RESEARCH BRIEF NO. 38 | MAY 2019

Single Payer: Can it Bend the Cost Curve?

With the 2020 presidential primaries ramping up, the United States is having a robust discussion about the merits of single-payer approaches to paying for healthcare. Single-payer proponents cite many benefits: a path to universal coverage, greater simplicity in the administration of healthcare financing and a strong payer to counteract the market power of high-cost providers, pharmaceutical companies and device manufacturers. To date, however, the debate has not fully examined the ability of single-payer approaches to "bend the cost curve"—addressing areas where we overspend on healthcare—while improving quality and reducing the nation's enormous health disparities.

SUMMARY

While there are many potential variations of a single-payer system, common features include funding for a core set of medical services that comes from a single, publicly financed source; provider reimbursement established by the public entity; and broad or universal coverage. The debate over single-payer approaches must include its potential to "bend the cost curve"—addressing areas where we overspend on healthcare while improving quality and addressing health disparities. This brief finds that single-payer is uniquely suited to address some reasons for high health spending (like excess administrative spending and monopoly pricing), but other healthcare value goals (such as reducing low-value care, increasing high-value care and improving health equity) will only be addressed if proposed legislation explicitly incorporates these as legislative goals and includes a flexible programmatic toolset and feedback mechanisms to ensure success.

This brief provides an overview of the single-payer approach and explores its potential to address the underlying reasons for poor healthcare value in the U.S.

What is a Single-Payer System?

While there are many variations of single-payer proposals, common features include:

- Funding for a core set of medical services that comes from a single public source, typically financed through taxes and overseen by a single nonprofit entity (the federal government, the state or even a quasi-governmental agency[1]);
- Provider reimbursement rates that are established by the public entity; and
- Insurance coverage that is broadly, or universally, available.

Single-payer approaches vary in the comprehensiveness of the benefits they cover, the extent to which out-of-pocket payments are required by enrollees and the mechanisms through which healthcare providers are paid for their services.[2] Importantly, a single-payer system does not require government ownership of hospitals or direct employment of physicians and other personnel.

Although single payer may seem like a foreign concept, there are already functioning single-payer systems in the U.S.:

- ***Medicare***, which covers seniors and those with disabilities, has approximately 66 percent of enrollees in "traditional" Medicare, which is a single-payer approach. The remaining enrollees are in Medicare Advantage, a for-profit, private payer alternative.[3]
- ***Veterans Health Care*** also uses a single-payer approach to deliver healthcare, whereby many facilities are publicly owned and providers are salaried.

- ***Maryland*** residents are covered by the usual assortment of Medicaid, Medicare and private plans, but ALL types of coverage use the same, state-determined rates for hospital payments.[4]

At the federal-level, a variety of proposals would vastly increase the number of people eligible for single-payer coverage, while attempting to fix the perceived flaws in our existing programs. These proposals vary with respect to who is eligible for coverage:[5]

- "Medicare-for-All," a single-payer coverage approach that would expand Medicare, with fixes, making it available to everyone;
- "Medicare-for-More," a Medicare buy-in option for older individuals who are not yet eligible for the current Medicare program (some variations also make improvements to the current Medicare program); and
- "Medicare-for-Some," a Medicare or Medicare-like plan offered to individuals through the Affordable Care Act Marketplaces (an alternative would do this through Medicaid).

Healthcare Value Problems in the U.S.

Recent polls have found broad public support for coverage approaches that offer universal coverage and do not discriminate based on pre-existing conditions.[6] While such support is heartening, it is important to ask the question: can a single-payer approach address our high healthcare spending, unwarranted price variation and wide disparities in health outcomes that ultimately harm consumers?

Many researchers agree that excess administrative spending and year-over-year increases in unit prices are the top reasons for high healthcare spending in the United States, especially when compared to countries that cover their entire populations while spending less (as a percentage of GDP).[7] Moreover, a failure to curtail low-value care, to coordinate patient care and to address unmet social needs contributes to greater disparities in health outcomes and poorer health outcomes in general than observed in comparably wealthy countries.

Below, we explore whether single-payer approaches are well suited to address our healthcare value problems or if additional policy prescriptions should be added to proposed legislation to address these important health system failures.

Single Payer and Administrative Spending

One of the strongest claims that can be made for single-payer approaches—particularly those with broad enrollment and few other coverage alternatives—is that they will curtail our nation's excessive spending on healthcare administration, based on the experience of other countries that utilize single-payer approaches.

