



# A Possible Future for the U.S. Health Care System

By Roy Goldman

**M**edical costs continue to rise faster than the gross domestic product (GDP). There has been no fix to the individual markets under the Patient Protection and Affordable Care Act (ACA) of 2010, and the underinsured rate, if not the uninsured rate, has risen.<sup>1</sup> Some people are now suggesting that it would simply be better to cover “everyone” in a “single-payer system.” But what is meant by a single-payer system? What are the pros and cons of such a system, and how could it be made to work in the United States? And who is everyone?<sup>2</sup>

## SINGLE-PAYER SYSTEM

The user of this term usually expects the federal (or state) government to finance health insurance coverage for all residents. The government is both the **payer** of claims and the **insurer** (i.e., the risk-taker). Despite the rhetoric, Canada and Taiwan are the only two industrialized countries with this type of system, although in Canada, each providence is a separate payer.<sup>3</sup>

Is a single-payer system “socialized medicine”? No; neither Canada nor Taiwan are examples of socialized medicine, as their governments do not own the hospitals and other facilities, nor do they employ the physicians and other providers. In the United Kingdom, the National Health Service (NHS) is funded by the government, but NHS—not the government—owns the facilities and employs the providers. This is an example of “socialized medicine.” In the U.S., the Veterans Health Administration is another example of socialized medicine.

Sometimes people mistakenly refer to a “single-payer system like Medicare.” But the federal government is not the single payer or risk-taker. Only traditional Medicare (Parts A and B) can be considered a single-payer system, although the actual payments and benefit decisions are made by private administrators under contracts with the government. Over one-third of Medicare beneficiaries have Medicare Advantage (MA) plans through



**private insurers** who pay the benefits and take risk in place of traditional Medicare.<sup>4</sup> In addition, the entire retail prescription drug component of Medicare (Part D) is insured by **private payers**.

Fifteen years ago, Medicaid could be considered a single-payer system in each state. But today, 69 percent of Medicaid members have comprehensive coverage with private managed care plans.<sup>5</sup> States have found that they can pay insurers less than they were paying for fee-for-service and require insurers to meet quality standards the states never had.

Do not confuse **funding** with risk-taking. Part D plans receive per capita payments along with reinsurance and low-income subsidies from the federal government. These payments come out of general taxes along with insureds’ monthly premium payments. Part A is funded from payroll taxes, while Part B is funded by general taxes and insureds’ premium payments. Medicaid

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funding is shared between federal and state taxes with the former now covering a majority of the costs in each state.<sup>6</sup>

## UNIVERSAL HEALTH CARE

Often, the term single payer is used when what is meant is “universal health care.” As defined by the World Health Organization, a universal health care (UHC) system provides all people with access to needed health services in sufficient quality to be effective without exposing the user to financial hardship.<sup>7</sup>

A single-payer system is only one type of UHC. Most countries’ systems fall in one of two broad categories:

- **Insurance mandates.** All citizens must purchase standard minimum coverage from private insurers (usually nonprofit) or a public option. Often there is no underwriting, and subsidies exist for low-income families. Examples include Switzerland, Germany, Japan and the Netherlands.
- **A combination of single-payer and private insurance.** Examples are the U.K., France, Singapore and Sweden.

It is important to note that *the U.S. is the only industrialized country in the world without a UHC system.* Meanwhile, it spends about 18 percent of GDP on health care,<sup>8</sup> while Switzerland spends about 12 percent, and countries like Germany, France, Sweden, Japan and Canada spend about 11 percent.<sup>9</sup>

## PROS AND CONS OF SINGLE-PAYER SYSTEM VERSUS OTHER UHC

Compared to the other 35 Organization for Economic Cooperation and Development (OECD) countries, U.S. health care is the most costly per capita. In 2018, the U.S. spent about \$10,600 per person. The next highest country was Switzerland at \$7,300, and the average OECD country spent \$4,000.<sup>10</sup> The cause is not a mystery: Studies show that *the unit cost of health care is simply greater in the U.S. than in other countries.*<sup>11</sup>

However, despite spending more, the U.S. ranks quite low compared to other OECD countries on certain quality-of-life measures, such as life expectancy at birth and infant mortality rate. On the other hand, it has some of the best acute care in the world, excelling, for example, in cancer care. We also rank high in innovation and patient-centered care.<sup>12</sup>

Other countries achieve better public health outcomes, but it cannot all be attributed to their health care spending as many countries have more generous spending for social services. This is not a minor point, though, and one the U.S. can emulate considering that social and medical needs are intertwined, especially for the most complex cases. As a result, many countries have higher general tax rates than the U.S. The main disadvantage often cited for other countries’ systems are delays in access to routine procedures and fixed budgets that lead to rationing of care. Of course, an argument can be made that in the U.S., we

also ration care, as access, quality and affordability all vary based on income, geography and race.

