Single-Payer Health Care: What Does it Mean for You?

By Suzanne Spradley
Chief Compliance Officer,
Associate General Counsel, NFP

A single-payer health care system, such as the proposal of "Medicare for All," has become a hot topic in the US and a defining issue for 2020 Democratic presidential hopefuls. The debate has undoubtedly been driven by the uninsured population, rising premiums and lack of options in the individual marketplace. At the same time, over fifty% of the US population are covered by employer-sponsored group health insurance, making it the single largest component of health insurance coverage in the United States and unique to other countries. Compared to the individual market, the employer-sponsored coverage is more innovative, cost-effective and has higher satisfaction ratings. If a single-payer solution is adopted broadly, millions of Americans are at risk of being pushed into the individual market created by a nationalized plan.

For us all, it's important to learn from current single-payer systems to gain a better understanding of how single-payer health care could impact how Americans obtain health care services. As the Congressional Budget Office affirmed, "The transition toward a single-payer system could be complicated, challenging, and potentially disruptive."[1]

EMPLOYER-SPONSORED COVERAGE

Truly unique to the United States, the employer-sponsored market has roots back to 1910 when Montgomery Ward established one of the earliest group health plans. Over the years, this system of health insurance coverage has been relied upon by millions of Americans and has allowed the United States to boast a significantly lower tax burden than other countries. Employers have been able to control costs more than the individual market while providing more robust health care benefits (average 83% actuarial value) compared to the non-group market (average 60% actuarial value). Employers are also in a unique position to provide incentives for innovation in design of health benefit programs that help to constrain costs and improve outcomes. Additionally, a number of surveys indicate that the vast majority of workers are very satisfied with the current health care coverage provided by their employer and rated health benefits as very important when making a decision about accepting a new job.

Although employer-sponsored health insurance is relatively young from a global perspective, most people in the US are familiar with it. Single-payer health care, on the other hand, is a new concept to many Americans. As it becomes more and more important in national discussions, it's key that we have a greater understanding of the concept and some of the ways it can be put into practice.

WHAT IS SINGLE-PAYER HEALTH CARE?

First, let's define "single-payer health care," which is a broad term that generally means a system in which the government provides nationalized health insurance. In its most moderate form, the single-payer system sits alongside a private health insurance market, as in the proposals named Medicare-X Choice, Choose Medicare, Medicare Buy-In, or the state public option. In its most extreme form, it eliminates the private health insurance market altogether, as in the Medicare for All or Medicare for America proposals of true nationalized health care programs. The following tables depict the various proposals and where they stand on the continuum.

PUBLIC PLAN FEATURES ADDED TO PRIVATE INSURANCE	SINGLE PUBLIC PLAN FOR ALL		
More private health plan and provider regulation	**National Health Insurance Program**		
Consumer Health Insurance Protection Act of 2018 (S.2582)	Medicare for America Act of 2018 (H.R. 7339)	Medicare for All Act of 2017 (S. 1804)	Medicare for All Act of 2019 (H.R. 1384)

A CHOICE OF PUBLIC AND PRIVATE PLANS			
Medicare-Like Plan in the Marketplace	**Medicare-Like Plan for People with Employer Coverage**	**Medicare Buy-In for Americans over 50**	**Medicaid Buy-In for All**
Medicare-X Choice Act of 2017 (S. 1970, H.R. 4094)	Choose Medicare Act (S. 2708, H.R. 6117)	Medicare Buy-In and Health Care Stabilization Act of 2019 (H.R. 1346)	State Public Option Act (S.489, H.R. 1277)
		Medicare at 50 Act (S.470)	

When it comes to polling results, the details of any single-payer proposal matter when determining whether there is support for a single payer system. For many years, Kaiser Family Foundation (KFF) has tracked public opinion on the idea of a single payer health system. In February 2019, KFF found broad support for proposals that expand the role of public programs like Medicare and Medicaid. Overall, about six in ten adults favor a national health plan or Medicare for All. But public support for Medicare for All shifts significantly when details are provided about potential tax increases (60% oppose) or delays in medical tests and treatment (70% oppose). The KFF poll also shows many people falsely assume they would be able to keep their current health insurance under a single-payer plan (58% oppose eliminating private insurance). So, polling demonstrates strong support for a single-payer system when it will not impact taxes, wait times, or the private insurance market. When such impact is factored in, support for a single-payer system drops significantly.

Though we don't know how a single-payer system would work for the US, there are examples we can draw on as we weigh the costs and benefits of these types of systems.

VETERANS ADMINISTRATION HEALTH CARE

To further understand what a single-payer system could mean for our country, we can look as close as the Veterans Administration (VA) health care system, which is a socialized, single-payer program funded by US taxpayers, with hospitals owned by the government, and health care providers who are government employees. Over the past few years, it's come to light that the VA system is plagued with cost overruns, inefficiencies, and prolonged wait times for care. A report by the Department of Veterans Affairs in 2018[2] showed that there were serious deficiencies in the Washington D.C. VA Medical Center, including:

- Patients who underwent prolonged anesthesia because surgical instruments were unavailable once the patients were put under.

- Doctors and nurses forced to make do by borrowing supplies from a nearby hospital, while 500,000 items sat unused at a warehouse.
- The government rented three home hospital beds for nearly $875,000 that would have only cost $21,000 to buy.

Clearly, this example of a nationalized program in the US is chronically dysfunctional, at least in its D.C. location.