Administrative spending is incurred by a variety of healthcare stakeholders—insurers, hospitals, doctor's offices and other entities—to conduct the business side of healthcare.[8] Administrative spending represents an estimated 25 to 31 percent of total healthcare expenditures in the U.S.[9] Moreover, growth in administrative spending has outpaced that of overall healthcare expenditures and is projected to increase.[10]

While some administrative spending is necessary, researchers have found that a significant portion of our current spending is unecessary. In fact, the National Academy of Medicine's seminal 2010 work, *The Healthcare Imperative: Lowering Costs and Improving Outcomes,* identified unnecessary administrative costs as one of six key areas that need to be addressed to improve healthcare value and lower costs.[11]

A great deal of excess administrative spending is associated with our multi-payer financing system, which has resulted in non-uniform rules and great complexity with respect to provider credentialing; quality assurance; billing and payment; and health plan marketing, selection and enrollment.[12] In contrast, single-payer approaches enjoy economies of scale and establish uniform rules for provider participation. Moreover, when used to provide broad or universal coverage, the single-payer approach can sharply reduce the administrative expenses associated with determining eligibility for coverage, marketing and underwriting. These savings extend to providers (reduced

expenses for billing and compliance with payer rules for licensing and accreditation) and to patients, who would theoretically have a simpler insurance system to navigate.

While the exact amount of savings is unclear, there is widespread agreement that a single-payer approach featuring broad enrollment and few other payers would significantly reduce administrative spending. Evidence from the current Medicare program demonstrates that large, unified payers can achieve significantly greater administrative efficiencies than multi-payer systems.[13] It has been estimated that a simplified financing system in the U.S. could save nearly 15 percent of overall healthcare spending.[14] These savings could be reinvested to cover more people and/or improve population health.

Single Payer and Unit Prices

Myriad studies have shown that year-over-year increases in healthcare spending are driven primarily by rising unit prices.[15] But research also suggests large differences in the role of unit price increases in the private sector (the largest driver) versus the public sector (a less important driver).

Medicare and Medicaid unit prices are dictated through a regulatory process that incorporates input from stakeholders.[16] For private insurers, provider reimbursement reflects the relative market power of the insurer and provider, and prices are generally determined though processes that lack transparency. The difference in approaches has resulted in substantial variation between what Medicare pays hospitals and what private payers pay hospitals (on average, more than twice as much).[17]

Moreover, variation in private payer and provider market powers can result in very different payments to providers *in the same geographic area*—researchers have found that private payer hospital reimbursements can vary two-fold in the same city.[18] In addition, recent increases in provider consolidation have raised concerns that private payer provider payment rates will increase furtyer in the future.[19]

The policy toolset for dealing with high unit prices is limited, especially when markets lack competition.[20] Given the consolidation of many U.S. healthcare markets, large, unified payer approaches are an important policy tool for counteracting the monopoly power of providers,

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drug companies and device manufacturers. Both Medicare and the Maryland system have a track record of limiting unit price increases over time.[21]

Better ability to control unit prices could have a downside: Some worry that the prices set by a large, unified payer could diminish the quantity or quality of healthcare providers and treatments. These concerns may be unfounded, however, given that high healthcare spending does not result in superior health outcomes,[22] and in light of high satisfaction with Medicare coverage[23] and the successful use of single-payer models in other countries.

Single Payer and Appropriate Use of Services

While the use of healthcare services is not typically cited as a driver of overall healthcare spending growth,[24] it is widely accepted that we don't provide the right level of medical care in the U.S. Specifically, we provide too much low-value care[25] and too little high-value care.[26] Additionally, there is tremendous variation in healthcare services used to treat patients with the same medical condition across providers and geographic areas.[27] Correcting these issues can reduce health inequities, improve health outcomes and potentially save money.

The evidence is fairly strong with respect to strategies to combat inappropriate use of services. These strategies range from increasing funding for comparative effectiveness research (so we know what works),[28] to provider feedback systems,[29] coverage and benefit design, and patient shared decision making.[30] Another policy tool, value-based provider reimbursement, has a mixed track record but remains part of the tool set. For the most part, these strategies can be used in a variety of coverage environments including, but not limited to, single payer.

The evidence is clear that people are struggling to pay not only their insurance premiums, but rising deductibles, copayments and co-insurance.

