Options for Dialing Down From Single Payer

There are formidable institutional obstacles to passing a single-payer health program in the United States. Advocates should consider incremental improvements that may better match legislative realities. There are three potential directions for incremental coverage policy.

One possibility is to build on the successes of the Affordable Care Act; this might include rolling back regulatory changes, further incentivizing Medicaid expansion, enhancing coverage in the Affordable Care Act marketplaces, and imposing regulations on private employer-based insurance to ensure that all Americans have access to affordable coverage that provides adequate financial security. A second direction is to offer more publicly sponsored insurance options, which might involve offering a public option to those eligible for marketplace coverage, creating a Medicare or Medicaid buy-in program, lowering the eligibility age for Medicare, or developing a public plan that serves as a default for those who do not choose to buy alternative private coverage. A third direction is to build on federalism, offering states incentives to expand coverage.

Federal and state legislators could also consider incremental cost-containment steps, such as rate setting. (*Am J Public Health*. 2019;109:1517–1520. doi:10.2105/AJPH.2019.305299)

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See also Donnelly et al., p. 1482.

After a decade in which the leading issue on the health care reform agenda was the passage, implementation, and potential repeal of the Affordable Care Act (ACA), there has been an explosion of new interest among Democrats at both the state and federal levels in enacting a single-payer health care system in the United States, often described as Medicare for all. This enthusiasm is notable because, to date, efforts to enact and implement a single-payer–like system in the United States have failed.[1]

The institutional obstacles to a single-payer plan are formidable. Although a single-payer plan may reduce national health expenditures, it will greatly increase the size of the government budget. Although a single-payer plan may improve almost everyone's coverage, it will also lead to substantial coverage disruption. And although a single-payer plan may reduce administrative costs, achieving significant savings is likely to require meaningful reductions in provider payment rates. Even an overwhelmingly Democratic legislature is likely to include many relatively conservative members, who will likely find the on-budget costs, coverage disruptions, and provider opposition untenable and lend support only to a watered-down plan. A policy idea, however compelling, is unlikely to get through the legislative meat grinder intact.

One approach to dealing with this institutional reality is to prioritize one or a very small number of substantive objectives—coverage, for example—and try to jam as much of this priority objective as possible into legislative constraints. That was, more or less, the Obama administration's approach, and it explains much of the fragmented design of the ACA. A single-payer proposal would take the opposite approach, offering legislatures a coherent proposal, anticipating that the legislature would likely shave off pieces of the proposal to fit it into its political constraints. Either way, advocates will be well advised to consider an array of policy options that will allow them to dial up or down their proposals based on legislative realities. In this commentary, I describe three categories of such proposals.

RESTORING AND ENHANCING THE ACA

Implementation of the ACA had enormous effects on coverage and access to care.[2] In 2016, the nonelderly uninsurance rate was at the lowest level recorded in the United States.[3] The percentage of Americans reporting that they could not afford care because of cost declined by 4.1 percentage points between 2013 and 2016.[4] In Massachusetts, which has had an ACA-like health insurance system in place since 2006, the nonelderly uninsurance rate in 2018 was below 5%.[5] Building on the chassis of the ACA, at either the federal or state level, could reinforce and extend these gains.

In this framework, policymakers could proceed in three directions.[6] The simplest, least costly option would be to roll back the post-2016 changes to the ACA. Legislation would be required to restore the individual mandate penalty, which was set to zero under the Tax Cuts and Jobs Act of 2017 (Pub L No. 115–97). A Democratic president, even without a legislative majority in Congress, could revert to previous standards with respect to short-term health insurance plans and association health plans and implement a more robust marketing and outreach effort. At the national level, the Urban Institute projects that such changes could reduce the number of people with inadequate health insurance by more than 15% and would actually lower federal costs while doing so.[6] Most of these gains could also be achieved by individual states acting independently, and some states have already moved along this path.

