Single-Payer vs. Public Option: Can Either System Address Rising Health Care Prices?

In February 2018, the Centers for Medicare and Medicaid Services (CMS) released data that National Health Expenditures accounted for 17.9% of Gross Domestic Product (GPD) and exceeded $10,300 per person. Even more alarming, CMS predicts that health expenditures will increase at an average rate of 5.5%, faster than inflation or increase in GPD, so that by 2026, health care will cost almost 20% of GDP. As a result of escalating costs of health care and increasing cost-sharing and co-pays for individual patients, those on the left of the political spectrum have increasingly called for single-payer health insurance or a public option. What is the difference between these two systems and can either system contain soaring health care expenditures?

The Single-Payer System: At the most basic level, a single-payer system refers to "a single, centralized, publicly organized means to collect, pool, and distribute money to pay for the delivery of consistent health care services for all members of a community."[1] The desire for a simpler, less costly health care system has widespread appeal and a single-payer system appears to be an efficient solution to rising health care costs and unequal access to health care.

Support for a Single-Payer System: The Kaiser Family Foundations Health Tracking Poll found that a slim majority of Americans now support a single-payer system and that the percentage of Americans supporting that system has slowly

risen every year since 1998.[2] Support for the system gained greater momentum when Bernie Sanders, a Democratic Senator from Vermont, made it a key issue in his presidential campaign, calling it "Medicare-For-All". More recently, the California Nurses Association (CNA) sponsored SB 562, the Healthy California Act, "to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of [California]."[3] Under this plan, all California residents, including illegal immigrants, would receive "all medical care determined to be medically appropriate" with no cost-sharing or premiums.

A major issue with the Healthy California Act, as with any single-payer program, is cost. The Legislative Analyst's Office estimates that healthcare expenditures in California will exceed $400 billion in 2017-2018, with about half of that paid for by federal funds including Medicare, Medicaid, and Obamacare subsidies. As a result, in order to implement the Healthy California Act, the state would have to find at least $100 billion in new revenue to pay for the elimination of employer and patient contributions to health insurance and health care.[4] SB 562 passed the California Senate in 2017 but stalled in the state Assembly. At the end of February 2018, the Select Committee on Health Care Delivery Systems and Universal Coverage held final hearings on the bill, but they could not reach a consensus about paying for coverage.[5] SB 562 appears unlikely to pass in the short-term, but support continues to increase for single-payer health coverage both at the state and federal level.

Criticisms of a Single-payer System: Many providers and scholars question if a single-payer system is the best path to universal coverage.[6] They contend that adopting a single-payer system risks losing the additional coverage protections and expansion of insurance coverage provided by the Affordable Care Act (ACA). If a single-payer program is not carefully and

thoughtfully designed and implemented, the system could wind up providing less complete coverage to many Americans. For example, SB 562, the Healthy California Act, would eliminate private insurance companies in California while offering few specifics on how to pay for the program. With no private insurance, government agencies must determine which physicians to include in the program, as well as what services to cover and at what rate. As a result, many providers may change the way they provide services to patients. Many individuals do not recognize, however, that adopting a single-payer program would likely mean they would have to change their physician. In an interview, Mollyann Brodie, Executive Director of Public Opinion and Survey Research at the Kaiser Family Foundation, said that "about half [of Americans] think they'll be able to keep their current insurance, which is flatly false."[7]

A report by Susan Philip and Marian Mulkey, sponsored by the California Health Care Foundation, identifies key questions that California should ask when considering a single-payer system. The authors urge a robust debate about what the goals of a single-payer system are and how policy and design decisions, including funding, link to those goals. For example, the single-payer system attempts to address many problems, but how should those be prioritized? How should California prioritize equal access to healthcare by all residents against consumer affordability and underinsurance? How should the state attempt to reduce total health care expenditure while providing comprehensive coverage to more individuals? In one example of the difficult decisions the government would face, Philip and Mulkey ask how the government would set physician reimbursements to encourage provider participation while simultaneously trying to cut health care costs.[8] The authors assert that adequate payments are necessary to ensure access to care and that a clear payment methodology, with incentives aligned with the program's goals, is critical to preventing fraud and increasing the value of healthcare. In addition, if the

government simply sets reimbursement rates for care, the lack of financial rewards for new treatments and medications will likely diminish funding for research and development.