To date, both private and public plans have a poor track record of reducing the use of low-value care, which represents an estimated 14 percent of healthcare spending.[31] Moreover, Medicare's authorizing legislation lacks the ability to nimbly change the cost-sharing and coverage parameters of traditional Medicare. The current benefit design (which reflects benefit design approaches from the 1960's) is widely considered to be "out-of-step" with designs that promote better health outcomes and protect beneficiaries from catastrophic expenses.[32]

Theoretically, a large, single-payer system is well positioned to implement effective, system-wide strategies to improve healthcare utilization. Both providers and patients would face a uniform set of incentives (both financial and non-financial). This type of alignment is substantially harder to implement in a fragmented, multi-payer insurance system.

It is worth noting that Medicare has had recent success in coordinating and managing care for the "dual-eligible" population—low-income, elderly patients who qualify for both Medicaid and Medicare. Economists attribute the successful care coordination of dual-eligibles as a major factor in Medicare's very low per-person spending increase between 2005 and 2015.[33]

It will be important for single-payer proposals to incorporate a flexible mechanism for addressing this priority, with robust feedback systems to ensure the strategies result in the desired outcomes.

Single Payer and Health Outcomes

Health coverage that ensures access to needed services is a key determinant of health outcomes.[34] To the extent that single-payer (or other) approaches achieve universal coverage, we should expect significant improvements in health among the newly insured. Further improvements in health outcomes are possible if the coverage approach successfully reduces potentially harmful low-value care and addresses shortfalls in the use of high-value care, as discussed above.

Even greater health improvements are possible when policymakers and providers look beyond the clinic walls and address the underlying social determinants of health. To date, both public and private payers have embraced pilot projects designed to address unmet social needs like housing, food and transportation. But these are often limited duration projects focused on narrowly-defined populations.[35]

A promising, but untested, approach is Maryland's Total Cost of Care Model, implemented in early 2019.[36] Maintaining Maryland's all-payer approach, this model transitioned hospitals to population-based payment methods with the goal of incentivizing them to focus on population-level health, such as reducing diabetes and opioid use. As noted above, it may be easier for unified payer approaches to create this type of public accountability featuring streamlined incentives and uniform definitions for quality and outcome measures.

As noted in the prior section, it will be important for single-payer proposals to incorporate an explicit, flexible mechanism for addressing unmet social needs in a targeted, evidence-based way.

Single Payer and Healthcare Affordability

The evidence is clear that people are struggling to pay not only their insurance premiums, but rising deductibles, copayments and co-insurance. In 2016, 26 percent of people ages 18-64 had problems paying their medical bills.[37] Additionally, 52 percent of debt collection actions involved medical debts.[38]

For several reasons, single payer may make healthcare more affordable, potentially reducing or eliminating medical debt and surprise medical bills. Affordability may arise not only from success in addressing the underlying cost of medical care, but by using an evidence-based approach to allocating cost sharing between the insurer and the patient.

Uniform access to an affordable, high-quality, comprehensive coverage program would greatly reduce (but not eliminate) health disparities in the U.S.

In a taxpayer-financed system of broad or universal coverage, premiums may be unnecessary and a wasteful driver of administrative spending. Furthermore, health coverage should include the full range of needed medical services to ensure fair access for all individuals and robust health outcomes. In contrast, there is an argument for maintaining evidence-based cost sharing to help address inappropriate use of low-value healthcare services, ideally without reducing the consumption of high-value care.[39]

Any cost sharing included in a single-payer approach must be affordable, easy to understand and predictable (like a simple system of standard copays).[40] Additionally, making healthcare affordable may require cost-sharing features that slide with family income. While it is possible to standardize cost-sharing designs across private-payers, few states have the legislative authority to do so. This type of cost sharing may be easier to achieve with a single-payer approach.

Finally, in order to truly address consumers' affordability concerns, a single-payer system must be designed in a way that does not create an unfair tax burden on individuals and families. Proposed legislation should minimize taxpayer burden by incorporating elements to constrain excess prices, addressing all forms of waste in the healthcare system and addressing upstream health needs before they become unnecessarily expensive. After these measures, the cost of the coverage program must be attributed fairly, with higher-income taxpayers paying a greater share than lower-income taxpayers.