Greater gains in coverage, especially for low-income Americans, could be achieved by extending the reach of the ACA's Medicaid expansion. Currently, 14 states have not yet opted into the

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Medicaid expansion. In addition, a growing number of states now impose or are considering imposing work requirements. Although these requirements are under litigation, early evidence suggests that they deter substantial numbers of otherwise eligible people from enrolling.[7,8] Any state could choose to participate in the expansion and refrain from imposing work requirements. In the 2018 elections, referendums to expand Medicaid passed in three conservative states, suggesting that there are realistic prospects for such expansions.[9] Federal legislation action could further incentivize participation in the expansion by increasing the federal match in newly participating states. Federal regulators could revoke waivers that deter enrollment, such as those permitting work requirements. Even greater gains in coverage could be achieved if states harmonized their Supplemental Nutrition Assistance Program, public benefit, and Medicaid systems and automatically enrolled participants; federal legislation could incentivize such actions. If all states simply expanded Medicaid, estimates suggest that the uninsurance rate among those legally present in the United States would decline to below 5%.[6]

Although the ACA expanded insurance coverage, there is growing concern that the legislation left many people, especially middle-income people, underinsured. The law could also be enhanced to make coverage more generous and accessible to people with middle incomes. Legislation could reduce cost sharing in benchmark marketplace plans, pegging subsidies to a more generous gold (80% of costs covered) or even platinum (90%) benchmark plan, rather than the current silver (70%) benchmark. A platinum plan benchmark, somewhat more generous in terms of out-of-pocket exposure than the average employer-sponsored plan, would bring deductibles down to about $300 and out-of-pocket maximums below $2500, levels of cost sharing comparable to those in the universal systems of the Netherlands, Norway, and Taiwan.[10–13] The cost of such enhancements could be titrated by targeting them on the basis of beneficiary income.

Another strategy would be to provide more protection against high premiums for middle-income Americans. For example, premiums for all Americans could be capped at 8.5% of household income, regardless of income, with added subsidies ensuring that costs did not exceed these caps. These changes would affect only those outside the employer market. Although states are limited in their ability to regulate the employer market by the federal ERISA (Employee Retirement Income Security Act of 1974; Pub L No. 93–406, 88 Stat. 829 [September 2, 1974]) statute, the federal government itself could go further.[14] Federal legislation could, for example, extend expanded marketplace protections on premiums and cost sharing to those with employer-sponsored coverage by aligning the rules related to the employer mandate with those in the marketplace. Such enhancements would provide middle-income people, especially those with preexisting conditions, substantially more financial protection than they now have, meaningfully reducing premiums and out-of-pocket costs.

OFFERING MORE PUBLIC OPTIONS

One attribute of a single-payer plan that is attractive to many advocates is that it minimizes the role of private insurance in the health care system. Although only a comprehensive single-payer plan would completely eliminate the role of the private sector, several incremental reforms proposed in Congress and by various outside organizations could substitute public insurance for private coverage to a more modest extent.[15–18]

One idea, a variant of which Congress considered in the original debate over the ACA, would be to require a public plan option in the ACA marketplaces. Most plans currently under consideration would have the federal government offer a Medicare fee-for-service–based plan as an option in the marketplaces, available to those currently eligible for marketplace coverage (e.g., the CHOICE Act, HR 2085/S. 1033). These plans would cover the same essential health benefits and provide the same premium subsidies and cost-sharing subsidies as other marketplace plans. All providers participating in Medicare would be required to participate in the new public option at or near Medicare payment rates. Other variants on this design would have the federal government require Medicare Advantage plans to offer products in all marketplaces or require Medicare Advantage plans or a traditional Medicare option to participate only as a fallback if there was insufficient insurer competition or prices were too high.[15–18]

States could similarly mandate that Medicaid managed care plans offer plans in the marketplaces (as in the Medicaid state Public Option Act HR 1277/S489). Estimates suggest that including public plan options in the marketplace could reduce premiums by about 7% to 8% and hence could reduce federal subsidy costs.[19] Although the public option approach seems modest and popular, the effort to incorporate it into the ACA failed and states have found this approach challenging. The difference between Medicare and private payment rates, an important feature of this proposal, has been a sticking point. This year, Washington State did succeed in passing a public option but, in the face of provider opposition, only by weakening its provisions—and potential effects—considerably.[20]

Offering a public option in the marketplaces under the existing ACA subsidy structure could also be a mechanism for implementing a broader public insurance buy-in program. Eligibility for such a plan could be limited to older adults, in effect lowering the eligibility age for Medicare (to 50 or 55 years), as proposed, for example, in the Medicare at 50 Act (S 470). Simply lowering the Medicare eligibility age has been under policy consideration for a long time, but passage of the ACA makes this option somewhat less attractive. The ACA offers more comprehensive benefits than does the combination of Medicare Parts A, B, and D, especially for those without supplemental Medigap coverage. Because of the limitations on age rating and because of the form of the ACA's subsidy structure, benefits for older adults, especially those of modest incomes, are more generous under the ACA than in traditional Medicare. Proposals currently under consideration generally incorporate the ACA subsidy structure (while retaining the Medicare benefit package) and would operate through the marketplaces, an approach that is more desirable, especially for those with modest incomes, than extending eligibility to traditional Medicare through a stand-alone program. This approach, however, would leave older adults facing a complex

choice between two quite different benefit designs.

