The American College of Physicians' Endorsement of Single-Payer Reform: A Sea Change for the Medical Profession

Steffie Woolhandler, MD, MPH, and David U. Himmelstein, MD

For a century, most U.S. medical organizations opposed national health insurance. The endorsement by the American College of Physicians (ACP) of single-payer reform marks a sea change from this unfortunate tradition (1, 2).

Like their U.S. counterparts in an earlier era, many Canadian physicians feared, and fiercely opposed, single-payer reform. "We were afraid it would destroy the profession . . . that our integrity would be destroyed . . . that the government would intrude on the private doctor–patient relationship," said E.W. Barootes, who as President of Saskatchewan's medical association led a 3-week doctors' strike in 1962 against that province's new single-payer program (3).

Yet despite a rocky start, most Canadians now embrace their single-payer system. Everyone is covered, and all doctors and hospitals are "in-network." Health costs, almost identical to U.S. levels in the 1960s, are now about 40% lower, with savings on administration accounting for half the difference (4). Although funding for some aspects of care has, in our view, been squeezed too tightly in Canada, physicians' incomes have not; Canadian internists' take-home pay averages about CAD$300 000. Canada's health outcomes surpass those of the United States, including for such conditions as cystic fibrosis, end-stage renal disease, and type 1 diabetes, whose outcomes reflect quality of care (5–7).

Canada's generally positive experience is among the strands of evidence underpinning the ACP's endorsement. A single-payer reform that reduced insurance overhead to 2% (the level for Canada and traditional Medicare) could save more than $200 billion annually. In addition, our multipayer system imposes complexity and expense on providers; the Cleveland Clinic has 210 000 000 different prices (8). Single-source payment could streamline reimbursement—for example, by replacing per patient hospital payment with global budgets and establishing uniform billing and documentation requirements. Hospitals and doctors could save billions on billing-related costs and repurpose those savings to expand care, making universal, first-dollar coverage affordable.

Achieving universal coverage would be costlier under the "public choice" model the ACP co-endorses along with single payer. Multipayer systems incorporating for-profit insurers have not gleaned large administrative savings. For-profit insurers' overhead is high everywhere (9), and the persistence of multiple payers would hinder efforts to streamline providers' billing-related work.

Moreover, real-world experience with 2 public choice models—Medicare's Advantage program and the Consumer Oriented and Operated Plans (CO-OPs) under the Patient Protection and Affordable Care Act (ACA)—warns that in health insurance competition, public option good guys finish last.

Twenty-three CO-OPs offering plans on the ACA exchanges received $2.4 billion in federal start-up loans. Only 4, covering 150 000 enrollees, survive. New York's defunct CO-OP, like many others, attracted many expensively ill patients, in part because its network—unlike that of other exchange plans—included Memorial Sloan Kettering Cancer Center. Iowa's CO-OP, which offered lower cost sharing for antiretrovirals than its competitors, reportedly enrolled 98% of all patients with HIV covered by Iowa's exchange plans. Although the ACA included special funding to compensate CO-OPs for high-risk enrollees, the losses far exceeded what Congress was willing to appropriate.

Small start-ups, such as the CO-OPs, often succumb to deep-pocketed competitors. However, the traditional Medicare program—a large, well-established public option—also is losing out in competition with private (Medicare Advantage) plans, despite their 6-fold higher overhead and 6% higher total costs (after accounting for "cherry picking" and upcoding) (10).

Medicare Advantage plans have flourished, because chicanery trumps efficiency. The Centers for Medicare & Medicaid Services uses patients' diagnoses to risk adjust its payments to Medicare Advantage plans and minimize incentives for cherry picking. However, insurers game the risk-adjustment formulas by labeling enrollees with new (often clinically insignificant) diagnoses and recruiting lower-cost patients within a diagnostic category, such as minimally symptomatic patients carrying such diagnoses as osteoarthritis, asthma, or congestive heart failure.

Plans also profit by "lemon dropping"—pushing out unprofitably ill enrollees. Imposing high copayments for chemotherapy agents and excluding specialized cancer providers from networks encourages oncology patients to disenroll. Seniors requiring nursing home stays or treatment for new-onset end-stage renal disease have transferred in droves from Medicare Advantage to traditional Medicare (11, 12). Moreover, Medicare Advantage plans that accumulate unprofitably ill seniors can, and do, pull out of entire counties, an option unavailable to their public option competitor.

Private insurers have turned traditional Medicare (like the ACA's CO-OPs) into a de facto high-risk pool, despite regulations banning cherry picking and lemon dropping. Enforcement of those regulations, already overmatched by insurers' stratagems, will surely become harder. Google, part owner of Oscar, an insurance start-up, knows who's playing tennis and who's

This article is part of the *Annals* supplement "Better Is Possible: The American College of Physicians' Vision for the U.S. Health Care System." The American College of Physicians was the sole funder for this supplement.

buying plus-size dresses and can micro-target marketing accordingly. As some suggest, insurers, like casinos, are profitable because they know the odds of every bet they place and can eject people who are beating the house (13).

Despite drawbacks, public choice reform offers 2 apparent advantages: It avoids confrontation with private insurers and allows individuals to retain their current coverage.

