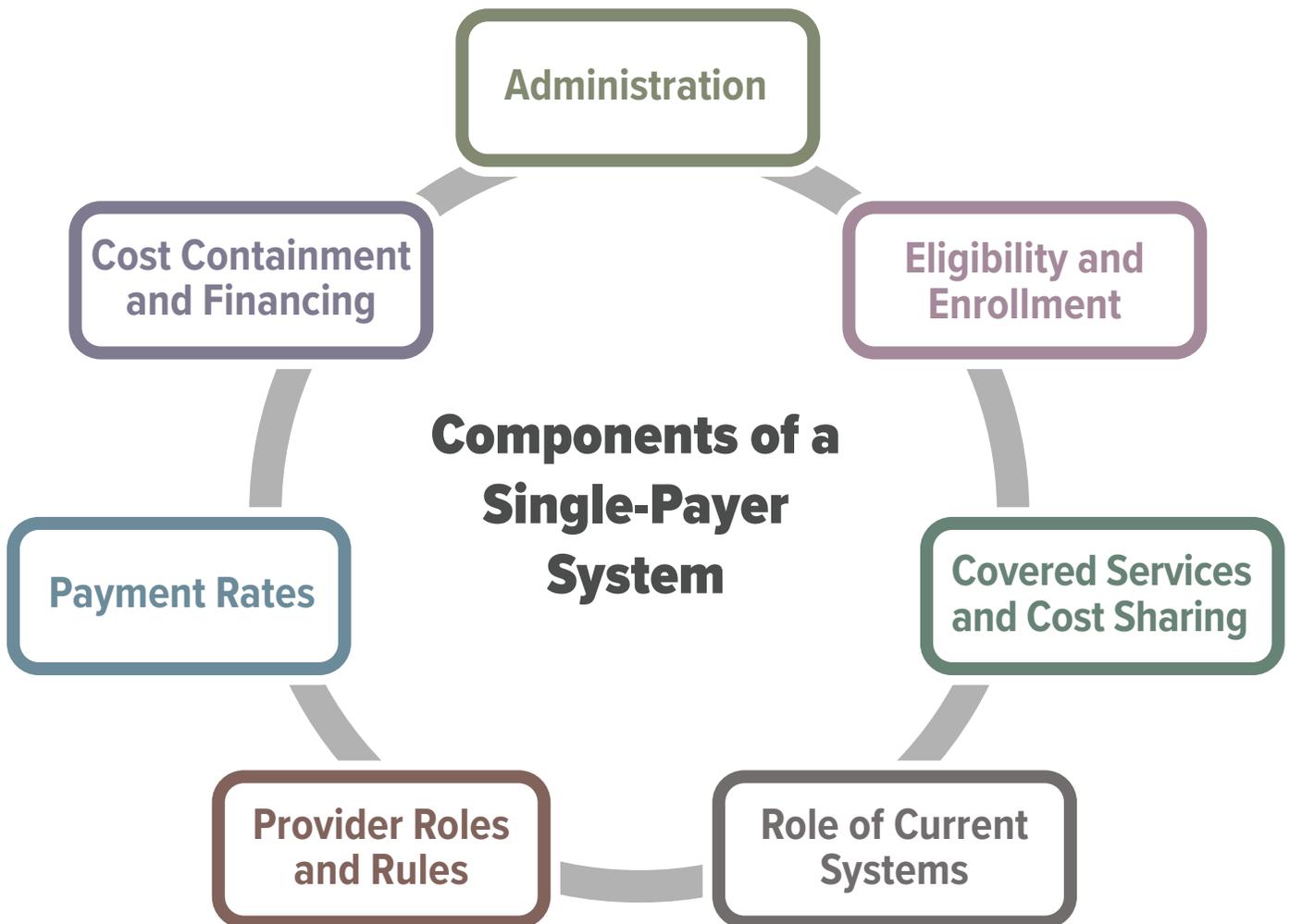


CBO

Key Design Components and Considerations for Establishing a Single-Payer Health Care System



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At a Glance

Some Members of Congress have proposed establishing a single-payer health care system in the United States to ensure that virtually everyone has health insurance. In a typical single-payer system, people enroll in a health plan operated by the government, and the receipts and expenditures associated with the plan appear in the government's budget.

This report describes the primary features of single-payer systems, and it discusses some of the design considerations and choices that policymakers will face as they develop proposals for establishing such a system in the United States. The report does not address all of the issues involved in designing, implementing, and transitioning to a single-payer system, nor does it analyze the budgetary effects of any specific proposal.

Some of the key design considerations for policymakers interested in establishing a single-payer system include the following:

- How would the government administer a single-payer health plan?
- Who would be eligible for the plan, and what benefits would it cover?
- What cost sharing, if any, would the plan require?
- What role, if any, would private insurance and other public programs have?
- Which providers would be allowed to participate, and who would own the hospitals and employ the providers?
- How would the single-payer system set provider payment rates and purchase prescription drugs?
- How would the single-payer system contain health care costs?
- How would the system be financed?

For each question, this report discusses various options and provides a qualitative assessment of the trade-offs they present.



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Key Design Components and Considerations for Establishing a Single-Payer Health Care System

Introduction

Congressional interest in substantially increasing the number of people who have health insurance has grown in recent years. Some Members of Congress have proposed establishing a single-payer health care system to achieve universal health insurance coverage. In this report, the Congressional Budget Office describes the primary features of single-payer systems, as well as some of the key considerations for designing such a system in the United States (see Figure 1).

Establishing a single-payer system would be a major undertaking that would involve substantial changes in the sources and extent of coverage, provider payment rates, and financing methods of health care in the United States. This report does not address all of the issues that the complex task of designing, implementing, and transitioning to a single-payer system would entail, nor does it analyze the budgetary effects of any specific bill or proposal.

About 29 million people under age 65 were uninsured in an average month in 2018, according to estimates by CBO and the staff of the Joint Committee on Taxation.¹ Although a single-payer system could substantially reduce the number of people who lack insurance, the change in the number of people who are uninsured would depend on the system's design. For example, some people (such as noncitizens who are not lawfully present in the United States) might not be eligible for coverage under a single-payer system and thus might be uninsured. This report uses the term “universal coverage” to characterize systems in which virtually all people in an eligible population have health insurance.

Single-Payer Health Care Systems

Although single-payer systems can have a variety of different features and have been defined in many ways, health care systems are typically considered single-payer systems if they have these four key features:

- The government entity (or government-contracted entity) operating the public health plan is responsible for most operational functions of the plan, such as defining the eligible population, specifying the covered services, collecting the resources needed for the plan, and paying providers for covered services;
- The eligible population is required to contribute toward financing the system;
- The receipts and expenditures associated with the plan appear in the government's budget; and
- Private insurance, if allowed, generally plays a relatively small role and supplements the coverage provided under the public plan.²

