Single-Payer: Panacea or Pandora's Box?

Is this a cure for a broken system?

BY MARILYN M. SINGLETON, MD, JD

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The California Senate's unipartisan passing of a sweeping single-payer healthcare bill in June 2017 brought attention to the idea of a national single-payer system as an antidote to the ailing Affordable Care Act (ACA). The Healthy California Act creates a government-run program that replaces all Californians' existing insurance plans.[1] All persons in the state would be covered for "medically appropriate" services with no premiums, co-payments, deductibles, or other cost sharing. Insurers are only allowed to offer coverage for services that are not covered by the state. In the face of record high healthcare costs, the bill has a glaring (or politically shrewd) omission: a funding mechanism.

National Health Expenditures

In 1945, President Truman lamented that all health services "absorb only about 4 percent of the national income" and he wanted to spend more.[2] Now we are struggling to rein in costs that constitute 17.8% of the GDP of the United States. In 2015, U.S. national healthcare expenditures in private and public health insurance, hospital care, physician and clinical services, and prescription drugs increased to $3.2 trillion, or $9990 per person.[3]

In the uphill battle to contain healthcare costs and increase access, Americans historically have not embraced single-payer as the solution.

Single-Payer in America

Over 80 years ago, President Franklin Roosevelt proposed national health insurance as part of his 1935 Social Security legislation. However, political opposition led him to drop the idea, fearing its inclusion would hinder the passage of the Old-Age and Survivors Insurance and Federal Disability Insurance (OASDI/Social Security) bill.[4] The 1943 Wagner-Murray-Dingell single-payer legislation was modeled after Social Security, with employers and employees contributing to a national health fund. In 1945, President Truman called for a national health insurance program where people could still use medical services "outside the health insurance system" and physicians were free to "accept or reject" patients.[2]

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President Johnson's Medicare and Medicaid legislation was a compromise from his goal of a federal universal healthcare program. President Nixon's employer-mandated insurance, and single-payer proposals by Senator Ted Kennedy and President Clinton gained no traction.

In 1997, the federal government began expanding its role in healthcare coverage with the State Children's Health Insurance Program. In 2003, Medicare Part D created a prescription drug benefit. In 2010, the ACA provided strict rules for insurers, mandated minimum "essential" benefits, expanded eligibility for Medicaid, and offered subsidies for insurance premiums.

The latest federal single-payer proposal, the Expanded and Improved Medicare for All Act, mirrors the California bill's coverage.[5] The program would be financed by current revenues and funds directed toward existing government health programs. Significantly, the bill provides for two payroll tax increases, a new tax on unearned income, and a new tax on stock and bond transactions. The bill also mandates a national electronic medical record (EMR) system. This generous program goes well beyond Medicare's

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benefits, which consume 15% of the federal budget.[6]

Medicare Is Not Free

Discussions about "Medicare for all" must acknowledge that Medicare has costs to the enrollee. For an average annual benefit per enrollee of $12,559, the government collects 2.9% payroll tax divided equally between employee and employer and a 0.9% surtax on earned income over $200,000.[7] The premium for Medicare Part A (hospital) is $413 per month, but is "free" for enrollees who have paid into the system for at least 10 years. All enrollees are responsible for a $1316 hospital deductible, a $329 daily copay after 60 days, and $658 after 90 days. Skilled nursing has a $164.50 daily copay after 20 days and no benefits after 100 days. There are no out-of-pocket limits.

Fourteen percent of financing for Part B physician and other outpatient clinical services comes from a means-tested monthly premium ranging from $134 to $428. Enrollees are responsible for an annual $183 deductible and a 20% copay for services. The Part D prescription drug program has a $400 deductible and 25% copay up to $3,700.[8]

To help defray these costs, 54% of beneficiaries purchase either Medi-gap supplemental insurance policies or Medicare Advantage (managed care) plans for about $2000 to $4000 per year. Medicaid covers cost-sharing for 20% of beneficiaries.[7]

"Medicare for all" is not as clear-cut as it sounds. Seventeen percent of the population receive Medicare benefits, and 22% are enrolled in Medicaid.[9,10] The federal government finances 29% of total health expenditures, and state and local governments finance 17%.[3] So why not put the rest of us on the government dole?