## COST SAVINGS

In a single-payer system, there are administrative cost savings but not necessarily medical cost savings.

### Administrative Savings

There certainly would be cost savings in administering a single-payer system. Currently, every insurer negotiates payment rates with every type of health care provider, and every provider tries to strike the best deal with insurers. Every insurer has different procedures, even if the claim forms are uniform. Clearly, there would be savings if all providers had to follow one payer’s rules. But who would set the providers’ payment rates and rules? We will discuss this topic further in the next section.

Some argue that there would be additional savings from the profits that insurers make. But health insurers’ profits as a percentage of revenue are lower than that of most industries,<sup>13</sup> and sometimes they lose money as in the individual market under ACA. Any insurer, including a nonprofit insurer, needs to have margin to operate a financially viable risk program. A government-run plan would need some margin as well, and, as will be explained further, the government will have to hire administrators to manage insureds and providers.

Some point to traditional Medicare’s low administrative costs compared to private insurers (as a percentage of claims paid) as an example of savings we could expect in a single-payer system. But this analysis is too simplistic. Medicare’s administrative costs are misleadingly low for several reasons. The most important one is that Medicare’s administrators exercise very little oversight over the quantity or medical necessity of claims submitted for payment. There is evidence among private insurers that higher administrative costs can produce lower *total* costs.

Unlike private insurers, Medicare does not employ nurses, physicians, pharmacists or social workers who provide services *directly* to beneficiaries and providers to:

- Coordinate care, especially for those with complex conditions
- Encourage preventive care
- Monitor drug utilization
- Reduce unnecessary hospital stays and duplicative tests

Private insurers incur these additional expenses to keep members healthier, reduce unnecessary care and reduce total medical expenses without reducing quality.<sup>14</sup>

An indication of the proof of this statement is the fact that MA plans’ bids to provide Part A and Part B are less than traditional Medicare benchmark rates in most parts of the country while also meeting dozens of quality measures.<sup>15</sup> I refer to Medicare because one can compare the single-payer features and results of

traditional Medicare with private payers under MA. But Medicare covers only 14 percent of the U.S. population. Employers cover 49 percent of the population, Medicaid 21 percent, and just 6.6 percent have individual insurance.<sup>16</sup> Fortunately, these same utilization and engagement techniques are used by private insurers to reduce health care trend rates in Medicaid, individual and employer-sponsored plans as well. Unfortunately, these efforts do not apply uniformly throughout the country or to all providers and all insureds. As a result, medical costs continue to grow faster than GDP, which brings us to medical cost savings.

### Medical Cost Savings

Administrative savings would not be the reason to cover everyone under a single-payer system. The focus on savings must be on the 85–90 percent of the dollars that go to cover medical expenses. Recall that we said that in the U.S. we pay more per service.

There are only a few ways to reduce the growth in medical costs under a UHC:

1. **Establish a global budget.** Once the funds are used up, presumably, private insurance or out-of-pocket funds are used to cover additional medical needs.
2. **Lower fee-for-service payments.** This would apply to all types of health care providers and cap annual increases.
3. **Rely on everyone to take better care of themselves.** The entire population should stop smoking; lose weight by eating healthier foods and in moderation; get more physical exercise; drink less alcohol; get required preventive care, prenatal care and follow-up care; fill prescriptions and use the required amount; have access to good nutrition and social services as needed; and so on.
4. **Move off a fee-for-service payment system.** On a national basis, as much as possible, use the best practices to develop beneficial provider-insurer-member relationships that reward efficient, quality care.

Option 1 is probably a nonstarter as it could lead to care rationing and long waits for care.