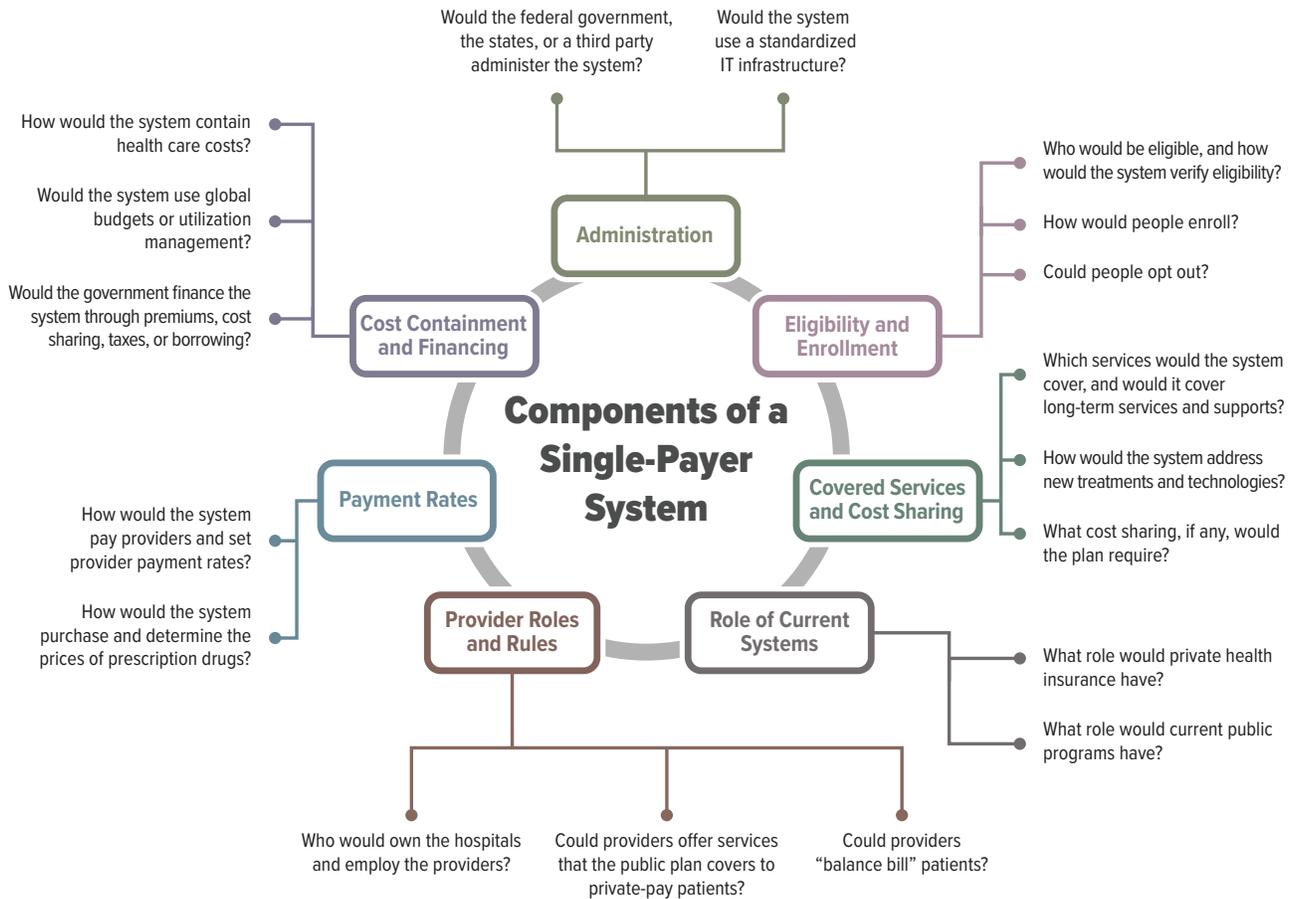
In the United States, the traditional Medicare program is considered an example of an existing single-payer system for elderly and disabled people, but analysts disagree about whether the entire Medicare program is a single-payer system because private insurers play a significant role in delivering Medicare benefits outside the traditional Medicare program. Medicare beneficiaries can choose to receive benefits under Part A (Hospital Insurance) and Part B (Medical Insurance) in the traditional Medicare program or through one of the private insurers participating in the Medicare Advantage program. Those private insurers compete for enrollees with each other and with the traditional Medicare program,

1. See Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

2. See Jodi L. Liu and Robert H. Brook, “What Is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S.,” *Journal of General Internal Medicine*, vol. 32, no. 7 (July 2017), pp. 822–831, <https://doi.org/10.1007/s11606-017-4063-5>.

Figure 1.

Designing a Single-Payer Health Care System



Source: Congressional Budget Office.

IT = information technology.

and they accept both the responsibility and the financial risk of providing Medicare benefits. The Medicare prescription drug program (Part D) is delivered exclusively by private insurers.

Australia, Canada, Denmark, England, Sweden, and Taiwan are among the countries that are typically considered to have single-payer systems. Although some design features vary across those systems, they all achieve universal coverage by providing eligible people access to a specified set of health services regardless of their health status (see Table 1). Other countries, including Germany, the Netherlands, and Switzerland, have achieved universal coverage through highly regulated multipayer

systems, in which more than one insurer provides health insurance coverage.³

Differences Between Single-Payer Health Care Systems and the Current U.S. System

Establishing a single-payer system in the United States would involve significant changes for all participants—individuals, providers, insurers, employers, and manufacturers of drugs and medical devices—because a

3. See Peter Hussey and Gerard F. Anderson, "A Comparison of Single- and Multi-Payer Health Insurance Systems and Options for Reform," *Health Policy*, vol. 66, no. 3 (December 2003), pp. 215–228, [https://doi.org/10.1016/S0168-8510\(03\)00050-2](https://doi.org/10.1016/S0168-8510(03)00050-2).

single-payer system would differ from the current system in many ways, including sources and extent of coverage, provider payment rates, and methods of financing. Because health care spending in the United States currently accounts for about one-sixth of the nation's gross domestic product, those changes could significantly affect the overall U.S. economy.⁴

For both the economy and participants in the single-payer system, the consequences would depend on how all stakeholders responded to the system's various design features and how those responses interacted within the health care system and with the rest of the economy. The magnitude of those responses is difficult to predict because the existing evidence is based on previous changes that were much smaller in scale. Although policymakers could design a single-payer system with an intended objective in mind, the way the system was implemented could cause substantial uncertainty for all participants. That uncertainty could arise from political and budgetary processes, for example, or from the responses of other participants in the system. To mitigate uncertainty during the system's implementation, policymakers could develop administrative and governance structures to continuously monitor its performance and respond quickly to any issues that arise.

The transition toward a single-payer system could be complicated, challenging, and potentially disruptive. To smooth that transition, features of the single-payer system that would cause the largest changes from the current system could be phased in gradually to minimize their impact. Policymakers would need to consider how quickly people with private insurance would switch their coverage to the new public plan, what would happen to workers in the health insurance industry if private insurance was banned entirely or its role was limited, and how quickly provider payment rates under the single-payer system would be phased in from current levels. Although the transition toward a single-payer system would require considerable attention from policymakers, this report does not focus on the transition process.

Coverage. In a single-payer system that achieved universal coverage, everyone eligible would receive health insurance coverage with a specified set of benefits regardless of their health status. Under the current system, CBO estimates, an average of 29 million people per month—11 percent of U.S. residents under age 65—were uninsured in 2018.⁵ Most (or perhaps all) of those people would be covered by the public plan under a single-payer system, depending on who was eligible. A key design choice is whether noncitizens who are not lawfully present would be eligible. An average of 11 million people per month fell into that category in 2018, according to CBO's estimates, and they might not have health insurance under a single-payer system if they were not eligible for the public plan. About half of those 11 million people had health insurance in 2018.

People who are currently insured receive their coverage through various sources. Almost all people age 65 or older, or about one-sixth of the population, receive coverage through the Medicare program. CBO and the Joint Committee on Taxation estimate that, in 2018, a monthly average of about 243 million people under age 65 had health insurance. About two-thirds of them, or an estimated 160 million people, had health insurance through an employer. Roughly another quarter of that population, or about 69 million people, are estimated to have been enrolled in Medicaid or the Children's Health Insurance Program (CHIP). A smaller proportion of people under age 65 had nongroup coverage, Medicare, or coverage through other sources.⁶

Under a single-payer system, people who currently have private insurance would enroll in the public plan. Depending on the design of the single-payer system, however, those people might be allowed to retain private coverage that supplements the coverage under the public plan. People who currently have public coverage could continue to have such coverage under a single-payer system, although their covered benefits and cost sharing might change, depending on the system's design.

Costs. Government spending on health care would increase substantially under a single-payer system because the government (federal or state) would pay a large

4. In 2017, health spending accounted for 17.9 percent of the nation's gross domestic product. See Anne B. Martin and others, "National Health Care Spending in 2017: Growth Slows to Post-Great Recession Rates; Share of GDP Stabilizes," *Health Affairs*, vol. 38, no. 1 (January 2019), pp. 96–106, <https://doi.org/10.1377/hlthaff.2018.05085>.

5. See Congressional Budget Office. *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

6. *Ibid.*

Table 1.

