Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs

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President Donald Trump and congressional Republicans have vowed to repeal and replace the Patient Protection and Affordable Care Act (ACA). Repealing it is relatively easy. Replacing it with "something great" is much trickier. The president has promised universal coverage and reduced deductibles and copayments, all within tight budgetary constraints. That is a tall order and unlikely to be filled by proposals that Republicans have offered thus far.

Speaker of the House Paul Ryan's blueprint (1) would rebrand the ACA's premium subsidies as "tax credits" (technically, the subsidies are already tax credits) and offer them to anyone lacking job-based coverage—even the wealthy—reducing the funds available to subsidize premiums for lower-income persons in the United States. He would allow "mini-med" plans offering miniscule coverage and interstate sales of insurance, circumventing state-based consumer protections. And he would augment tax breaks for health savings accounts, a boon for persons in high tax brackets.

Speaker Ryan would also end the long-standing federal commitment to match states' Medicaid spending, substituting block grants that state governments could divert to nonmedical purposes. Moreover, decoupling federal contributions from actual medical expenditures amounts to a sotto voce cut. For Medicare, he would trim federal spending by delaying eligibility until age 67 years; replace seniors' guaranteed benefits with vouchers to purchase coverage; and tie the vouchers' value to overall inflation, which lags behind health care inflation.

In sum, Speaker Ryan's proposal, and a similar one from Secretary of Health and Human Services Tom Price, would shrink the coverage of poor and low-income persons in the United States while maintaining (or expanding) outlays for some higher-income groups. That approach might save federal dollars by shifting costs onto patients and state budgets. But containing overall health care costs requires denting the revenues (and profits) of corporate giants that increasingly dominate care—an unlikely outcome of policies that expand the role of private insurers and weaken public oversight.

Although Republicans' proposals seem unlikely to achieve President Trump's triple aim (more coverage, better benefits, and lower costs), single-payer reform could. Such reform would replace the current welter of insurance plans with a single, public plan covering everyone for all medically necessary care—in essence, an expanded and upgraded version of the traditional Medicare program (that is, not Medicare Advantage).

The economic case for single-payer reform is compelling. Private insurers' overhead currently averages 12.4% versus 2.2% in traditional Medicare (2). Reducing overhead to Medicare's level would save approximately $220 billion this year (**Table**) (3). Single-payer reform could also sharply reduce billing and paperwork costs for physicians, hospitals, and other providers. For example, by paying hospitals lump-sum operating budgets rather than forcing them to bill per patient, Scotland and Canada have held hospital administrative costs to approximately 12% of their revenue versus 25.3% in the United States (4). Simplified, uniform billing procedures could reduce the money and time that physicians spend on billing-related documentation.

All told, we estimate that single-payer reform could save approximately $504 billion annually on bureaucracy (**Table**). Any such estimate is imprecise; however, this figure is in line with Pozen and Cutler's estimate ($383 billion, updated to reflect health care inflation) (5), which excludes potential savings for providers other than physicians and hospitals. Additional savings could come from adopting the negotiating strategies that most nations with national health insurance use, which pay approximately one half what we do for prescription drugs.

Of course, single-payer reform would bring added costs as well as savings. Full coverage would (and should) boost use for the 26 million persons in the United States who remain uninsured despite the ACA. And plugging the gaps in existing coverage (abolishing copayments and deductibles, covering such services as dental and long-term care that many policies exclude, and bringing Medicaid fees up to par) would further increase clinical expenditures.

Studies provide imperfect guidance on the probable magnitude of changes in use under single-payer reform. Microlevel experiments indicate that when a few persons in a community gain full coverage, their use surges (6). But when many persons gain coverage, the fixed supply of physicians and hospitals constrains community-wide increases in use. For example, when Canada rolled out its single-payer program, the total number of physician visits changed little; increased visits for poorer, sicker patients were offset by small declines in visits for healthier, more affluent persons (7). Despite dire predictions of patient pileups, Medicare and Medicaid's start-up in 1966 similarly shifted care toward the poor but caused no net increase in use (8).

