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Single Payer Healthcare

New Developments in Structure, Cost, and Politics

Key Takeaways:

Single-payer health insurance in the United States has been politically and intellectually resurrected as a serious policy position. The single-payer debate has expanded to the state level, as well as gaining traction as a semi-mainstream national issue.

While "Medicare-for-All" is the predominant political messaging around single-payer, there are a myriad of potential manifestations of how single-payer health insurance could be structured beyond an expansion of the Medicare program.

There is nothing inherent in the single-payer model that would guarantee universal healthcare or equal quality of healthcare across the population, though proponents typically assume these goals would be part of a single-payer system.

Similarly, the structure of single-payer health insurance is neutral with regards to the issue of payment reform (e.g., single-payer could reimburse providers on a fee-for-service basis, a capitated basis, or another payment model).

National-level polling has shown mixed results with regards to the public's support for single-payer. Support for a "Medicare-for-All" program is high, but that support dips significantly when some of the potential consequences of a transition to a single-payer system are presented.

Attempts at the state level to implement single-payer healthcare systems have proven unsuccessful, with cost being the primary barrier.

There is deep debate and little certainty regarding the costs of a single-payer system, as well as the potential funding sources to support those costs.

Updates on Single-Payer Healthcare

Since the failure of Republican efforts to repeal and replace the ACA, single-payer has attracted an increasing amount of attention from both sides of the political spectrum. Several leading 2020 Democratic presidential hopefuls have touted single-payer healthcare. Former Acting

Administrator of Centers for Medicare and Medicaid Services (and Zetema Panelist) Andy Slavitt has stated that there is "at least a 50 percent chance that the Democratic standard bearer [in 2020] is going to be running on a single payer platform."

The current administration has come out strongly opposed to implementing a national single-payer system, but states seem to be exploring the possibility of their own single-payer systems. California is currently working on a single-payer system similar to the attempts made by Colorado and Vermont. The definition and implications of single-payer healthcare could affect its support among both experts and the American public.

The Single-Payer Debate

Many Americans support some of the key components of single-payer healthcare, such as the potential for universal coverage, presumed lower costs, greater equity, lower overhead, elimination of job lock and surprise bills, and reduced profit motive within the healthcare system. Others are opposed to it, seeing it as an unwelcome government takeover of the health insurance system that will result in higher costs, poorer quality, less innovation, higher taxes, and other concerns.

> "At the same time that M4A would dramatically increase federal spending, it would increase taxable worker wages net of employer-provided benefits, while also relieving individuals, families, and employers of the substantial health expenditures they would experience under current law."
>
> - Charles Blahous, George Mason University, "The Costs of a National Single-Payer Healthcare System"

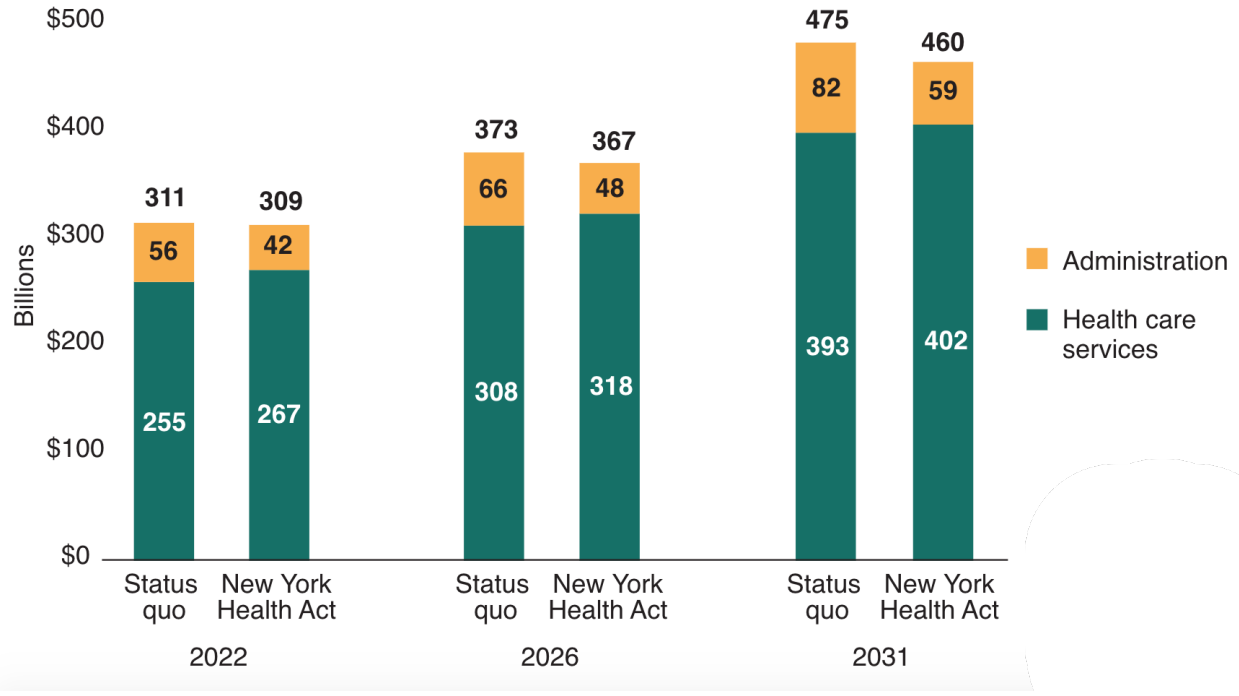
Interestingly, two recent studies, one from the Mercatus Center at George Mason University, a conservative think tank, and another by RAND Corporation, both showed potential *overall* savings in healthcare spending under federal and state single-payer models, respectively.