Others question if the government can effectively execute funding while also preventing corruption and misappropriation of money. As Henry Aaron from the Brookings Institute wrote in a perspective in the New England Journal of Medicine about a national single-payer system, Americans "would have to trust a federal government that stumbled badly in rolling out ACA coverage that directly covers less than 4% of the U.S. population to successfully engineer a transition for more than 300 million people to a wholly government-run system."[9] The concept of a single-payer program is appealing, but the implementation is difficult and many of the necessary choices are likely to be unpopular.

The Public Option: A public option, a.k.a "Medicare You Can Buy Into," addresses many of the concerns of the single-payer system. Former President Barack Obama promoted the idea of a public option during his election campaign and included it in initial versions of the ACA.[10] In February 2018, the Center for American Progress (CAP), a liberal think-tank, released a public-option proposal confusingly entitled "Medicare Extra for All."[11] In contrast to "Medicare for All" proposals that would replace all insurance with government-based coverage, the "Medicare Extra for All" program would combine Medicaid and individual marketplace coverage into one program and allow Medicare beneficiaries and others the *option* of buying coverage through the program. Employers could choose to purchase Medicare Extra coverage for their employees, and employees could choose the government program instead of the one offered by their employer. The program would offer the same high-quality coverage that Medicare currently offers, with a limit on out-of-pocket spending and integrated drug benefits. In the CAP's proposal, individuals without other

coverage would be automatically enrolled in Medicare Extra and the premiums would be collected through individual tax withholding or tax returns (essentially replacing the individual mandate created by the ACA). In addition, Medicare Extra would cap premiums based on income, with no premium required for families earning up to 150% of the Federal Poverty Level (FPL), a premium of 10% of family income for families earning more than 500% of the FPL, and a sliding scale premium for families with incomes between 150 and 500% of the FPL. The crucial difference between the single-payer program and a public option is that a public option allows people the option to keep their existing insurance coverage and private insurance companies to compete with the public option for beneficiaries.

Public/Private Competition Already Exists in Medicare: This competition is analogous to Medicare Advantage (MA), often called Medicare Part C. In MA, private managed care plans compete with traditional Medicare (Parts A and B) and the beneficiary may choose whether to enroll in MA or in traditional Medicare. MA plans typically offer lower co-pays and broader coverage, including hearing, vision, prescription drugs and wellness benefits, than traditional Medicare. As with other managed care programs, however, MA plans typically have a more limited network of providers and, unlike in traditional Medicare, beneficiaries typically need referrals to see specialists. A report by the Commonwealth Fund, released in March 2018, found that enrollment in MA plans grew significantly from 10.5 million seniors in 2009 to 18.5 million in 2014, and that these private plans cover more than a third of all Medicare beneficiaries. At the same time that they have grown in popularity, MA plans have also reduced costs. While costs of traditional Medicare increased by 5 percent per enrollee between 2009 and 2014, total costs per enrollee for MA *dropped* 0.7 percent in the same time period. The success of the MA program suggests that private insurers can be effective at both controlling costs and attracting

beneficiaries to their plans.

Restoring Competition with a Public Option: The U.S. relies on competition to contain health care costs, improve quality, and encourage innovation. Allowing the federal government to set a standard against which all other insurance plans must compete will help drive innovation in care and allow individuals greater choice in coverage. For example, one patient might choose a very limited provider network in exchange for lower costs, while the other might choose a broad provider network at a higher cost. Physicians could choose to participate in networks based on reimbursement rates, but would have to accept Medicare reimbursement rates in order to treat the majority of Americans likely to have coverage through the program. All of these choices exist in theory in the current market, but horizontal consolidation of providers and plans, along with vertical integration between plans and providers, have severely limited competition. The consensus among scholars is that antitrust law has been ineffective at maintaining competition in provider networks.[12] A public option could, therefore, restore competition in a highly consolidated market. This competition has the potential to bring down prices for people covered by the public option, as well as those covered by private insurance plans.