Key Features of Single-Payer Health Care Systems in Selected Countries

Design Features	Australia	Canada	Denmark	England	Sweden	Taiwan
Level of Administration	National government	Provincial or territorial government	National government; administrative regions provide care	National government	National government; county councils responsible for most financing and purchasing	National government
Eligibility						
Universal coverage	Yes	Yes	Yes	Yes	Yes	Yes
Separate public programs for certain groups other than military	Yes	Yes	Yes	No	No	No
Mandated Benefit Package						
Hospital and physicians' services	Yes	Yes	Yes	Yes	Yes	Yes
Outpatient prescription drugs	Yes	No	Yes	Yes	Yes	Yes
LTSS	Limited	No	Yes	Limited	Yes	No
Dental, vision, and mental health services	Limited	No	Yes	Yes	Yes	Yes
Cost Sharing						
Hospital and physicians' services	Yes	No	No, except visits without referrals	No	Yes	Yes
Prescription drugs	Yes	n.a.	Yes	Yes	Yes	Yes
LTSS	Yes	n.a.	No	Yes	Yes	n.a.
Dental, vision, and mental health services	Yes	n.a.	Yes, for dental and vision	Yes	Yes	Yes
Limit on out-of-pocket spending	Yes, for prescription drugs	No	No, but copayments decrease with higher out-of-pocket spending on prescription drugs	No	Yes	Yes
Reduction or exemption available	Yes	Yes ^a	Yes	Yes	Yes	Yes
Private Health Insurance						
Supplemental ^b	Yes	Yes	Yes	No	No	Yes
Substitutive ^c	No	No	No	No	No	No
Other types of private insurance ^d	Yes	No	Yes	Yes	Yes	No
Participating Provider Rules						
Balance billing allowed	Yes	No	No	No	No	No
Payments from private-pay patients for covered services	Yes	No	Yes	Yes	Yes	No
Hospitals^e						
Primary ownership	Mixed	Mixed	Public	Public	Public	Private
Primary payment method	Global budgets and DRG in public hospitals; FFS in private hospitals	Global budget	Global budget	DRG	Global budgets and DRG	FFS with overall global budget

Continued

Table 1.

Continued

Key Features of Single-Payer Health Care Systems in Selected Countries

Design Features	Australia	Canada	Denmark	England	Sweden	Taiwan
Primary Care Physicians^e						
Primary employment	Private	Private	Private	Private	Mixed	Private
Primary payment method	FFS	FFS	FFS	Capitation	Capitation	FFS with overall global budget
Outpatient Specialist Physicians^e						
Primary employment	Mixed	Private	Mixed	Public	Mixed	Private
Primary payment method	FFS	FFS	FFS for self-employed providers; salary for public hospital employees	Salary	Per-case payment	Salary
Prescription Drugs						
Primary payment method	Internal reference pricing	External reference pricing	Internal reference pricing; price-cap agreement for drugs with no generic equivalents	Negotiated profit caps	Value-based payment	Value-based payment
Main Source of Financing						
	General tax revenues and earmarked tax revenues	Provincial and federal general tax revenues	Earmarked income tax	General revenues and payroll taxes	General revenues raised by county councils, municipalities, and nationally	Payroll-based premium, supplementary premium based on nonpayroll income, general revenues, tobacco tax, lottery gains

Source: Congressional Budget Office.

DRG = diagnosis-related groups; FFS = fee for service; LTSS = long-term services and supports; n.a. = not applicable.

- Cost-sharing reductions or exemptions are available for prescription drugs in some provinces.
- Supplemental insurance could cover services not included in the single-payer plan, such as dental, vision, or hearing. It could also reduce enrollees' cost sharing, like the private plans that many Medicare beneficiaries purchase.
- Substitutive insurance, which duplicates the benefits of the single-payer health plan, could be offered to people who are not eligible for the single-payer system, such as noncitizens who have recently entered the country or temporary visitors. It could also be an alternative source of coverage if people are allowed to opt out of the single-payer system.
- Other types of private insurance could provide benefit enhancements, such as faster access to care, private rooms instead of semiprivate rooms for inpatient stays, and a greater choice of providers.
- Refers to the characteristics of a typical entity in each system.

share of all national health care costs directly. Currently, national health care spending—which totaled \$3.5 trillion in 2017—is financed through a mix of public and private sources, with private sources such as businesses and households contributing just under half that amount and public sources contributing the rest (in direct spending as well as through forgone revenues from tax subsidies).⁷ Shifting such a large amount of expenditures from private to public sources would significantly increase government spending and require substantial additional government resources. The amount of those additional resources would depend on the system’s design and on the choice of whether or not to increase budget deficits. Total national health care spending under a single-payer system might be higher or lower than under the current system depending on the key features of the new system, such as the services covered, the provider payment rates, and patient cost-sharing requirements.

Other Consequences. A single-payer system would present both opportunities and risks for the health care system. It would probably have lower administrative costs than the current system—following the example of Medicare and of single-payer systems in other countries—because it would consolidate administrative tasks and eliminate insurers’ profits. Moreover, unlike private insurers, which can experience substantial enrollee turnover over time, a single-payer system without that turnover would have a greater incentive to invest in measures to improve people’s health and in preventive measures that have been shown to reduce costs. Whether the single-payer plan would act on that incentive is unknown.

7. The estimate of national health care spending is from Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, “National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960–2017” (accessed February 15, 2019), <https://go.usa.gov/xEUS6>. To estimate the share of national health care spending that comes from private sources, CBO adjusted those published figures to include the federal tax exclusion for employment-based health insurance as a part of spending from public sources. The federal government subsidizes a substantial part of private spending (as defined in the National Health Expenditure Accounts), primarily through the tax exclusion for employment-based health insurance. That tax exclusion cost the federal government about \$300 billion in 2018. See Congressional Budget Office, “Reduce Tax Subsidies for Employment-Based Health Insurance,” *Options for Reducing the Deficit: 2019 to 2028* (December 2018), www.cbo.gov/budget-options/2018/54798.

An expansion of insurance coverage under a single-payer system would increase the demand for care and put pressure on the available supply of care. People who are currently uninsured would receive coverage, and some people who are currently insured could receive additional benefits under the single-payer system, depending on its design. Whether the supply of providers would be adequate to meet the greater demand would depend on various components of the system, such as provider payment rates. If the number of providers was not sufficient to meet demand, patients might face increased wait times and reduced access to care. In the longer run, the government could implement policies to increase the supply of providers.

Because the public plan would provide a specified set of health care services to everyone eligible, participants would not have a choice of insurer or health benefits. Compared with the options available under the current system, the benefits provided by the public plan might not address the needs of some people. For example, under the current system, young and healthy people might prefer not to purchase any coverage, or they might prefer to purchase coverage with high deductibles or fewer benefits. And, unlike a system with competing private insurers, the public plan might not be as quick to meet patients’ needs, such as covering new treatments. Policymakers could try to design the governance structure of the single-payer system so that it would respond to the shifting needs of enrollees in a timely manner.

In addition to its potential effects on the health care sector, a single-payer system would affect other sectors of the economy that are beyond the scope of this report. For example, labor supply and employees’ compensation could change because health insurance is an important part of employees’ compensation under the current system.

Design Components and Considerations for Establishing a Single-Payer System

This report focuses on the following key design components and considerations for policymakers interested in establishing a single-payer system:

- How would the government administer a single-payer health plan?
- Who would be eligible for the plan, and what benefits would it cover?

- What cost sharing, if any, would the plan require?
- What role, if any, would private insurance and other public programs have?
- Which providers would be allowed to participate, and who would own the hospitals and employ the providers?
- How would the single-payer system set provider payment rates and purchase prescription drugs?
- How would the system be financed?

How Would the Government Administer a Single-Payer Health Plan?

The federal government could administer a single-payer health plan at the national level; the federal government could administer some functions and delegate other functions to state and local governments; or state governments could administer the single-payer health plan with broad federal oversight. Regardless of the level of administration, a standardized information technology (IT) system could help the single-payer system coordinate patient care. The design and infrastructure of the single-payer system would affect its administrative costs.