Single Payer and Healthcare Equity

Our current system is rife with health disparities, including disparities in outcomes that arise from unmet social needs, lack of access to coverage and biases in treatment approaches.[41] These disparities are strongly linked to geography, income, race and primary language.

Uniform access to an affordable, high-quality, comprehensive coverage program would greatly reduce (but not eliminate) health disparities in the U.S. As many have noted, achieving health equity will require additional, significant efforts beyond solely implementing a universal coverage system.[42] Efforts must include targeted actions to address unmet social needs and, in some cases, strategies to address community-wide needs. Implicit bias on the part of providers must be addressed through training and effective clinical feedback mechanisms.

A unified single-payer system features some specific advantages with respect to health equity. For example, extending coverage to all individuals negates concerns about adverse selection. Including all people in one large risk pool facilitates risk adjusting payments to providers and prevents plans from "cherry picking" enrollees.[43,44] In a 2018 study, researchers found that a single-payer system increased health equity and performed better in risk pooling compared to multiplayer systems.[45] Moreover, as discussed above, single payer can explicitly control how the burden of healthcare costs falls on individuals and families, an insurmountable challenge in the current, fragmented healthcare system. A single financing entity (e.g., the federal government) can also be explicit and deliberate in distributing health spending to fund the population's healthcare costs and needs.[46]

A Role for Private Payers?

A key question in this debate is whether there is a role for private healthcare plans in a single-payer system. As noted above, today's Medicare system includes a private payer alternative called Medicare Advantage (not available in all parts of the country). In addition, most "traditional" Medicare enrollees purchase highly regulated, but privately purchased, supplemental health plans that "wrap around" the Medicare benefit.

Private plan proponents, particularly those who believe private plans are inherently more efficient than public plans, hope that having a role for private health plans will impose discipline on the public payer. For this public-private approach to be successful, the public insurer would need flexibility in how it designs health

A single-payer system should not replicate the defects of our current system.

benefits, credentials providers and develops other aspects of coverage architecture. However, to date, there is little evidence showing that private payers are more efficient. Unlike other private health plans, Medicare Advantage plans can limit their provider reimbursement to traditional Medicare payment rates.[47] Even with this ability, relatively few Medicare Advantage plans are able to keep their costs below those of traditional Medicare. Those that have successfully accomplished this are concentrated in just a few counties and exclusively deploy health maintenance organization approaches that do not pay for out-of-network care.[48]

Opponents of private plan alternatives are concerned that having multiple plan options will undermine the efficiencies that stem from broad enrollment in a single-payer plan (increasing overall spending if private payers are not able to mirror the efficiencies of the public payer) and burden consumers if their choices become difficult to navigate. Cherry picking of healthy enrollees is also a significant concern, and studies show that high-cost beneficiaries typically transition from Medicare Advantage back to traditional Medicare.[49]

Experience with Medicare Advantage also suggests that regulators will have to remain vigilant with respect to healthcare disparities. Some studies show significant racial and ethnic disparities with respect to minority enrollees in Medicare Advantage.[50] Medicare CAHPS surveys reveal that individuals who are Black, American Indian, Hispanic or Alaska Natives report worse clinical experiences than those of White beneficiaries.[51] Black beneficiaries report having less healthcare access and using fewer preventive services, such as flu vaccinations, diabetes management care and blood pressure control.

An approach that allows for supplementary private plans (in addition to the single-payer plan) raises concerns about health equity, as some individuals will be able to afford supplemental coverage that provides more options for care. As noted above, ensuring that all needed services are covered with cost sharing set at affordable levels may be administratively more efficient and produce better and fairer outcomes.

Conclusion

With more than 70 percent of Americans in favor of a single-payer system,[52] it is important for lawmakers, advocates and other stakeholders to address concerns about taxes, quality and access, and ensure that single-payer proposals maximize the value of our healthcare spending. A single-payer system should not replicate the defects of our current system.

The advantages of a single-payer approach with respect to reducing excess administrative spending and addressing high unit prices have been widely acknowledged. But other healthcare value problems must be explicitly addressed in single-payer proposals to ensure that the system is able to curtail low-value care, increase high-value care, address disparities in treatment, move healthcare spending upstream (including addressing unmet social needs in a more systematic way) and ensure that care is affordable. Program approaches to correct current deficiencies must be flexible, with robust feedback systems to allow for continuous quality improvement and to ensure that patients are ultimately better off.

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Support provided by the Robert Wood Johnson Foundation