In order for a public option to work, however, the option must be allowed to compete effectively with private plans. A public option could significantly decrease prices because it would have the bargaining power to negotiate with monopolistic drug manufacturers and highly concentrated provider networks. This bargaining power will only work to drive down prices if the government does not prohibit the public option from using it. Because of intense lobbying by the pharmaceutical industry, current law prohibits Medicare from negotiating drug prices on behalf of its beneficiaries. To effectively bring down health care costs, the government needs to stand up to industries with political power and negotiate on behalf of the

American people.

Health care costs continue to dominate the U.S. economy. Healthcare spending reached 17.9% of gross domestic product in 2017, about twice the healthcare spending of other wealthy countries.[13] Health care premiums also continue to rise for both individuals and employers. After a substantial decrease in the number of uninsured Americans under the ACA, the repeal of the individual mandate and other policy changes by the Trump administration suggest that the number of uninsured Americans will again rise. Given these trends, the time is ripe to consider additional measures to increase coverage and decrease costs. Single-payer programs, if successful, will offer coverage to more people, but the public option shows promise at both increasing the number of covered individuals and decreasing overall healthcare costs.

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[1] Susan Philip and Marian Mulkey. "Key Questions When Considering a State-Based, Single-Payer System in California." California Health Care Foundation. November 2017. Available at: https://www.chcf.org/publication/key-questions-when-considering-a-state-based-single-payer-system-in-california/.

[2] Liz Hamel, Bryan Wu, and Mollyann Brodie. "Data Note: Modestly Strong but Malleable Support for Single-Payer Health Care." Kaiser Family Foundation. July 5, 2017. Available at: https://www.kff.org/health-reform/poll-finding/data-note-modestly-strong-but-malleable-support-for-single-payer-health-care/.

[3] CA SB 562 (2017-2018). Text available at: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?b

ill_id=201720180SB562.

[4] LAO calculates the state would need to contribute $150-200 billion additionally to cover health care costs, and it acknowledges difficulty in estimating this number due to different policy proposals. The CNA and other economists suggest the number might be closer to $100 billion due to lower administrative fees, lower provider reimbursement rates, and increased preventative care. (See http://healthcare.assembly.ca.gov/sites/healthcare.assembly.ca.gov/files/FINAL%20LAO.pdf)

[5] Michael Hiltzik, "California confronts the complexities of creating a single-payer healthcare system." LA Times. February 9, 2018. Available at: http://www.latimes.com/business/hiltzik/la-fi-hiltzik-singlepayer-20180209-story.html.

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[7] Marilyn Serafini. "Why Clinicians Support Single-Payer – and Who Will Win and Lose." NEJM Catalyst. January 17, 2018. Available at: https://catalyst.nejm.org/clinicians-support-single-payer-win-lose/.

[8] Philip and Mulkey 2017.

[9] Aaron 2017.

[10] H.R.3962 – Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010111th Congress (2009-2010).

[11] https://cdn.americanprogress.org/content/uploads/2018/02/21130

514/MedicareExtra-report.pdf.

[12] Health Affairs Special Issue on Market Concentration, Vol. 36 No. 9. September 2017. Available at: https://www.healthaffairs.org/toc/hlthaff/36/9; Fuse Brown, Erin C. and King, Jaime S., The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control (2016). Indiana Law Journal, vol. 92, 2016; Georgia State University College of Law, Legal Studies Research Paper No. 2016-01. Available at SSRN: https://ssrn.com/abstract=2736310 or http://dx.doi.org/10.2139/ssrn.2736310 .

[13] Papanicolas I, Woskie LR, Jha AK. **Health Care Spending in the United States and Other High-Income Countries**. *JAMA.* 2018;319(10):1024–1039. doi:10.1001/jama.2018.1150.