Federal and State Roles

A single-payer health plan administered at the federal level could be modeled on the medical benefit portion of the Medicare fee-for-service (FFS) program.⁸ By contrast, a state-based single-payer health plan could follow the Medicaid program, with some or all costs of the system appearing in the states' budgets. Alternatively, the federal government could contract with a third party to administer the benefits of the single-payer plan.

For a single-payer health plan administered at the state level, the federal government could still mandate certain nationwide design features and determine the amount of flexibility states would have in specifying their own design features. For example, the federal government could give states matching funds if they met certain minimum standards for eligibility, covered benefits, or other conditions. States could then accept the federal funding and implement a single-payer health plan, or they could

also offer more expansive benefits but be responsible for the additional costs. If a state decided not to accept federal funding, it would probably not be required to adopt a single-payer health plan, much like states' current voluntary participation in the Medicaid program.⁹ In addition, states would need to establish agreements with other states to address issues such as payment for services received out of state and the eligibility and plan contributions of nonresidents who work in a state.

In other countries, single-payer systems are administered at different levels of government. England's single-payer system is administered at the national level. In Canada, the provinces and territories administer the system, and the federal government imposes certain requirements in exchange for federal funding.

Standardized Information Technology Infrastructure

A standardized IT system could help a single-payer system coordinate patient care by implementing portable electronic medical records and reducing duplicated services. To achieve those potential benefits, the IT system would need to accommodate all types of providers, particularly those in small practices or rural areas, and address compatibility issues between existing electronic medical records systems.¹⁰ Establishing an interoperable IT system under a single-payer system would have many of the same challenges as establishing an interoperable IT system in the current health care system with its many different providers and vendors. The IT system would also need to overcome the challenges of interfacing across multiple state and federal agencies.

8. This report uses the common practice of referring to the traditional Medicare program as the Medicare FFS program, even though the program pays for some services on an FFS basis and other services using other methods.

9. The Medicaid program was created in 1965. State participation is voluntary, and participating states receive federal funds for providing a defined set of medical and long-term care benefits to the eligible population. Nearly all states adopted Medicaid by January 1970, but Alaska did not join until 1972 and Arizona implemented Medicaid through a waiver program in 1982. See Kaiser Family Foundation, *A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage* (August 2012), <https://tinyurl.com/yc7pqtbj> (PDF, 438 KB). See also *National Federation of Independent Business v. Sebelius* 567 U.S. 519 (2012).

10. See Julia Adler-Milstein and others, "Electronic Health Record Adoption in US Hospitals: Progress Continues, but Challenges Persist," *Health Affairs*, vol. 34, no. 12 (December 2015), pp. 2174–2180, <https://doi.org/10.1377/hlthaff.2015.0992>; Dawn Heisey-Grove and Jennifer A. King, "Physician and Practice-Level Drivers and Disparities Around Meaningful Use Progress," *Health Services Research*, vol. 52, no. 1 (February 2017), pp. 244–267, <https://doi.org/10.1111/1475-6773.12481>.

Taiwan's single-payer program has a robust IT system. Participants have National Health Insurance cards that store personal information, including recent visits to health care providers, diagnoses, and prescriptions. Providers must report all services delivered to patients each day to the National Health Insurance Administration, which tracks use of services and costs in near-real time. Other IT initiatives in Taiwan track patients' medical history and monitor prescription drugs.¹¹

Administrative Costs

The design of the single-payer system and its infrastructure would affect its administrative costs. In the United States, administrative costs as a share of total expenditures vary greatly by type of insurer. In 2017, the federal government's cost of administering the Medicare program accounted for 1.4 percent of total Medicare expenditures. When the administrative costs of Medicare Advantage and Part D plans are included, total administrative costs for the Medicare program accounted for about 6 percent of its expenditures. By comparison, private insurers' administrative costs averaged about 12 percent in 2017.¹²

Who Would Be Eligible for the Plan, and How Would People Enroll?

Policymakers designing a single-payer system would need to determine whether the entire U.S. population would be eligible to participate and whether the system would allow for any opt-outs among the eligible population. To ensure that everyone eligible for the single-payer system received coverage, the system would need to establish an infrastructure to verify eligibility and enroll participants.

Eligibility

A single-payer plan could restrict eligibility to U.S. citizens and lawfully present noncitizens, a group that CBO estimates accounted for about 97 percent of the U.S. population in 2018. Other people, such as noncitizens who are not lawfully present, might be ineligible for coverage, eligible for full coverage, eligible for a limited set of benefits, or able to buy into the system without any government subsidies. A waiting period for noncitizens

who have newly entered the country to become eligible could also be implemented.

Under a state-administered single-payer system, states could establish their own residency and eligibility requirements, such as providing coverage for noncitizens who are not lawfully present. However, the federal government might impose certain conditions in exchange for providing matching funds.

Certain groups, such as veterans and indigenous people, could continue to be covered through other public programs. In Canada, a separate federal health care system covers indigenous people, refugees, veterans, military personnel, federal police officers, and those in federal prison, even though its single-payer system is administered by the provinces and territories.¹³

Opting Out

Another key decision for a single-payer system is whether it would allow people to opt out of receiving benefits offered by the public plan. The system could allow people to opt out for moral or religious reasons. It might also allow people to opt out and purchase private insurance that duplicated the benefits of the single-payer health plan as an alternative, but such a system would be more akin to a multipayer system.

If people could opt out, policymakers would need to decide if they would be required to contribute to the single-payer system and, if so, how much they would need to contribute. Those people could still be required to contribute fully to support the single-payer system, or they could receive a tax credit or tax deduction to offset some or all of their premium payments for private insurance. If contributions were mandatory, the single-payer system could enforce compliance through existing automatic payroll withholdings and taxes.

Verification and Enrollment

A single-payer system would need a way to verify eligibility and enroll participants in the system. Verifying eligibility would be easier than it currently is for public programs, such as with Medicaid's income verification, because the single-payer system would have fewer eligibility exclusions. A verification and enrollment system

11. See Tsung-Mei Cheng, "Reflections on the 20th Anniversary of Taiwan's Single-Payer National Health Insurance System," *Health Affairs*, vol. 34, no. 3 (March 2015), pp. 502–510, <https://doi.org/10.1377/hlthaff.2014.1332>.

12. That estimate of private insurers' administrative costs also includes profits. See Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, "NHE Tables" (accessed February 15, 2019), Table 4, <https://go.usa.gov/xEPqW>.

13. See Nancy Miller Chenier, *Federal Responsibility for the Health Care of Specific Groups* (Library of Parliament, Canada, December 2004), <https://tinyurl.com/y4pnvbs7>.

could build on the current Medicare Part A enrollment system. People could also be automatically enrolled when they were issued Social Security numbers, newborns could be enrolled in hospitals at birth, and other eligible individuals could be enrolled when they sought medical care.

What Health Care Services Would the Plan Cover?

The benefit package included in a single-payer health plan could resemble the essential health benefits provided by the Affordable Care Act (ACA), Medicare, or Medicaid, or it could be based on something else, such as a cost-effectiveness criterion or the federal government's willingness to pay to cover certain services. The benefit package could cover some or all services that are not typically covered by private insurance or by Medicare, such as long-term services and supports (LTSS). A single-payer system would also need a way to decide which new treatments and technologies it would cover. If a single-payer system was implemented at the state level, the federal government could define some specified benefits but allow states to cover additional benefits, in the same way that states currently can cover optional Medicaid benefits.¹⁴

Covered Services

In most other countries with single-payer systems, such as England and Taiwan, the benefit package provides comprehensive major medical coverage, including hospital and physician care, as well as mental health services, diagnostic tests, and prescription drugs. Canada's single-payer system does not cover outpatient prescription drugs, and it is up to provincial and territorial governments to administer their own prescription drug benefit program. (Most Canadians have access to prescription drug coverage through a combination of private and public insurance plans.)¹⁵

Some single-payer systems cover other health care services, such as dental, vision, and hearing, that are not typically covered by Medicare FFS. Those services could be covered for everyone under a single-payer system, or coverage could be restricted to low-income people. If coverage was restricted to low-income people, those services could be administered through the single-payer system or through a residual Medicaid program that only covered cost sharing and LTSS for low-income and disabled people. Some provinces in Canada provide coverage to certain low-income populations for prescription drugs and other services that are not covered under its single-payer systems.¹⁶

Although covering a wider range of services under a single-payer system would provide greater financial protection to enrollees, it would also increase costs to the government. People who received an additional health care benefit for the first time would probably increase their use of that benefit, and that increase might be greater initially because of previously unmet health care needs. Cost-sharing requirements or utilization management could mitigate the increase in use, but government spending would increase even for people with existing coverage because the funding for such services would shift from private sources to the government.