The first study, written by Charles Blahous, projected that Medicare-for-All would increase the federal budget by about $32.6 trillion in its first 10 years of implementation. Changes in cost would stem from the expansion of the healthcare system to the uninsured, the addition of

benefits to be included in a Medicare-for-All system, and the total coverage of financial burden for individuals. Analysts, politicians, and pundits were quick to point out, however, that one of Blahous's models actually found an overall *reduction* in national healthcare expenditures (relative to the status quo) under Medicare-for-All due to Medicare's reimbursement rates for providers, which are significantly lower than the extant mixed public/private marketplace. The savings were modeled to reduce costs by $2 trillion over ten years.

The RAND Corporation released a study that suggested a statewide single-payer healthcare system could result in overall savings in total health spending. The New York Health Act is a proposal to implement a single-payer system for all New York residents, including seniors and undocumented immigrants. The system would be funded by new resident and employer taxes in addition to state waivers granted by the government. The figure below shows an overall savings across three sample years.

Figure 1. Total Health Spending Would Be Similar Under the Status Quo and the NYHA



While the notion of a single-payer healthcare system appeals to many, experts struggle to find solutions that would increase the chance of implementation. How much will the system cost? Who will pay for it, and through what means? How might single-payer disrupt the current system? What, specifically, does the term "single-payer" even mean?

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Single-Payer: Meanings and Possibilities

Single-payer itself has multiple definitions. On a national level, it could be a Medicare expansion, more commonly recognized as "Medicare-for-All." Medicare-for-All proposes a federally administered single-payer healthcare system that provides comprehensive coverage for all Americans. Some states have either attempted or plan to attempt their own versions of single-payer. The California Health Care Foundation has provided a few examples of how single-payer may appear on a state level:

Medicaid expansion: Medicaid covers a wide range of benefits with minimal or no cost sharing, but eligibility is currently limited by income. Those concerned with consumer affordability and improved access (particularly access to comprehensive services) see advantages in extending Medi-Cal on either a mandatory or an optional "buy in" basis. Such expansion, though, could introduce provider participation and funding challenges.

Medicare expansion: Medicare, available to most individuals age 65 or over and certain people with disabilities, has a long track record and a robust administrative structure. Beneficiaries have substantial cost-sharing responsibilities, and benefits are less comprehensive than those offered through Medicaid. Medicare offers two payment approaches: fee-for-service (FFS) arrangements based on structured fee schedules, and Medicare Advantage, a prepaid arrangement with access to a defined provider network. Those seeking to achieve greater efficiency through established structures and processes see Medicare as offering a solid infrastructure for further coverage expansion. Notably, however, current premiums and beneficiary cost sharing cover only a portion of total program costs; for example, beneficiary premium contributions made up only 13% of the total Medicare expenditures in 2016.