Option 2 would obviously have an immediate cost effect, but it would not be a long-term or even a short-term solution. In traditional Medicare, the government sets the *methodology* and *scale* for determining payment, which many providers find to be insufficient. Medicaid payments to providers are set at even lower levels. As a result, providers require higher payments from private insurers and employers, although they may follow Medicare’s methodology.

While there needs to be some adjustments in how various providers and drug companies are paid, the history of traditional

Medicare and traditional Medicaid has shown that simply having the centralized power to set providers’ rates is not sufficient to control the growth of health care costs. As shown by private insurers in both Medicare and Medicaid, there needs to be some control over utilization as well.

Option 3 would be nirvana. With chronic disease accounting for 90 percent of health care costs,<sup>17</sup> I have heard estimates that as much as 50 percent of medical expenses could be saved if Americans would take better care of themselves no matter what their current health condition is. While we should encourage Option 3, we cannot rely on it to happen by itself.

That leaves Option 4. The misplaced incentives of fee-for-service medicine are well known. Medicare and private insurers recognized this long ago and revised the way hospitals and other facilities are paid. On the other hand, there are documented successful arrangements that have been shown to reduce medical trend rates while increasing quality. These include medical homes, accountable care organizations, global capitation arrangements, and other types of programs that encourage physicians/hospitals/members to seek the most efficient care.<sup>18</sup>

To be successful in administering a health insurance program for the entire country, a single insurer would need many of these same resources as private insurers employ today. These include membership, claims and customer care professionals; analysts and actuaries; pharmacists, physicians and nurses; and management personnel.

### A POSSIBLE FUTURE FOR U.S. HEALTH CARE SYSTEM

Taking all these arguments into account, I suggest a possible future single-payer alternative would designate the federal government as the single payer and insurer, using Option 4, *but* the government would bid out the *management* of the health system to private companies who would perform the functions that private insurers do now for a *fixed fee*. These firms would be responsible for:

- Providing administrative services to beneficiaries and providers
- Coordinating beneficiaries’ care
- Designing incentive systems for providers to deliver quality care in the most efficient manner
- Developing incentive systems for members to take better care of themselves

The winning bidders would have targets for cost and quality and would compete for the business in various geographical areas. If they exceed these targets, bonuses may be payable. This proposal has not been discussed broadly, but it seems to be the only way to have a single-payer system that saves some administrative expenses while retaining control over quality and cost of services.

After all, historically, the government has not made concurrent medical decisions directly with patients or providers.

But as we have observed, most countries have a universal health care system that avoids a single payer. Why not move to a system that is closer to what we have and has been found to be successful in other industrialized countries? To save administrative costs and burden, it would still make sense to have a *single-payment system* for providers; in effect, have a single payer but not a single risk-taker. Insurers would compete on efficiency and on the services and support they give to members and providers. There needs to be a *strong mandate* for everyone to purchase coverage with *sufficient premium and benefit subsidies* so that everyone could afford coverage. Insurers would need protection in the form of a national *risk adjustment*, like in the MA program, and a national *reinsurance* program.

Indeed, these four elements are what has made Part D a successful program with fairly constant premiums. If we had a consensus in the U.S. to incorporate those four features into *one* individual market (instead of the four we have now) and combine it with Medicaid (since members regularly move in and out of qualifying), we could probably achieve universal health care coverage. However, we would still need to adopt a single-payment system and Options 3 and 4 on a national basis to reduce the trend in medical costs. ■



Roy Goldman, Ph.D., FSA, CERA, MAAA, is a “retired” actuarial executive and 2019–2020 president-elect of the SOA. He can be reached at [roygo@earthlink.net](mailto:roygo@earthlink.net).