New Treatments and Technologies

Decisions about which new treatments and technologies would be covered would have a significant effect on patients' access to those innovations, as well as on the development of new treatments and technologies over time and the costs of the single-payer system.¹⁷ An independent board could recommend whether or not new treatments and drugs should be covered after their clinical and cost-effectiveness had been demonstrated—a role fulfilled in England by the National Institute for Health Care and Excellence.¹⁸ Alternatively, coverage decisions could be limited to items or services that were judged to

14. Medicaid has a set of mandatory benefits that states are required to provide and a set of optional benefits that states can cover if they choose. The Medicaid benefit package varies across states because states can choose which optional services to provide. If a single-payer system was based on the Medicaid benefit package, policymakers would need to decide which Medicaid benefit package would be used. See Centers for Medicare & Medicaid Services, "Mandatory and Optional Medicaid Benefits" (accessed February 15, 2019), <https://go.usa.gov/xEUhc>.

15. See Government of Canada, "Prescription Drug Insurance Coverage" (August 13, 2018), <https://tinyurl.com/y2nm3qd8>.

16. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

17. See James D. Chambers and others, "Medicare Is Scrutinizing Evidence More Tightly for National Coverage Determinations," *Health Affairs*, vol. 34, no. 2 (February 2015), pp. 253–260, <https://doi.org/10.1377/hlthaff.2014.1123>.

18. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

be reasonable and necessary for the diagnosis or treatment of illness and injury, similar to Medicare's existing national coverage determination process.¹⁹ If states administered the single-payer system, then they would need to make those decisions.

Long-Term Services and Supports

A single-payer system could cover LTSS, such as nursing home and home health services, for everyone enrolled in the system or only for those with low income and few assets (as with Medicaid). If the single-payer system did not cover LTSS, however, the government could retain the Medicaid program to cover such services.

Public spending would increase substantially relative to current spending if everyone received LTSS benefits. Under the current system, many people receive Medicaid benefits for such services but use their own funds to pay for LTSS before they qualify for Medicaid; state Medicaid programs currently pay about half of the cost of such services. Private insurance accounts for a small portion of LTSS spending.²⁰ Under a single-payer system, government payments could replace payments by individuals and private insurance. Further, if the single-payer system eliminated the Medicaid program, federal spending on LTSS would increase considerably unless the system required states to continue their current funding or unless state (or local) governments covered LTSS benefits entirely.

Currently, much of LTSS is unpaid (or informal) care provided by family members and friends. If a single-payer system covered LTSS with little or no cost sharing, a substantial share of unpaid care might shift to paid care. That effect could be particularly large if the single-payer plan covered home- and community-based services.

Even if coverage for LTSS remained the same as under current law, the use of such services would probably increase relative to current use because of the broader expansion of health insurance coverage. For example, people who are currently eligible for but not enrolled in Medicaid LTSS benefits might become more aware of such benefits through greater outreach efforts.²¹

In England, the National Health Service (NHS) pays for some LTSS, but most LTSS benefits are provided at the local level and by the private sector. Local authorities are required to assess the needs of everyone who requests it, but LTSS benefits funded by the local government are not guaranteed, and such benefits are typically based on income and need.

In Canada, LTSS benefits are not mandated; each province and territory funds such services, but coverage varies by area. About half of the provinces provide home care without regard to income, although access may depend on availability and priority.²²

What Cost Sharing, If Any, Would the Plan Require?

Under a single-payer system, enrollees could pay nothing or pay a portion of the cost when they received care. Enrollees in private insurance plans and Medicare generally share costs for most services.

Cost sharing affects beneficiaries' financial well-being and total health care spending. Under a single-payer system, greater cost sharing would expose beneficiaries to more financial risk, whereas less cost sharing would shift costs from private to public sources. Moreover, existing evidence indicates that people use more care when their

19. See Centers for Medicare & Medicaid Services, "Medicare Coverage Determination Process" (March 6, 2018), <https://tinyurl.com/ybj9t57j>.

20. In 2016, total spending on LTSS was \$366 billion. Medicaid accounted for 42 percent of such expenditures, Medicare accounted for another 22 percent, and other public programs accounted for another 6 percent. Out-of-pocket expenses, private insurance, and other private sources accounted for an additional 16 percent, 8 percent, and 7 percent, respectively. See Congressional Research Service, *Who Pays for Long-Term Services and Supports* (August 2018), <https://fas.org/sgp/crs/misc/IF10343.pdf> (340 KB).

21. See Julie Sonier, Michel H. Boudreaux, and Lynn A. Blewett, "Medicaid 'Welcome-Mat' Effect of Affordable Care Act Implementation Could Be Substantial," *Health Affairs*, vol. 32, no. 7 (July 2013), pp. 1319–1325, <https://doi.org/10.1377/hlthaff.2013.0360>; Julie L. Hudson and Asako S. Moriya, "Medicaid Expansion for Adults Had Measurable 'Welcome Mat' Effects on Their Children," *Health Affairs*, vol. 36, no. 9 (September 2017), pp. 1643–1651, <https://doi.org/10.1377/hlthaff.2017.0347>; and Benjamin D. Sommers, Genevieve M. Kenney, and Arnold M. Epstein, "New Evidence on the Affordable Care Act: Coverage Impacts of Early Medicaid Expansions," *Health Affairs*, vol. 33, no. 1 (January 2014), pp. 78–87, <https://doi.org/10.1377/hlthaff.2013.1087>.

22. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

cost is lower, so little or no cost sharing in a single-payer system would tend to increase the use of services and lead to additional health care spending, as well as more government spending.²³ The extent to which use of services would increase in response to less cost sharing under a single-payer system could be constrained by providers' capacity to supply those services.²⁴

In addition, a change in use of services in response to changes in cost sharing in one part of the health care system could affect use of services and spending in another part of the system. For example, one study found that when Medicare beneficiaries faced higher cost sharing on physicians' services and drugs, the savings from reduced use of those services were partially offset by an increase in inpatient hospital use and spending.²⁵

Cost sharing could vary across services in a single-payer system. A value-based insurance design could eliminate cost sharing for effective or high-value care, such as certain preventive services, but require cost sharing

for low-value services.²⁶ Similarly, a value-based design might have no cost sharing for generic prescription drugs but substantial cost sharing for brand-name drugs that have generic substitutes. Because some judgment would be required to determine the value of services, some of those determinations would be imperfect, and the use of value-based insurance design would increase the administrative complexity and costs of the single-payer system.

Beneficiaries' responsibility for cost sharing could also vary by income level or other factors. People with low incomes could be eligible for cost-sharing reductions, and people with certain catastrophic conditions, such as cancer or HIV, could receive cost-sharing exemptions. Currently, the ACA requires insurers that participate in the health insurance marketplaces to offer cost-sharing reductions to eligible people; the size of the subsidy varies with the recipient's income. Although an income-based cost-sharing structure would be more difficult to administer because of the need to collect and verify income, that process could be simplified by building on existing systems, such as the current income tax system.

Cost sharing in a single-payer system could include one or more of these components:

- A **deductible**—the amount patients pay out of pocket before an insurance plan starts to pay;
- A **copayment**—a fixed dollar amount paid for a specific health care service (after reaching the deductible, if applicable);
- **Coinsurance**—a fixed percentage of costs paid for a specific health care service (after reaching the deductible, if applicable); and
- An **out-of-pocket maximum**—a limit on a patient's total cost sharing.