State-based public option: Developing a public health plan option (through Covered California, Medi-Cal, CalPERS, or another state-based entity) that allows buy in for some or all of the population could expand access to coverage. Those concerned about consumer choice see this option as providing an alternative to private health plans, particularly in locations where competition among private plans is limited. The capacity of a public option plan and private

health plans to coexist and compete effectively and fairly hinges upon how the public plan secures contracted provider reimbursement levels and whether selection effects are adequately managed via risk pooling, reinsurance, and risk adjustment mechanisms. This plan does not necessarily require a single-payer system, but would be a path to universal coverage.

State-based universal coverage: A state guarantee of access to certain health care services, with a mechanism to pay for services for people not otherwise insured, has been considered in Colorado and Vermont. While both are considered “single-payer” approaches, both states allowed for exemptions of populations covered by existing federal programs. Vermont’s proposal would have allowed those with existing employer-sponsored insurance to maintain their coverage and obtain “wraparound” coverage. Those concerned with universality and comprehensiveness of coverage seek to build on existing coverage arrangements while addressing remaining coverage gaps. SB-562, The Healthy California Act, aims to create a single pool of healthcare funds that will cover all California residents. This will need to be done through state request waivers approved by the Trump administration.

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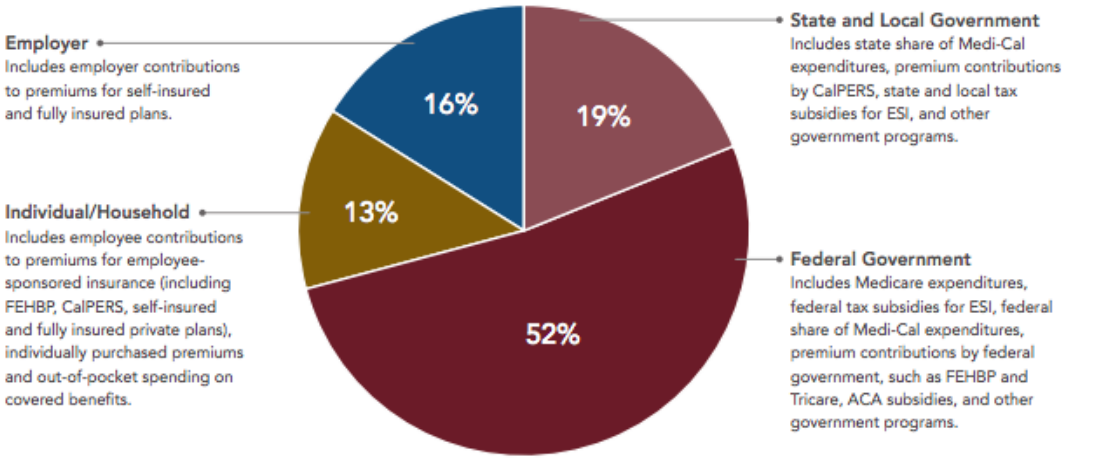
Single-Payer Healthcare in California

Senate Bill 562 , The Healthy California Act, was presented in 2017 as a proposal to implement a single-payer healthcare system in California. While it was shelved in the Assembly in June 2017, the popularity of single-payer has since increased, especially amongst California politicians.

Single-payer in California is estimated to cost approximately $400 billion per year. SB 562 suggests that the state can use federal, state, and local funding for half the cost and reallocate its employment-based insurance funding to offset an additional $100 to $150 billion. California has yet to elaborate on how it will shift its funding system and raise money for the remainder of the cost to allow for single payer.

In a recent Q&A at the Commonwealth Club in San Francisco, California, Centers for Medicare and Medicaid Services Administrator Seema Verma was asked by Zetema Project Chair Mark Zitter about whether the administration would support California's movement into a single-payer system. Administrator Verma stated that CMS will not likely grant state innovation waivers for a statewide single-payer healthcare system.

Figure 1. Main Health Care Funding Sources, California, 2016



Notes: Categories do not include other sources of funding for health care such as philanthropy, investments, or individual/household spending for non-covered health care services. Payroll taxes are not explicitly categorized by this chart.