SINGLE-PAYER SYSTEMS OUTSIDE THE US

What about other countries? Let's take a look at Canada. The Canada Health Act (CHA) was introduced in 1984. CHA coverage is publicly-funded, meaning that the funds come from federal and provincial taxes. Care is provided by plans created in each province or territory, rather than a single, unified federal health plan. The Canadian government pays into these plans, but each territory and province is responsible for taking this money to create their own system under the guidelines set forth by the CHA. Unlike Britain's National Health Services (NHS), where health care is socialized and hospitals are run by the NHS, in Canada health care is technically delivered privately, although the system is by no means market-based given all the restrictions.

When it comes to quality of care, Canada lags behind most other developed Western nations. The 2017 Commonwealth Fund study ranked Canada last in timeliness of care.[3] As noted by a Fraser Institute report, research has repeatedly indicated that wait times for medically necessary treatment can, and do, have serious consequences such as increased pain, suffering, and mental anguish. In certain instances, they can also result in worse medical outcomes.[4]

Although the 2017 edition of the Commonwealth Fund study lacks a breakdown of the timeliness category, the 2014 report showed that 29% of adult Canadians who fell ill and needed to see a specialist waited two months or longer, compared with 6% of Americans.[5]

The Fraser Institute highlights distressingly long wait times throughout Canada for a variety of critical treatments. Wait times vary from province to province, but the median wait time to treatment after a general practitioner's referral is 15.4 weeks, in Saskatchewan.[6] Interestingly, wait times have increased dramatically within an already universalized system: the Fraser study compares wait times since 1993, when the CHA act was almost a decade old.

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We now turn to Britain's NHS, which has been around longer than Canada's, since 1948. Again, the data on wait times is not promising. For example, according to the Guardian, the number of NHS patients waiting for hospital treatment could soar to more than five million in just two years' time. Such an increase puts major strain on the system, and if no action is taken, twice as many people will be forced to wait more than 18 weeks (an NHS standard) for non-emergency surgery such as hip replacements and cataract operations in 2019.[7]

On the other hand, the UK ranks much better than Canada in terms of timeliness for "specialty services," according to the 2017 Commonwealth Fund study, as do the Netherlands and Germany, both of which provide universal coverage.[8] What's unique about the Netherlands and Germany is that their universal health care systems rely on private insurers and private health care providers. In the Netherlands, people are required to buy private insurance, with financing shared between individuals and employers. Germany allows its residents to choose between two systems: nonprofit private insurance in the statutory health insurance system or private health insurance that varies in benefits and cost.

SINGLE-PAYER COMES IN MANY FORMS

To summarize, as the discussion on a single-payer system in the US heats up, it's important to understand the various versions of the single-payer solutions. Truly nationalized government-run health care is not the answer if we want to avoid lengthy wait times and significant tax increases. Preserving the central role of employer-sponsored coverage while offering public solutions for the individual market may be the balance we're looking for to stabilize this nation's health care system.

ABOUT SUZANNE SPRADLEY

Chief Compliance Officer, Associate General Counsel, NFP

Suzanne spearheads NFP's corporate compliance initiatives, emphasizing the company's commitment to legal and regulatory compliance, integrity and business ethics. Her primary areas of focus are legal and regulatory compliance, corporate governance, corporate ethics, legislative affairs, interactions with government agencies and corporate compliance communications. Suzanne has 17+ years of insurance industry experience and joined NFP in 2007 as Vice President, Legal and Compliance, to lead the benefits compliance department and create a centralized insurance licensing department. Prior to joining NFP, Suzanne worked as an insurance regulatory attorney for Akin Gump Strauss Hauer & Feld and was awarded the Rising Star Designation by the Super Lawyers edition of *Texas Monthly* magazine. She serves on the Legal Counsel Working Group of the Council for Insurance Agents & Brokers and the Women in Leadership Council. Suzanne earned her bachelor's in business administration from the University of Texas and graduated *cum laude* from the Southern Methodist School of Law.

[1] Congressional Budget Office, Key Design Components and Considerations for Establishing a Single-Payer Health Care System, www.cbo.gov, 2019; https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf

[2] Veterans Health Administration. "Critical Deficiencies at the Washington DC VA Medical Center." Department of Veterans Affairs, Office of Inspector General, www.va.gov, 2018; https://www.va.gov/oig/pubs/vaoig-17-02644-130.pdf.

[3] Eric Schneider, Dana Sarnak, David Squires, Arnav Shah, and Michelle Doty. "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Care." The Commonwealth Fund, www.commonwealthfund.org, 2017; https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and.

[4] Bacchus Barua and David Jacques. "Waiting Your Turn: Wait Times for Health Care in Canada, 2018 Report." Fraser Institute, www.fraserinstitute.org, 2018; https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2018.pdf

[5] Karn Davis, Kristof Stremikis, David Squires, and Cathy Schoen. "Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally." The Commonwealth Fund, www.commonwealthfund.org, 2014; https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_jun_1755_davis_mirror_mirror_2014.pdf.

[6] See Fraser Institute, above.

[7] Rajeev Syal and Denis Campbell. "Expect a rise in patients suing NHS over long waits, watchdog warns." The Guardian, www.theguardian.com, 2019; https://www.theguardian.com/society/2019/mar/22/patients-nhs-long-waiting-time-watchdog-national-audit-office

[8] See note two, the 2017 Commonwealth Fund Study, above.