Unfortunately, achieving universal, affordable coverage through public choice would, like single payer, impose painful sacrifices on private insurers. In Germany, an oft-cited example of a universal multipayer system, insurers offering the mandatory coverage are nothing like ours. By law, Germany's "statutory" insurers must be nonprofit, pay the same fees, charge the same premiums, and contract with every hospital and every doctor. Insurers with low-risk patients must cross-subsidize others, effectively creating a single risk pool. In sum, Germany's statutory insurers (like Switzerland's and Holland's) "are not as a matter of public policy conceived of . . . [or] allowed to function as private businesses" (14); they are more akin to the fiscal intermediaries that process traditional Medicare claims. U.S. insurers would surely fight tooth and nail against such transformation.

Public choice's second purported advantage may also be illusory. Although surveys indicate that voters value choice, it's choice of doctor and hospital—not insurer—that they care about.

Although no reform achieves perfection, evidence indicates that a well-structured single-payer reform might resolve our nation's coverage and affordability problems, preserve the choices patients value, and allow doctors to focus on what matters most: caring for our patients.

Three decades after leading the Saskatchewan strike, Dr. Barootes had changed his view: "Today I support the universal healthcare program . . . . There has been no interference in the decision making between a doctor and his [sic] patient . . . . A politician is more likely to get away with canceling Christmas than he is with canceling Canada's health insurance program" (15).

Steffie Woolhandler, MD, MPH
David U. Himmelstein, MD
City University of New York at Hunter College
New York, New York

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M19-3775.

Corresponding Author: Steffie Woolhandler, MD, MPH, City University of New York at Hunter College, 2180 Third Avenue, New York, NY 10035; e-mail, swoolhan@hunter.cuny.edu.

Current author addresses are available at Annals.org.

Ann Intern Med. 2020;172:S60-S61. doi:10.7326/M19-3775

References

1. **Doherty R, Cooney TG, Mire RD, et al; Health and Public Policy Committee and Medical Practice and Quality Committee of the American College of Physicians.** Envisioning a better U.S. health care system for all: a call to action by the American College of Physicians. Ann Intern Med. 2020;172:S3-6. doi:10.7326/M19-2411
2. **Crowley R, Daniel H, Cooney TG, et al; Health and Public Policy Committee of the American College of Physicians.** Envisioning a better U.S. health care system for all: coverage and cost of care. Ann Intern Med. 2020;172:S7-32. doi:10.7326/M19-2415
3. **Nagle P.** Tragedy marked Medicare's first day. Toronto Star. 19 June 1992:A1 and A24.
4. **Himmelstein DU, Campbell T, Woolhandler S.** Health care administrative costs in the U.S. and Canada, 2017. Ann Intern Med. 2020: 172:134-42. doi:10.7326/M19-2818
5. **Stephenson AL, Sykes J, Stanojevic S, et al.** Survival comparison of patients with cystic fibrosis in Canada and the United States: a population-based cohort study. Ann Intern Med. 2017;166:537-546. [PMID: 28288488] doi:10.7326/M16-0858
6. **Guyatt GH, Devereaux P, Lexchin J, et al.** A systematic review of studies comparing health outcomes in Canada and the United States. Open Med. 2007;1:e27-36. [PMID: 20101287]
7. **Gaffney A, Christopher A, Katz A, et al.** The incidence of diabetic ketoacidosis during "emerging adulthood" in the USA and Canada: a population-based study. J Gen Intern Med. 2019;34:1244-50. [PMID: 31065950] doi:10.1007/s11606-019-05006-6
8. Cleveland Clinic letter to CMS. Quoted in: Livingston S. Hospitals, insurers urge CMS to abandon plan to force negotiated price disclosure. Modern Healthcare. 30 September 2019. Accessed at www.modernhealthcare.com/hospitals/hospitals-insurers-urge-cms-abandon-plan-force-negotiated-price-disclosure on 26 November 2019.
9. **Hagenaars LL, Klazinga NS, Mueller M, et al.** How and why do countries differ in their governance and financing-related administrative expenditure in health care? An analysis of OECD countries by health care system typology. Int J Health Plann Manage. 2018;33: e263-e278. [PMID: 29024036] doi:10.1002/hpm.2458
10. **Curto V, Einav L, Finkelstein A, et al.** Health care spending and utilization in public and private Medicare. Am Econ J Appl Econ. 2019;11:302-32. [PMID: 31131073] doi:10.1257/app.20170295
11. **Rahman M, Keohane L, Trivedi AN, et al.** High-cost patients had substantial rates of leaving Medicare Advantage and joining traditional Medicare. Health Aff (Millwood). 2015;34:1675-81. [PMID: 26438743] doi:10.1377/hlthaff.2015.0272
12. **Li Q, Trivedi AN, Galarraga O, et al.** Medicare Advantage ratings and voluntary disenrollment among patients with end-stage renal disease. Health Aff (Millwood). 2018;37:70-7. [PMID: 29309223] doi: 10.1377/hlthaff.2017.0974
13. **Ames S.** Letter to the editor. New York Times. 1 August 2019: A26.
14. **Jost TS.** The experience of Switzerland and the Netherlands with individual health insurance mandates: a model for the United States? Accessed at http://law2.wlu.edu/deptimages/Faculty/Jost%20The%20Experience%20of%20Switzerland%20and%20the%20Netherlands.pdf on 22 November 2019.
15. **Lyons SA.** The 1962 battle over Canadian health care: Labor pains. Whole Earth Rev. 1995(Winter):74-81.

Current Author Addresses: Drs. Woolhandler and Himmelstein: City University of New York at Hunter College, 2180 Third Avenue, New York, NY 10035.