Source: Adapted from *Public Funds Accounts for Over 70 Percent of Health Care Spending in California*, August 2016, UCLA Center for Health Policy Research.

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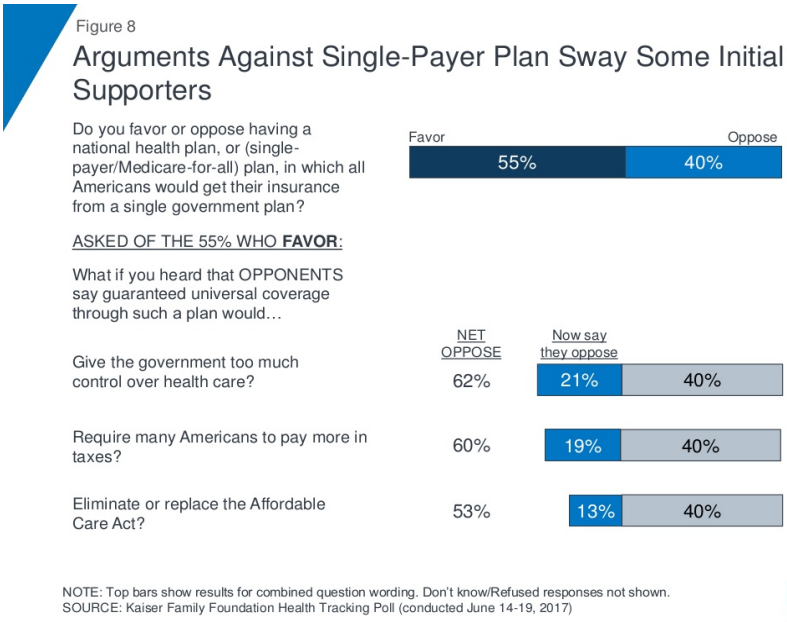
Single-Payer's Relationship with the American Public

National polling has shown increases in interest for a single-payer healthcare system, but also that the public is unclear about its effects and implications. The Kaiser Family Foundation found significant decreases in favorability amongst those who were told that single-payer would increase government control, require higher taxes, and eliminate the Affordable Care Act.



The results of the poll suggest that while many Americans seem to be in favor of the idea of single-payer healthcare, they may not understand how it might affect them. For example, support for single-payer healthcare drops significantly once respondents learn they would lose their employer-based health insurance.

Since the majority of the US healthcare spending goes to labor costs for nearly all domestic workers, any savings from single-payer may lead to a decrease in American jobs and wages. Changes to the healthcare workforce will cause a major disruption, especially for small towns in which hospitals are the largest employers. Single-payer also brings into question the need for insurance companies. Could a single-payer system cause insurance companies to become obsolete? Insurance companies could continue processing claims and performing administrative tasks, but there is no guarantee.

Funding for single-payer healthcare will likely come from taxes. Economists say that higher wages for workers would cover the difference, but this does not guarantee support from the

American workforce. Employers fear they may be taxed by the government to fund single-payer. This would additionally lead to a loss in control over their employee benefits.

In a nation that seems to distrust the federal government to set limits, could a national single-payer healthcare system enforce the difficult choices necessary to control costs? The evidence from current government healthcare programs is quite mixed. Single-payer healthcare would need to overcome significant barriers to achieve national coverage. Republicans struggled implementing Medicare Part D for the 59 million Medicare beneficiaries in the United States. Democrats had trouble with the Affordable Care Act, which covers approximately 11.8 million Americans. Experts will need to further discuss how single-payer could operate on a national scale in order to cover 328.7 million Americans.

Discussion Questions

- What are the benefits of a single-payer system? Could other systems achieve them in an equal or more effective manner?
- What are some disruptive effects that could potentially follow an implementation of a single-payer healthcare system?
- Is a single-payer system likely to be more or less expensive than the current system?
- How might quality of care be affected in a single-payer healthcare system?
- Could the federal government launch a single-payer system successfully from an operational standpoint?
- Is single-payer more likely to be effective on a national or state level?
- Could California achieve a single-payer system given its current limitations?
- Is there a version of single-payer that is more feasible than others?
- In what ways could the 2020 Presidential Election affect single-payer prospects?

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