Unsustainability

The California bill was quickly thrown on the back burner when it became clear the tax increases necessary for funding were unpalatable to the voters.[11] Vermont abandoned its 2011 legislatively created Green Mountain Care plan in 2014, citing costs and tax increases as too high to implement.[12]

The Congressional Budget Office (CBO) projects that federal budget deficits will rise from 2.9% of GDP in 2017 to 9.8% in 2047.[13] The CBO expects the 50-year trend of health spending outpacing the economy to continue as the over-65 population increases faster than those paying into the trust fund.[13]

The funding of Social Security by the workforce is instructive. From 1974 through 2008, the ratio of workers to beneficiaries hovered around 3.3. In 2016, there were only about 2.8 workers for every beneficiary.[14] This ratio is expected to decline further, to 2.2 by 2035 and to 2.1 in 2040 (the year in which the Social Security trust fund is projected to be exhausted).

To compound the problem, the U.S. birth rate is at a record low: 62 births per 1000 women between the ages of 15 and 44.[15] By contrast, the 1957 rate was 122.9 births per 1000 women.[16] The demand is outstripping the supply.

No Mechanism for Cost Containment

Along with universal access, containing overall healthcare costs has been a goal of policymakers for decades. But a program that boasts no patient cost-sharing of any kind could lead to overutilization.

Cost-saving efforts have focused on lowering payments to providers, yet physician and clinical services account for only 20% of overall costs.[3] Predictably, physicians' operating costs increase along with expanded bureaucracy. Government programs already require additional obligations, including reporting complex quality and efficiency measures and mandatory use of EMRs.[17]

With a single-payer system, the government can set the prices, just as it does with Medicare and Medicaid. The government's complete control means the payments may go so low as to drive providers out of the system. Thus, patients would have longer wait times and less choice. Payers also control costs by limiting "covered" services. For example, although 21% of prescriptions are for off-label use, Medicare or private insurance often do not cover such uses.[18,19]

Overemphasis on price controls and central planning could lead to decreased quality, so that physicians would be paid only for robotically following treatment guidelines rather than providing individualized care. Moreover, there could be more instances of sicker patients losing their fee-for-service physician and being involuntarily placed into capitated managed care.[20]

As the Social Security trustees concluded, maintaining solvency of the OASDI program will require some combination of increased revenue or reduced benefits.[9] The same formula would apply to government financed health benefits.

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The Two-Tiered System May Worsen

Our current healthcare system is criticized for favoring the well-heeled. Some posit that a single-payer system provides equal access to all. However, most countries that have single-payer systems (e.g., Canada, France, Great Britain, Singapore) have two tiers of healthcare. This means the government-provided healthcare system covers basic care (as defined by the government), and a secondary tier of care exists for those who can pay for additional benefits, better quality, or improved accessibility—whether more providers or faster appointments.

Single-Payer Ignores What Consumers and Patients Want

The political call for single-payer ignores what voters and patients really want. A 2016 Associated Press poll found that 39% of those polled liked "Medicare for all" (versus 33% opposed). Nearly half changed their minds when asked whether they would be willing to either pay higher taxes or give up their own employer-sponsored plans for a government-run insurance plan.[21] Even a majority of California residents polled were in favor of universal government-run healthcare—as long as

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it did not raise their taxes.[22]

This attitude has been borne out when single-payer has been put to the electorate. Oregon's 2002 single-payer Ballot Measure 23 was rejected by a margin of nearly four to one.[23] The 2016 citizen-initiated Colorado State Health Care System Initiative called for a single-payer healthcare system funded by a 10% payroll tax split two to one between employers and employees. It was rejected by 79% of the electorate.[24]

With regard to doctor visits, Deloitte's 2016 Consumer Priorities in Health Care Survey found that patients overwhelmingly want "personalized provider interactions."[25] Next, people want "economically rational coverage." They did not say free; they just want value for their dollar. They also want convenient access. None of these things will be found in a government-run healthcare factory staffed by captive providers.

