VIEWPOINT

HEALTH POLICY

Single-Payer Reform—"Medicare for All"

Steffie Woolhandler, MD, MPH
School of Urban Public Health, City University of New York, Hunter College, New York, New York; and Harvard Medical School, Boston, Massachusetts.

David U. Himmelstein, MD
School of Urban Public Health, City University of New York, Hunter College, New York, New York; and Harvard Medical School, Boston, Massachusetts.

The prospect of single-payer "Medicare-for-all" reform evokes enthusiasm and concern. Proponents maintain that a single-payer system would be the simplest route to universal coverage; every US resident would qualify for comprehensive insurance under a public, tax-financed plan that would replace private insurers, Medicaid, and Medicare. Others are concerned that costs would escalate or that the government would limit and underfund care, particularly hospital care, which commands the largest share of health spending; innovation might lag; and government may infringe on medical decisions.

Physicians are understandably cautious about prescribing a radical cure for minor ills. However, current health policies have substantial shortcomings for many individuals, minor changes appear certain to fail, and the single-payer remedy may be less disruptive than often portrayed.

Few argue with the need for reform. The United States has fallen behind other nations in measures of life expectancy and access to care. Drug prices in the United States, already twice those in Europe, continue to increase, compromising patient adherence to vital medications, such as insulin. Twenty-nine million US residents remain uninsured, and co-payments and deductibles force many individuals with insurance to choose between skipping care and incurring overwhelming debts.

Many physicians feel frustrated by mandates and restrictions of insurers and by electronic health records (EHRs) with designs driven by the logic of billing. New payment modalities, euphemistically labeled "value-based," favor large systems at the expense of small practices and community-controlled hospitals and impose new layers of quality reporting and fiscal managers. However, these payment modalities appear to have done little to improve care or moderate costs, and physicians continue to bear responsibility for patients even as their authority in many health care settings erodes.

Single-payer reform could mitigate the stresses on patients and clinicians. A well-designed reform could potentially generate large savings on billing-related costs and lower drug prices, which would make expanded coverage more affordable.

The current, fragmented payment system entails complexity that adds no value. Physicians and hospitals must navigate contracting and credentialing with multiple plans and contend with numerous payment rates and restrictions, preauthorization requirements, quality metrics, and formularies. Narrow clinician and hospital networks and the constant flux of enrollment/disenrollment as patients change jobs or their employers switch plans disrupt long-standing patient-physician relationships. Many insurers devote resources to recruiting profitable enrollees and encouraging unprofitable enrollees to disenroll.

This complexity drains resources from patient care. According to official estimates, insurance overhead is projected to cost an estimated $301.4 billion in 2019, including an estimated $252 billion for private insurers, approximately 12% of their premiums.[1] In contrast, overhead is 1.6% in Canada's single-payer system and 2.2% in Medicare's fee-for-service plan. Reducing US system-wide insurance overhead to 2.2% could save an estimated $238.7 billion.[1]

The complex payment system also increases hospital costs and prices. Single-payer nations, such as Canada and Scotland, pay hospitals global budgets, analogous to the way US cities fund fire departments. That payment strategy obviates the need to attribute costs to individual patients and insurers and minimizes incentives for upcoding, gaming quality metrics, bolstering profitable "service lines," and other financially driven exertions; a 1272-bed multihospital system in Toronto employs only 5.5 full-time equivalent employees to handle all billing and collections.[2] A 2014 report suggested that administration consumes 12.4% of hospital budgets in Canada (and 11.6% in Scotland) vs 25.3% in the United States,[3] a difference of an estimated $162 billion annually.

Interacting with multiple insurers also raises physicians' overhead and, in turn, the prices they must charge. In 2016, an efficient group practice at a North Carolina academic medical center spent $99 581 (and 243 hours of physician time) per primary care physician on billing.[4]

As in Canada, a US single-payer system could pay physicians based on a simple fee schedule negotiated with medical associations. All patients would have the same coverage and office staff would not need to process prior authorizations, collect co-payments, or field pharmacists' calls driven by the confusion that arises from multiple formularies. Anecdotal reports suggest that Canadian physicians have been spared much of the burden imposed by poorly conceived privacy regulations, "meaningful use" requirements, and quality and efficiency metrics.[2] A 2011 study found that US physicians spent 4 times more money interacting with payers than their Canadian counterparts,[5] who report spending only 24.7% of gross revenues on practice overhead (including rent and staff) and 4% of their workweek on insurance-related matters.[6] US insurers try to detect billing abuses by demanding substantial amounts of documentation. In single-payer nations, the sole insurer can use comprehensive claims data to monitor for outlandish billing patterns.

A 2019 Congressional Budget Office (CBO) report[7] concluded that single-payer reform could lower administrative costs, increase incentives to improve health, and substantially reduce the number of uninsured individuals. However, if undocumented immigrants were excluded, 11 million US residents could remain uninsured.

Corresponding Author: David U. Himmelstein, MD, 255 West 90th St, New York, NY 10024 (dhimmels@hunter.cuny.edu).

Realizing the benefits of single-payer reform entails many challenges and potential pitfalls. As the CBO report noted, the effects on the economy and individuals would depend on key features of the design of the program, such as how it paid clinicians and what services were covered. While single-payer reform could simplify bureaucracy and free up hospital resources and physicians' time to meet the increased demand for care, poorly designed legislation might perpetuate Medicare's burdensome payment and monitoring strategies. Even in a well-designed system, waiting time for care might increase; however, the Affordable Care Act, which covered 20 million uninsured individuals, did not significantly increase waiting time or compromise access for previously insured individuals. Nonetheless, enhanced funding for training programs might be needed to ensure an adequate supply of clinicians, particularly in primary and behavioral health care and in regions with physician shortages. In addition, as with Medicare, politics could affect decisions regarding coverage in a single-payer system.