23. According to the RAND Health Insurance Experiment, the price elasticity of health care is -0.2. In other words, a 10 percent decrease in out-of-pocket costs would lead to a 2 percent increase in total health care spending. See Emmett B. Keeler and John E. Rolph, "The Demand for Episodes of Treatment in the Health Insurance Experiment," *Journal of Health Economics*, vol. 7, no. 4 (December 1988), pp. 337–367, [https://doi.org/10.1016/0167-6296\(88\)90020-3](https://doi.org/10.1016/0167-6296(88)90020-3). Findings in subsequent studies are largely consistent with that estimate of -0.2 from the RAND experiment. See Aviva Aron-Dine, Liran Einav, and Amy Finkelstein, "The RAND Health Insurance Experiment, Three Decades Later," *Journal of Economic Perspectives*, vol. 27, no. 1 (Winter 2013), pp. 197–222, <https://dx.doi.org/10.1257/jep.27.1.197>.

24. The estimates of patients' use of services in response to changes in cost sharing are based on changes in cost sharing for a limited segment of the population, so the supply of providers would probably be able to meet any increase in demand. The supply of providers might not be able to meet the demand under a single-payer system, however, because any change under that system would affect the entire population. Although the government could establish policies designed to increase the supply of providers to meet the increased demand from less cost sharing, patients might face longer wait times or a decrease in quality until the supply of providers adjusted. Those effects could worsen if provider payment rates were simultaneously lowered or more stringent cost-containment methods were implemented.

25. See Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," *American Economic Review*, vol. 100, no. 1 (March 2010), pp. 193–213, <https://dx.doi.org/10.1257/aer.100.1.193>.

26. Several organizations have assessed the value of services, such as the Choosing Wisely campaign in the United States, the U.S. Preventive Services Task Force, the National Institute for Health Care Excellence in England, and the Canadian Agency for Drugs and Technologies. By one estimate, 2.7 percent of Medicare spending is on low-value services. See Aaron L. Schwartz and others, "Measuring Low-Value Care in Medicare," *JAMA Internal Medicine*, vol. 174, no. 7 (July 2014), pp. 1067–1076, <https://dx.doi.org/10.1001/jamainternmed.2014.1541>.

In the current system, private insurers and public plans typically use a combination of those four cost-sharing components. The Medicare FFS program has different cost-sharing requirements for different services.²⁷ Most Medicare Part D plans have a tiered cost-sharing structure, with less cost sharing for generic drugs and more cost sharing for more expensive brand-name drugs. Medicaid imposes little or no cost sharing, depending on the type of enrollee.

Cost-sharing rules in private insurance plans vary widely, but most plans require copayments or coinsurance for physician visits, hospital services, and prescription drugs. In 2018, 85 percent of workers covered by employment-based health insurance plans also had to pay deductibles, and the average deductible was about \$1,500 for a single plan.²⁸

The limit on out-of-pocket spending varies by type of plan. Under current law, most employment-based and nongroup plans are required to have an out-of-pocket maximum below a specified amount: \$7,900 for an individual plan and \$15,800 for a family plan in 2019.²⁹ The actual out-of-pocket maximum varies by plan and usually falls below that level. The Medicare FFS program and Part D plans do not have a limit on out-of-pocket spending, but Medicare Advantage plans do.

Cost sharing varies among countries with single-payer systems. Canada and England have no or minimal cost sharing for physicians' and hospital services, whereas Sweden and Taiwan require some cost sharing on most services.

What Role Would Private Health Insurance Have?

A single-payer system offering comprehensive benefits would probably limit the role of private insurance to three main categories:

- **Supplemental insurance** could cover services not included in the single-payer plan, such as dental,

vision, or hearing. It could also reduce enrollees' cost sharing, like the private plans that many Medicare beneficiaries purchase.

- **Substitutive insurance**, which duplicates the benefits of the single-payer health plan, could be offered to people who are not eligible for the single-payer system, such as noncitizens who have recently entered the country or temporary visitors. It could also be an alternative source of coverage if people were allowed to opt out of the single-payer system.³⁰
- **Other types of private insurance** could provide benefit enhancements, such as faster access to care, private rooms instead of semiprivate rooms for inpatient stays, and a greater choice of providers that do not participate in the single-payer system.

If such private insurance was allowed, policymakers would need to decide whether it would be required to cover people with preexisting conditions and whether premiums could vary by health status, age, sex, or other factors. Another consideration is whether the government would encourage the use of private insurance through tax credits, tax deductions, or penalties. If employers sponsored the private insurance, policymakers would need to determine whether to exclude employers' premium contributions from taxation.³¹ For example, although Australia has a single-payer system, the government encourages people to enroll in private insurance that offers benefit enhancements and supplemental coverage by providing a tax rebate. People with income above a certain amount must pay a penalty if they do not have private insurance.³²

27. For example, inpatient hospitalization and physicians' services require a deductible, and physicians' services also require 20 percent coinsurance. Other services, such as preventive care, home health visits, and laboratory tests, require no cost sharing.

28. See Kaiser Family Foundation, *Employer Health Benefits: 2018 Annual Survey* (October 2018), <http://tinyurl.com/y8bjvazq> (PDF, 18.1 MB).

29. See Centers for Medicare & Medicaid Services, "Affordable Care Act Implementation FAQs—Set 18" (accessed June 1, 2018), <https://go.usa.gov/xQfbJ>.

30. See Jodi L. Liu and Robert H. Brook, "What Is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S.," *Journal of General Internal Medicine*, vol. 32, no. 7 (July 2017), pp. 822–831, <https://doi.org/10.1007/s11606-017-4063-5>.

31. Under current law, contributions made by employers to pay for employees' health care costs and the amount that employees pay for their share of premiums are excluded from income and payroll taxes; those exclusions cost the federal government about \$300 billion in forgone revenue in 2018. See Congressional Budget Office, "Reduce Tax Subsidies for Employment-Based Health Insurance," *Options for Reducing the Deficit: 2019 to 2028* (December 2018), www.cbo.gov/budget-options/2018/54798.

32. In December 2018, 45 percent of the Australian population had private hospital coverage and 54 percent had general treatment coverage. See Australian Prudential Regulation Authority, *Statistics: Quarterly Private Health Insurance Statistics, December 2018* (February 2019), <https://tinyurl.com/y44v9ova> (PDF, 1 MB).

In the United States, most beneficiaries in Medicare FFS have supplemental insurance plans that reduce their out-of-pocket expenses.³³ Because those plans lessen or eliminate cost sharing, they contribute to greater use of services and spending.³⁴ Supplemental insurance and other types of private insurance are also common in countries with single-payer systems, including Canada and many members of the European Union.³⁵

By contrast, proposals to establish single-payer systems often prohibit substitutive insurance because of concerns that it might interfere with the operation of the public plan.³⁶ If it was allowed, some high-income people might prefer to purchase substitutive insurance that offered more generous benefits or greater access to providers. If providers were allowed to participate in both the single-payer system and the substitutive insurance market and if provider payment rates in the substitutive insurance plan were higher than in the single-payer system, providers might prioritize treating those enrollees. If many people enrolled in substitutive insurance, patients in the single-payer health plan might have longer wait times.

Instead of prohibiting substitutive insurance, policymakers could discourage it by requiring individuals who purchased it to make full contributions toward the single-payer system, in addition to paying the cost of the substitutive insurance. However, that requirement could make substitutive insurance unaffordable for many people. Policymakers could also make enrollees

with substitutive insurance less attractive to providers by requiring providers who treated both publicly and privately insured patients to spend a minimum number of hours in the single-payer system or to treat a minimum number of publicly insured patients.

Conversely, allowing substitutive insurance could benefit some patients and providers. Some people might prefer to enroll in a substitutive insurance plan that suited their needs better than the public plan. Substitutive insurance might also improve the quality of care for people in both private and public plans. For example, private plans might introduce innovative design features to compete with the public plan, such as selectively contracting with higher-quality providers. That might encourage all providers to improve their quality, which could also benefit publicly insured patients. Allowing private plans might also increase providers' income.