In 2001, a large public health study of 50 years of American public opinion regarding various healthcare plans found that a "national healthcare plan" had general support. On the other hand, respondents were satisfied with their current medical arrangements, had trust in the honesty and ethical standards of individual physicians, did not trust the federal government to do what is right, and did not favor a single-payer type of national health plan.[26]

Universal Health Coverage is not Necessarily Single-Payer

In looking at options for achieving a healthy America, universal healthcare and a single-payer system are not synonymous. Universal healthcare describes any program designed to give access to healthcare to all residents, regardless of their ability to pay. Single-payer is one type of universal coverage financing mechanism, including revenue collection and payment for provider services by one entity, generally the government. Some politicians continue to beat the single-payer drum as though this were the natural progression of healthcare reform. Perhaps single-payer is not right for our population.

Other Paths to Maximize Healthcare Delivery

The Affordable Care Act (ACA) was an attempt at universality. Unfortunately, the ACA decreased competition and plan availability in health insurance and left patients with unaffordable premiums, deductibles, and copays. Moreover, the ACA did nothing to lower medical costs.

Making patients partners in achieving good health leads to appropriate use of medical services.

Ideally, our goals are improved access to medical care, choice of physicians, a variety of insurance products suited to individual needs, portability of coverage, protection against high out-of-pocket expenses, protection of the vulnerable, and containment of overall healthcare costs. Additionally, policymakers cannot ignore the fact that 50% of healthcare dollars are spent on the 5% of the population with mainly chronic diseases.[27] One size does not fit all.

Also important, but sometimes overlooked, is the need for patients to be invested in their own health. Making patients partners in achieving good health leads to appropriate use of medical services. Reasonable prices and good relationships with trusted physicians beget increased patient adherence and improved outcomes.

Private Market Changes

Americans have indicated that they do not want to trade freedom for government control through taxation and limited services. There would be public outcry if private medical practice were prohibited. Re-designing the private market may attain America's healthcare goals consistent with our values.

The unhealthy relationship between the pharmaceutical industry and insurers and the government must be confronted. Large political donations likely have netted favored treatment.[28,29] The House of Representatives took a step forward by passing the Competitive Health Insurance Reform Act nearly unanimously.[30] The bill removes the anti-trust exemption from the health insurance market, subjecting insurers to existing federal laws against price fixing, among other things.

Insurance reform aside, retrieving medical payments from the hands of third-party payer middlemen can lower costs of services. There can be as much as an 89% price discount for pharmaceuticals or services purchased with cash than if they had been purchased with insurance.[31,32] With their lower overhead and reduced paperwork, direct-pay physician practices can charge up to 80% less than traditional offices, and the doctors can spend more time with patients.[33] The use of direct pay can be enhanced by expanding existing tools, such as Health Savings Accounts and reasonably priced public or private major medical insurance without age limits.

Communities and physicians must collaborate to provide volunteer and low-cost health and social services to the vulnerable. With regard to the particular needs of financially challenged and chronically ill patients, we must think local. President Truman, when recommending a national healthcare program, cautioned that "the local administrative unit must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions."[2] Communities and physicians must collaborate to provide volunteer and low-cost health and social services to the vulnerable.

Conclusion

Making America healthy should transcend political rhetoric. Single-payer is not a cure for a broken system. When the government runs out of money and the taxpayers are drained dry, provider payments and patient services will be reduced. Moreover, single-payer would further the depersonalization of patients and doctors and convert them to obedient participants trapped in a system with no exit. **PM**

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Dr. Singleton is a board-certified anesthesiologist and President-elect of the Association of American Physicians and Surgeons. She graduated from Stanford and earned her MD at UCSF Medical School. Dr. Singleton completed 2 years of surgery residency at University of California at San Francisco Medical Center, then her anesthesia residency at Harvard's Beth Israel Hospital. She was on the faculty at Johns Hopkins Hospital in Baltimore, Maryland before returning to California for private practice at Cedars-Sinai Medical Center in Los Angeles and Alta Bates Medical Center in Berkeley. She attended UC Berkeley Law School and interned at the National Health Law Project, and practiced insurance and health law. e-mail: marilynmsingleton@gmail.com.