Most individuals would have an insurance transition, but they could keep their physicians and would be spared future transitions. Although patients would not be able to choose among insurers, they would no longer face network restrictions and, in many cases, could have improved benefits. To protect innovation, some drug price savings could be used to augment federal research funding.

Single-payer reform would be best done at the federal level. Without federal waivers, state-based reforms cannot redirect federal and employer spending through the single-payer system, compromising the administrative savings needed to make expanded care affordable—a problem that bedeviled Vermont's reform effort.

Consolidation of purchasing power in a public agency may raise concerns that funding reductions would endanger quality or cause rationing, and that physicians would essentially become tradesperson paid by a single entity. Schulman et al calculated that hospitals' average margins would decline to −9% if all inpatient stays were reimbursed at Medicare's current rates.[8] While hospitals' savings on their own administrative costs (as much as $162 billion) could allow them to transition to a leaner cost structure, a sensible phase-in plan would be needed. Although neither of the congressional Medicare-for-all bills calls for the adoption of Medicare's rates, their budgeting is predicated on the assumption that hospitals could redirect resources from billing to clinical sites, allowing them to provide more care within current budgets.

Previous experience with coverage expansions is also reassuring. In Canada, mean physician income (in 2010 inflation-adjusted Canadian dollars) increased from about $100 000 in 1962 to $248 113 in 2010 (from 2.5 times the average worker's income to 4.3 times),[9] which was comparable to US physician income at the time. Similarly, hospital revenue per patient-day increased 8.9% annually in the 3 years after the 1959 startup of Canada's universal hospital insurance program.[10] The implementation of Medicare in 1966, the closest US analogue of a single-payer startup, also was associated with increased physician and hospital revenues.

State and federal legislators have introduced dozens of single-payer bills. Sixteen US senators and 110 representatives are cosponsoring companion Medicare-for-all bills that would implement universal, first-dollar coverage without network restrictions. Both federal bills would raise taxes, but those increases are projected to be fully offset by savings on premiums and out-of-pocket expenses. Both bills would augment funding for clinical services by redirecting funds now wasted on bureaucracy and excessive drug prices and the payer would pay physicians on a fee-for-service basis or salaries from hospitals or clinics that receive global budgets. The bill in the US House of Representatives adopts Canadian-style global budgeting for hospitals. However, the current US Senate bill retains Medicare's payment strategies (although not Medicare's payment rates), a provision that would modestly attenuate savings on hospital administration and maintain some unnecessary regulations that frustrate physicians. This shortcoming underscores the importance of physician input in crafting single-payer legislation.

Several legislators have introduced public-option (Medicare buy-in) proposals, portraying these proposals as more practical variants of Medicare for all. However, such reform would do little to simplify billing and paying, generating minimal administrative savings for clinicians or hospitals. Savings on insurance overhead would also be modest unless Medicare Advantage (in which overhead averages 13.7%) was excluded. Moreover, private insurers might selectively enroll healthy patients, turning the public option into a de facto high-risk pool requiring large subsidies. Hence, as the CBO report noted, expanded coverage would be costlier than under single-payer reform.

Halfway measures are politically attractive but economically unworkable. The $11 559 per capita that the United States spends on health care could provide high-quality care for all or it can continue to fund a vast health-managerial apparatus—it cannot do both.

ARTICLE INFORMATION

Published Online: May 31, 2019. doi:10.1001/jama.2019.7031

Conflict of Interest Disclosures: Drs Woolhandler and Himmelstein reported cofounding and remaining leaders of Physicians for a National Health Program, which advocates for a single-payer reform and reported serving as unpaid health policy advisors to Bernie Sanders' 2016 presidential campaign.

REFERENCES

1. NHE historical and projections 1960-2027. Centers for Medicare & Medicaid Services website. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html. Updated February 26, 2019. Accessed April 14, 2019.

2. Meyer H. Why does the U.S. spend so much more on healthcare? *Modern Healthcare*. https://www.modernhealthcare.com/article/20180407/NEWS/180409939/why-does-the-u-s-spend-so-much-more-on-healthcare-it-s-the-prices. Published April 7, 2018. Accessed April 28, 2019.

3. Himmelstein DU, Jun M, Busse R, et al. A comparison of hospital administrative costs in eight nations. *Health Aff (Millwood)*. 2014;33(9):1586-1594.

4. Tseng P, Kaplan RS, Richman BD, Shah MA, Schulman KA. Administrative costs associated with physician billing and insurance-related activities at an academic health care system. *JAMA*. 2018;319(7):691-697. doi:10.1001/jama.2017.19148

5. Morra D, Nicholson S, Levinson W, Gans DN, Hammons T, Casalino LP. US physician practices versus Canadians. *Health Aff (Millwood)*. 2011;30(8):1443-1450.

6. Canadian Medical Association. Hours on administrative forms. https://surveys.cma.ca/en/list?q=%22Q14.%20Hours%20on%20administrative%20forms%22&p=1&ps=20&sort=title_sort%20asc. 2017. Accessed April 28, 2019.

7. Congressional Budget Office. Key design components and considerations for establishing a single-payer health care system. https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf. Published May 2019. Accessed May 29, 2019.

8. Schulman KA, Milstein A. The Implications of "Medicare for All" for US hospitals [published online April 4, 2019]. *JAMA*. doi:10.1001/jama.2019.3134

9. Grant HM, Hurley J. Unhealthy pressure: how physician pay demands put the squeeze on provincial health-care budgets. *University Calgary Sch Public Policy Res Pap*. 2013;6(22):1-35.

10. Reed LS, Carr W. Utilization and cost of general hospital care. *Soc Secur Bull*. 1968;31:12.