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- 13 See Margins by Sector (U.S.), New York University, [http://pages.stern.nyu.edu/~adamodar/New\\_Home\\_Page/datafile/margin.html](http://pages.stern.nyu.edu/~adamodar/New_Home_Page/datafile/margin.html) for a comparison of net margins. Health insurers are included under Healthcare Support Services. See also Where Does Your Health Care Dollar Go?, *AHIP*, <https://www.ahip.org/health-care-dollar/> for a breakdown of health insurance premium dollar and Norris, Louise. 2019. Are Health Insurance Companies Making Unreasonable Profits? *Very Well Health*, May 22, <https://www.verywellhealth.com/health-insurance-companies-unreasonable-profits-1738941> for a discussion on limits on health insurers' profits
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# Expanding Access to Public Insurance Plans

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*The primary drafter of this publication is Academy Senior Health Fellow Cori E. Uccello, FSA, FCA, MAAA, MPP, who worked with the Academy's Health Practice Council in developing it.*

Proposals to expand access to public health insurance plans are being put forward to provide a way to supplement efforts to strengthen insurance markets under the Affordable Care Act (ACA) or to replace the ACA marketplaces and/or other health insurance programs altogether.

Goals of these proposals vary and include increasing access to affordable coverage, exerting downward pressure on provider prices, increasing plan availability, and reducing the number of uninsured. This issue paper from the American Academy of Actuaries Health Practice Council briefly outlines four approaches aiming to achieve such goals and highlights the key design elements that would need to be specified for an approach to be fully evaluated and implemented. Note that there are not clear lines demarcating these options, and particular proposals could have elements of more than one approach. In addition, different proposals often use different terminology to describe similar approaches. The nomenclature used in this paper attempts to accurately reflect each approach and could differ from the terms used in particular proposals.

## INCLUDING A GOVERNMENT-FACILITATED PLAN IN THE ACA MARKETPLACES

Under this option, a government-facilitated or administered health plan would compete with other plans in the ACA marketplaces. The public plan would generally follow the requirements of the ACA marketplaces, including the issue, rating, and bene-



fit coverage rules, and would be part of the single risk pool. The difference would be that the government-facilitated plan would likely use provider payment rates based on Medicare or Medicaid, or some rate between those levels and commercial payment levels.

## CREATING A MEDICAID BUY-IN

Under a Medicaid buy-in, all or certain individuals not currently eligible for Medicaid would be able to enroll directly into Medicaid and pay any applicable premiums. It would be administered by states or by private entities such as managed care organizations. Unlike a government-facilitated plan in the ACA marketplaces, it would likely operate outside of the exchange, would not be part of the ACA single risk pool, and would not necessarily be subject to the same rules as ACA plans.

## CREATING A MEDICARE BUY-IN

Under a Medicare buy-in, all or certain individuals not currently eligible for Medicare would be able to enroll directly into Medicare and pay any applicable premiums. It would have many similarities to a Medicaid buy-in, but rather than being administered by states, it would be administered by the federal government or by private entities such as managed care organizations. It would likely operate outside of the exchange, would not be part of the ACA single risk pool, and would not necessarily be subject to the same rules as ACA plans.

## MEDICARE FOR MORE OR FOR ALL

Rather than creating a Medicare buy-in option, other approaches would more directly expand Medicare. These approaches range from extending Medicare eligibility by lowering the eligibility age (e.g., to age 55), extending Medicare eligibility to

all U.S. residents, or extending Medicare eligibility to all and also restructuring the program to provide more comprehensive coverage.

When designing or evaluating a proposal to expand access to public health insurance plans, it's important for the goals of the proposal to be explicit. Regardless of the policy goal, many major and minor design elements need to be specified. These include:

- Who is the eligible population? Would the plan be available to all or would certain subgroups of the population or areas of the country be targeted? Would employers be allowed to enroll their workers in the public plan?
- Would coverage in the plan be an option among other coverage choices or the sole coverage source available?
- How would the program be funded and what entities would bear the financial risk?
- Who would administer the program?
- Would the program rely solely on public coverage (e.g., traditional Medicare) and/or include private plan choices [e.g., Medicaid managed care, Medicare Advantage (MA)]?
- What benefits would be covered and what patient cost-sharing would be required?
- If other coverage options are available, would the public plan follow the same rules governing private plans competing for the same enrollees? Would the plan be part of the ACA single risk pool?
- How would provider payment rates be set? Would there be a provider network?
- How would premiums be determined and how would they vary among enrollees? Would premiums and/or cost-sharing be subsidized for low-income enrollees?
- Would the new plan be implemented all at once or phased in over time?

How these details are decided would affect the viability of the plan and the impacts it would have on coverage availability and affordability, not only of the public plan, but also of other coverage sources. ■