Despite some uncertainties, analysts from government agencies and prominent consulting firms have concluded that administrative and drug savings would fully offset increased use, allowing universal, comprehensive coverage within the current health care budgetary envelope (9). International experience with

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Table. Estimated Administrative and Prescription Drug Savings Under Single-Payer Reform, 2017

Sector	2017 Spending Without Reform, *$ (billion)*	Savings With Single-Payer Reform, %	Savings Available to Expand and Improve Coverage Under Single-Payer Reform, 2017, *$ (billion)*
Insurance overhead and administration of public programs	323.3*	68.0	220.0†
Hospital administration and billing‡	283.9	52.6	149.3
Physicians' office administration and billing§	187.6	40.1	75.3
Total administration§	1091.7	46.1	503.6
Outpatient prescription drugs	362.7*	31.2‖	113.2
Total administration plus outpatient prescription drugs	–	–	616.8

* From National Health Expenditure Amounts by Type of Expenditure and Source of Funds: Calendar Years 1960–2025 in projections format (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE60-25.zip).
† Based on the assumption that insurance overhead would decrease to 2.2% (overhead in traditional Medicare program according to the 2016 Medicare Trustees' report) and that the share of expenditures covered by insurance would increase from the current value of 74% to 80%.
‡ Based on data from reference 4 applied to the national health expenditure accounts estimate of 2017 hospital spending.
§ Based on data from reference 3 applied to 2017 national health expenditure estimates. Total administration estimates include additional administrative savings for nursing homes, home care agencies, nonphysician practitioners, and employers.
‖ Assumes no savings for Medicaid, U.S. Department of Veterans Affairs, and other federal government programs that already receive discounts; 50% savings on brand-name drugs; and no savings on generics, which account for approximately 28% of prescription drug spending.

single-payer reform provides further reassurance. It has been thoroughly vetted in Canada and other nations where access is better, costs are lower, and quality is similar to that in the United States.

The potential health benefits from single-payer reform are more important than the economic ones. Being uninsured has mortal consequences. Covering the 26 million persons in the United States who are currently uninsured would probably save tens of thousands of lives annually. And underinsurance now endangers many more by, for example, delaying persons from seeking care for myocardial infarction or causing patients to skimp on cardiac or asthma medications. Single-payer reform would also free patients from the confines of narrow provider networks and lift the financial threat of illness, a frequent contributor to bankruptcy and the most common cause of serious credit problems.

The ACA has helped millions. However, our health care system remains deeply flawed. Nine percent of persons in the United States are uninsured, deductibles are rising and networks narrowing, costs are again on the upswing, the pursuit of profit too often displaces medical goals, and physicians are increasingly demoralized. Reforms that move forward from the ACA are urgently needed and widely supported. Even two fifths of Republicans (and 53% of those favoring repeal of the ACA) would opt for single-payer reform (10). Yet, the current Washington regime seems intent on moving backward, threatening to replace the ACA with something far worse.

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References

1. **A Better Way.** A better way: our vision for a confident America. 22 June 2016. Accessed at https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf on 1 February 2017.
2. **The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.** 2016 annual report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 22 June 2016. Accessed at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf on 2 February 2017.
3. **Woolhandler S, Campbell T, Himmelstein DU.** Costs of health care administration in the United States and Canada. N Engl J Med. 2003;349:768-75. [PMID: 12930930]
4. **Himmelstein DU, Jun M, Busse R, Chevreul K, Geissler A, Jeurissen P, et al.** A comparison of hospital administrative costs in eight nations: US costs exceed all others by far. Health Aff (Millwood). 2014;33:1586-94. [PMID: 25201663] doi:10.1377/hlthaff.2013.1327
5. **Pozen A, Cutler DM.** Medical spending differences in the United States and Canada: the role of prices, procedures, and administrative expenses. Inquiry. 2010;47:124-34. [PMID: 20812461]
6. **Baicker K, Taubman SL, Allen HL, Bernstein M, Gruber JH, Newhouse JP, et al; Oregon Health Study Group.** The Oregon experiment–effects of Medicaid on clinical outcomes. N Engl J Med. 2013;368:1713-22. [PMID: 23635051] doi:10.1056/NEJMsa1212321
7. **Enterline PE, Salter V, McDonald AD, McDonald JC.** The distribution of medical services before and after "free" medical care–the Quebec experience. N Engl J Med. 1973;289:1174-8. [PMID: 4754965]
8. **Wilder CS.** Volume of physician visits. United States–July 1966-June 1967. Vital Health Stat 10. 1968;10:1-60. [PMID: 5303847]
9. **Physicians for a National Health Program.** How much would a single payer cost? A summary of studies compiled by Ida Hellander, MD. 2016. Accessed at www.pnhp.org/facts/single-payer-system-cost on 2 February 2017.
10. **Newport F.** Majority in U.S. support idea of fed-funded healthcare system. Gallup. 16 May 2016. Accessed at www.gallup.com/poll/191504/majority-support-idea-fed-funded-healthcare-system.aspx on 2 February 2017.

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