the government or anyone else. People had to figure it out on their own and everyone did their own thing. I remember when EMR software companies were asking for guidance on how to proceed forward. And now we have software interoperability issues because everyone did their own thing rather establishing a standard framework and standard protocol for every everyone to follow in order to eliminate the interoperability issue. IT is similar to establishing super highway where all institutions could plug-into and be able to share and exchange information no matter where you are with permission from the patient.

Consideration four: **How to structure payments to providers? Likely global budgets**

Most existing single-payer systems use a global budget to pay providers, and may also apply in tandem other payment approaches such as capitation or bundled payments according to the report.

Global budgets are rare in the U.S., though Maryland hospitals operate under an all-payer system. These models put more of the financial risk on providers to keep costs within the budget constraints.

Many international single-payer systems pay based on volume, but the CBO said value-based contracting could be built into any of these payment arrangements.

Comment:

If the definition of a global budget is the concept of accountable care organizations (ACOs) where there is a lump sum payment per patient to manage their disease, this has not proven to work for many institutions classified as ACOs so far because the system is very complex. Institution have found that when they fix one piece of the process, they need to fix another piece and then another in delivering better healthcare according to these institutions presenting at healthcare conferences. It's getting there but slowly.

We already have a system similar to a global budget for hospitals called "DRGs" where the hospitals receive a lump sum for a procedure or hospitalization. In addition to DRGs, insurers are not paying for readmission if the patient comes back in 48 hours. Is this working for the hospitals?

If we look at past history, many smaller hospitals have gone out of business due to DRGs in addition to a number of other things. Today, there has been numerous consolidation of

Consideration five: **Premiums and cost-sharing are still in play, especially depending on tax structures**

A government-run health system would, by its nature, need to be funded by tax dollars, but some countries with a single-payer system do charge premiums or other cost-sharing to offset some of those expenditures.

The type of tax considered would have different implications on financing, according to the CBO. A progressive tax rate, for instance, would impose higher levies on people with higher incomes, while a consumption tax, such as one added to cigarettes, would affect people more evenly.

The CBO did not offer any cost estimates in terms of the amount the federal government would need to raise in taxes to fund a single-payer program.

Comment:

A single-payer system would definitely increase taxes whether it is income tax, sales tax or more taxes on social security which pays for your Medicare premium is taken out before you get your social security check. Will there be equality in care?

Nothing is free. In countries such as Germany, Sweden, Canada where there is a single-payer system where they receive free healthcare and education, they are paying for it with 40-50% (healthcares, education etc.) of taxes being deducted before they get their pay check.

In countries such as Canada, people purchase additional insurance if they want to choose the physician they want to see or cover things that are not normally covered. When they don't want to wait for an elective procedure, they come to the US to get it done and pay for it out of pocket.

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Closing Thoughts

There is no perfect healthcare system. Every system has it's pros and cons and going to a single-payer system has it's issues, we just don't know what they are until we are in it. Some countries with a single-payer system do charge premiums or other cost-sharing to offset some of those expenditures which defeats the purpose of a single-payer system in lowering cost and delivering equality in care.

Yes, our system is broken and it needs fixing but going to a single-payer system will be disastrous from a cost (2xs our current expenditure for 10 years) and implementation (administrative nightmare and getting people to change is extremely difficult in a short period of time) perspective as mentioned above. If we do move to a single-payer system, is there a guarantee that it will work or be better? No. Every country that has a single-payer policy is different because each country is different in terms of culture, politics, behavior, and mindset.

The best way to solve this healthcare issues is not by the politicians who don't understand how the current system works and imposes legislation based on what they think should be done, it just causes more problems.

Having a committee of people, one representing each stakeholder who thoroughly understand the healthcare system and reimbursement is far better equipped to solve the current system. This mean representation for the patient, the provider (physician, nurse etc), the hospital, the pharmacy, the drug/biologic/med device/diagnostic manufacturer, and the payer. At some point, everyone has to come together to figure out how to make it work where everyone is satisfied. Each stakeholder may have to compromise a little, but the alternative is far worse where we will have spent trillions of dollars and paid more taxes for a single-payer system that everyone hates.

This is my perspective on things. Would like to hear from you on your thoughts on this topic.

Should you have any questions or need of assistance with your business due diligence, determining your product's value proposition, target product profile and economic value of your product for reimbursement, feel free to contact me at 781-935-1462 or regina@biomarketinginsight.com.

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