Most expansively, a state or the federal government could offer a public plan as a universal default option. Under this model, all residents would be autoenrolled into the public program, which could be waived or supplemented by an acceptable alternative source of coverage. The Medicare for America proposal (HR 2452) takes this approach; it would create a new, publicly operated coverage option, with ACA-like benefits and subsidies and payment rates determined by, but slightly higher than, current Medicare rates. Universal public default option models like Medicare for America build on earlier pay-or-play reform efforts that offered employers a choice between providing coverage directly or enrolling their employees in a government-established program and paying a payroll-based tax. Because coverage under this kind of model is intended to be attractive to those currently on Medicare, as well as those in the marketplaces and those with employer coverage, it would likely be more costly and comprehensive than are the more incremental models.

Implementation of this kind of hybrid model can be complicated, because there is so much scope for individual and employer choice. Financing rules need to be calibrated to address the likelihood that employers with low-wage, high-cost employees will be more likely to join the public plan, whereas employers with high-wage, low-cost employees remain outside the system. Allowing individuals to opt into a public option raises concerns that employers will "dump" their sickest employees into such a plan or that the availability of the public option will destabilize employer coverage, making it unavailable to those who might prefer it. Opposition to a Medicare-based default plan is also likely to come from Medicare providers, who would object to shifting a substantial share of the population from paying at private insurance rates to paying at near Medicare rates. Nonetheless, there is precedent for such an approach: Australia currently operates a model of this sort.[21]

USING FEDERALISM

The ACA already offers a platform for state-based reform, the 1332 waiver structure. Under the ACA, a state can apply to the federal government to implement an alternative health insurance structure, using ACA funds, as long as the new structure provides a comparable number of residents with access to equivalent coverage and does not increase the federal deficit. The Trump administration has encouraged states to use 1332 waivers to reduce the public role in their health insurance systems, but a progressive administration could take the opposite tack and encourage states to seek waivers for single-payer–style reforms. Under existing administrative authorities, these 1332 waivers could be combined with Medicaid waivers and even Medicare waivers, such as Maryland's recently renewed and expanded all-payer waiver, enabling states to enact system-wide reforms.[22]

Congress could go much further down this path and offer states per capita block grants to provide universal coverage to their residents. This is the basic structure of the Canadian health care system, which is administered entirely by the provinces under simple but rigorous federal rules, and funded through provincial funds and federal per capita block grants.[23,24] Concerns about inequities among states would likely make this a difficult approach at the federal level, and the burden on states to finance the remaining share of health care expenditures would likely be quite daunting if the option were available.

CONTROLLING COSTS

Single-payer proponents argue that their preferred model combines universal coverage with the realistic potential for system-wide cost containment. States or the federal government could alternatively implement reforms short of single payer to reduce health care costs. For example, the federal government (and to a more limited extent, constrained by ERISA, a state) could impose regulated payment rates on all providers and drug and device suppliers, without moving financing of the system to a single-payer model. A government could implement price regulation of this sort for some subset of providers, such as those in areas with limited competition. Offering consumers an option to buy in to a public option plan that paid providers at lower rates might also constrain prices outside that plan. Similarly, restricting payments for out-of-network services, as several states are considering in the case of surprise bills, might limit prices for in-network services as well.

Efforts to contain health care costs will face severe political headwinds, whether in a single-payer structure or separate from one. As Uwe Reinhardt pointed out, every dollar of health spending is income to someone.[25] And whereas the losers from cost containment will be very obvious, the winners will be much harder to identify. Savings that accrue to the overall health care system do not automatically translate into evident savings for individuals. Indeed, the Congressional Budget Office, the health reform scorekeeper, does not routinely estimate the likely effects of policies on national health care spending.

CONCLUSIONS

Whether the next attempt at health policy takes the approach of focusing on a priority objective or starts from a set of policy principles, it will need to adapt to legislative and political realities. The good news is that there are a broad range of health policy options, particularly for coverage and financial protection, which can form the basis of negotiation. AJPH

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CONFLICTS OF INTEREST

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