Other types of private insurance provide benefit enhancements. In England, private insurance gives people access to private providers, faster access to care, or coverage for complementary or alternative therapies, but participants must pay for it separately in addition to paying their individual required tax contributions to the NHS.³⁷ In Australia, private insurance covers services that the public plan does not, such as access to private hospitals, a choice of specialists in both public and private hospitals, and faster access to nonemergency care.³⁸

Private insurance that provides benefit enhancements could potentially hinder the operation of a single-payer system. Allowing privately insured patients faster access to care could create inequity in access to care (as discussed above with substitutive insurance), but private

33. In 2015, 87 percent of noninstitutionalized beneficiaries in the Medicare program had some type of supplemental coverage or participated in Medicare managed care. See Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program* (June 2018), p. 29, <https://go.usa.gov/xEU4R> (PDF, 1.58 MB).

34. See, for example, Medicare Payment Advisory Commission, *Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly* (August 2014), <https://go.usa.gov/xQdGG> (PDF, 388 KB).

35. For example, about 11 percent of the United Kingdom's population has some form of voluntary private insurance. See Commission on the Future of Health and Social Care in England, *The UK Private Health Market* (King's Fund, 2014), <https://tinyurl.com/y37zg72s> (PDF, 60.8 KB).

36. See Jodi L. Liu and Robert H. Brook, "What Is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S.," *Journal of General Internal Medicine*, vol. 32, no. 7 (July 2017), pp. 822–831, <https://doi.org/10.1007/s11606-017-4063-5>.

37. See Thomas Foubister and Erica Richardson, "United Kingdom," in Anna Sagan and Sarah Thomson, eds., *Voluntary Health Insurance in Europe, Country Experience* (European Observatory on Health Systems and Policies, 2016), p. 157, <https://go.usa.gov/xEUhY> (PDF, 2.5 MB); Thomas Foubister and others, *Private Medical Insurance in the United Kingdom* (European Observatory on Health Systems and Policies, 2006), p. 4, <https://tinyurl.com/y66ux4xj> (PDF, 444 KB).

38. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB); Sharon Wilcox, "Promoting Private Health Insurance in Australia," *Health Affairs*, vol. 20, no. 3 (May/June 2001) pp. 152–161, <https://doi.org/10.1377/hlthaff.20.3.152>.

insurance could also relieve some of the pressures on a publicly funded system.³⁹

A single-payer system could permit private insurers to deliver the benefits, much like the Medicare Advantage program does. A key design choice for the system is how policymakers would structure the competition among private insurers. Such a system could be more akin to a multipayer system than a single-payer system (see Box 1). However, some analysts would consider that type of system—in which private insurers play a larger role, including paying providers—to be a single-payer system if the government defined the eligible population, specified the covered services, collected the resources needed for the plan, required the eligible population to contribute toward financing the system, and showed the receipts and expenditures associated with the plan in the government's budget.

If the single-payer system banned private insurance entirely or limited its role—such as, to contract work providing administrative services and claims processing—many workers in the health insurance industry would be displaced. However, that reduction in private-sector employment would probably be partially offset by an increase in government workers needed to administer the new system. Under those circumstances, workers who were displaced could receive job training assistance or financial benefits, and shareholders of for-profit insurers could receive compensation, which would increase government spending.

What Role Would Other Public Programs Have?

The federal government would need to determine whether other public programs, such as Medicaid, TRICARE (the health care program of the Department of Defense), and programs of the Veterans Health Administration (VHA) and the Indian Health Service, would continue to exist alongside the single-payer system. Those public programs were created to serve populations with special needs. Under a single-payer system, some components of those programs could continue to operate separately and provide benefits for services not

covered by the single-payer health plan. For example, Medicaid could continue to provide LTSS benefits and premium and cost-sharing subsidies only for low-income populations. The Indian Health Service, TRICARE, and VHA, which operate their medical facilities and also pay for care delivered by private providers, could also remain as separate systems and provide benefits to their specific populations. Similarly, in Canada, veterans receive health care through Veterans Affairs Canada rather than through the single-payer systems of the provinces and territories.⁴⁰

What Rules Would Participating Providers Follow?

As with any insurer under the current system, a single-payer plan would need to establish a process to certify and accredit physicians and facilities to provide care to its beneficiaries. It could adapt Medicare's standards and procedures to select providers who are eligible to participate in the system. For eligible providers who decided to participate in the single-payer plan, it could further establish guidelines for billing and for the treatment of private-pay patients.

Balance Billing

In establishing a single-payer system, policymakers could decide whether providers would be allowed to “balance bill” patients. Balance billing occurs when a provider bills a patient for the difference between the provider's charge and the amount allowed under an insurance policy. For example, a physician might attempt to charge \$200 for a service, but the allowed amount for that service—which could be paid by the individual as cost sharing, by the insurer, or by both—might only be \$150. Billing the patient for the \$50 difference between the two amounts would be balance billing.

Nearly all physicians have agreed not to balance bill Medicare patients for Medicare-covered services. Such physicians are designated “participating providers” in Medicare. By one estimate, 96 percent of physicians and other health care professionals are participating providers. About 4 percent are nonparticipating providers; they

39. See Joseph White, “Gap and Parallel Insurance in Health Care Systems With Mandatory Contributions to a Single Funding Pool for Core Medical and Hospital Benefits for All Citizens in Any Given Geographic Area,” *Journal of Health Politics, Policy, and Law*, vol. 34, no. 4 (August 2009), pp. 543–583, <https://doi.org/10.1215/03616878-2009-015>.

40. See Nancy Miller Chenier, *Federal Responsibility for the Health Care of Specific Groups* (Library of Parliament, Canada, December 2004), <https://tinyurl.com/y4pnvb7>.

may choose whether to balance bill Medicare patients on a claim-by-claim basis, up to a certain limit.⁴¹

Other types of providers, such as hospitals and skilled nursing facilities, are not allowed to balance bill Medicare patients. Balance billing is prohibited for all providers in Medicaid. Most private insurers prohibit balance billing for providers in their networks, but they allow balance billing for out-of-network providers.⁴²

A prohibition on balance billing in a single-payer system would help ensure affordability for patients. If provider payment rates under such a system were much lower than average rates under current law, however, prohibiting balance billing could discourage some providers from participating—particularly if they could treat private-pay patients for higher amounts. If the single-payer system permitted balance billing, it could set a limit on that amount (as in Medicare), which would help ensure affordability and access to care. Regulations that made the billing process transparent would also protect beneficiaries against unexpected charges. Many international single-payer health systems prohibit balance billing for participating providers.⁴³

Private-Pay Patients

Another key question is whether the single-payer plan would allow participating providers to offer services that the plan covered to private-pay patients and, if so, under what conditions. For example, if participating providers could treat private-pay patients, policymakers might consider whether to impose any restrictions on that activity—for example, by specifying the number of private-pay patients they could treat or the amount they could charge. If a single-payer system did not allow providers to treat private-pay patients, some providers might opt out, especially if substitutive insurance plans

were allowed or the system's payment rates were low and enough private patients were willing to pay for their services. Conversely, if the single-payer health plan covered a comprehensive set of services and care could be accessed in a timely manner, the demand for private care would probably be limited, and fewer providers would opt out.

The rules for providing private care for covered services vary across single-payer systems. In England, specialists in the NHS system can provide private care in their spare time within designated private units of NHS hospitals or at private hospitals, and private providers can contract with the NHS to provide public care.⁴⁴ In Canada, providers are generally prohibited from providing both public and private care.⁴⁵

Who Would Own the Hospitals and Employ the Providers?

Currently, about 70 percent of U.S. hospitals are privately owned: About half are private, nonprofit entities, and 20 percent are for-profit.⁴⁶ Almost all physicians are self-employed or privately employed. A single-payer system could retain current ownership structures, or the government could play a larger role in owning hospitals and employing providers. In one scenario, the government could own the hospitals and employ the physicians, as it currently does in most of the VHA system. A greater government role could also include converting for-profit hospitals to nonprofit hospitals or quasi-public providers. In quasi-public organizations, the government or its appointees would oversee or manage daily operations.

By owning and operating hospitals and employing physicians, the government would have more control over the health care delivery system, but it would also take on more responsibilities. The transition from the

41. Fewer than 1 percent of all physicians and other health care professionals opt out of Medicare entirely and have private contracts with their Medicare patients; about half who opt out are psychiatrists. See Cristina Boccuti, "Paying a Visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services" (Kaiser Family Foundation issue brief, November 30, 2016), <https://tinyurl.com/ybfc8yww>.

42. See Karen Pollitz, "Surprise Medical Bills" (Kaiser Family Foundation issue brief, March 17, 2016), <https://tinyurl.com/ybjc34rn>.

43. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

44. See Seán Boyle, "United Kingdom (England): Health System Review," *Health Systems in Transition*, vol. 13, no. 1 (2011), pp. 1–486, <https://tinyurl.com/lqw8k2t> (PDF, 7.5 MB).

45. See Health Canada, *Canada Health Act Annual Report 2016–2017* (February 16, 2018), <https://tinyurl.com/y8q2lfst>.

46. Fewer than 20 percent of hospitals are owned by state and local governments, and fewer than 5 percent are federally owned; most federal facilities are military and veterans' hospitals. See American Hospital Association, "Fast Facts on U.S. Hospitals, 2019" (accessed February 15, 2019), <https://tinyurl.com/y8nquhjs>. Outside the VHA system, uniformed military health care providers, and the Indian Health Service, physicians are largely privately employed.

Box 1.

Key Features of Multipayer Health Care Systems That Aim to Achieve Universal Coverage

A multipayer health care system is one in which more than one insurer provides health insurance coverage and also pays for enrollees' health care services. In multipayer systems that aim to provide coverage to almost everyone, the federal and state governments would probably play a smaller role in the health care system than they would in a single-payer system with that same goal. In a multipayer system, a greater share of total national health care spending would be financed through private sources (private insurers, employers, and individuals) and might not appear in federal and state budgets.

The United States currently has a multipayer system, but it has not achieved universal coverage. A multipayer system designed to achieve universal coverage for all U.S. citizens and lawfully present noncitizens could use design elements commonly observed in multipayer systems that have achieved universal coverage (for example, in Germany and Switzerland). In the United States, some of those elements are already in place in the health insurance marketplaces established under the Affordable Care Act.

A multipayer system that aims to achieve universal coverage could have the following elements:

- **Guaranteed issue and community rating of premiums.** In a system with guaranteed issue, insurers are required to issue policies to all applicants regardless of health status, age, sex, or other factors that might affect their use of health care services. Under community rating, insurers are prohibited from varying premiums on the basis of health status or past use of health care services. Without those regulations, people with characteristics that are associated with high medical spending, such as old age and chronic conditions, could be denied coverage or face prohibitively high premiums.
- **Highly regulated benefit design across insurers.** To ensure access to a specified set of health care services, the mandated set of benefits typically includes hospital and physician care and prescription drugs, but individual health plans within the multipayer system could be permitted to vary certain features of their plans, such as provider networks, cost sharing, and drug formularies, or to cover additional services that are not mandated. Variation across plans would be minimal, however, if the plan design was highly regulated and the mandated set of benefits was comprehensive.
- **A robust mandate to purchase insurance or another mechanism to ensure enrollment and compliance.** With regulated benefit design and regulated premium rating, people who expect low health care spending, such as young and healthy people, might not want to purchase any coverage. An effective enforcement mechanism could discourage such selective disenrollment and stabilize the insurance market through robust participation. A strongly enforced mandate could include automatic payroll withholdings, the loss of a tax benefit, or fines and penalties. People who did not enroll in a health plan on their own could be automatically enrolled.
- **Subsidized insurance costs to ensure affordability.** Multipayer health systems typically impose cost sharing for services and require tax or premium contributions to finance the system. Multipayer health systems that aim for universal coverage typically feature a cap on out-of-pocket costs, as well as exemptions from cost sharing for preventive care. In addition, cost sharing and tax or premium contributions may be reduced or waived for certain groups, including low-income beneficiaries, the elderly, the disabled, children, students, and pregnant women.

Germany and Switzerland include those four elements in their multipayer systems, although their approaches differ in some respects. In both countries, health insurance is mandatory for all citizens and lawfully present noncitizens. Both countries impose fines on people who do not have coverage. People obtain coverage from one of the competing nonprofit insurers, each of which offers a comprehensive benefit package established by the central government in consultation with stakeholders. Insurers cannot deny coverage to anyone.

Cost sharing is assessed for most services in Germany and Switzerland. In Germany, children under age 18 are exempt from cost sharing, and cost-sharing payments for adults are capped at 2 percent of annual household income. That cap is lower for people with certain chronic illnesses. In Switzerland, maternity care, some preventive services, and hospital inpatient care for children and young adults are exempt from cost sharing. About a quarter of Swiss residents also receive income-related subsidies to reduce or eliminate their premiums.

Compared with a single-payer system, establishing a multipayer health system in the United States that aimed to achieve universal coverage would have several advantages:

Box 1.

Continued

Key Features of Multipayer Health Care Systems That Aim to Achieve Universal Coverage

- The United States could build on its existing insurance market and infrastructure for care delivery and payment, which would help reduce disruption to health insurers, providers, manufacturers, and beneficiaries during the transition and after the system was implemented.
- Multipayer systems have historically had fewer provider capacity issues (such as waiting lists and rationing of care) than single-payer systems because of specific design elements of single-payer systems, such as financing and payment methods.¹ For example, because nearly all national health care spending under a single-payer system would appear on the government's budget and would become the responsibility of taxpayers, the system would face greater budgetary pressure to contain costs and manage the population's health. Without sufficient incentives through the payments they receive, providers might opt out of a single-payer system.
- Multipayer systems offer a greater choice of insurer and health benefits than single-payer systems, which might address the needs of a broader group of people. For example, young and healthy people might prefer to purchase coverage with high deductibles or fewer benefits. Multipayer systems might also be able to adjust more quickly than single-payer systems to meet patients' needs, such as covering new treatments or procedures.

But multipayer systems tend to have higher total spending than single-payer systems for several reasons:

- Single-payer systems typically have stronger purchasing power than multipayer systems to achieve lower prices. As a result, payment rates under multipayer systems tend to be higher. Control of health care spending in such systems could be enhanced by adopting an all-payer rate-setting system. Under such a system, all insurers typically pay providers using the same payment method and price for each service, but the price could vary across providers. The payment methods and rates could be determined through negotiation between all insurers in a region (or an agency representing the health insurers) and all providers in that region (or a provider association). Instead of negotiations, the government could set the rates administratively for all insurers and providers. In Maryland, an all-payer rate-setting system is used in conjunction with a global budget to pay acute-care hospitals. Alternatively, the government or an independent body could set a ceiling on provider payment rates and allow insurers and providers to negotiate payment rates subject to that ceiling. For example, West Virginia uses a state-based rate-setting system to regulate hospital rates for private payers by setting both a ceiling and a floor, and hospitals and payers can negotiate the payment methods and rates as long as they are within those limits.²
- Because people can choose among different plans under a multipayer system, they might choose health plans based on their health status or expected medical spending. That behavior (called risk selection) could lead to instability in the insurance market and therefore higher costs. Highly regulated benefits could limit the variation across plans and mitigate the selection issue. Risk-adjustment mechanisms can minimize the impacts of risk selection, but those mechanisms only work well if predictions about people's health care use are accurate.
- Administrative costs under a multipayer system would probably be higher than those of a single-payer system because insurers under a multipayer system would probably incur additional costs, such as for marketing activities, sales, and profits. In addition, administrative costs per beneficiary would probably be higher for each insurer under a multipayer system than under a single-payer plan because the multipayer system would have fewer gains from its scale. Insurers' administrative costs under a multipayer system could be regulated by requiring insurers to spend a minimum share of premiums collected on medical services and other activities that improve the quality of care, as they are currently. Providers' administrative costs under a multipayer system would also probably be higher than under a single-payer system because they would need to deal with different payment methods and rules for each insurer.

1. See Joseph White, "Gap and Parallel Insurance in Health Care Systems With Mandatory Contributions to a Single Funding Pool for Core Medical and Hospital Benefits for All Citizens in Any Given Geographic Area," *Journal of Health Politics, Policy, and Law*, vol. 34, no. 4 (August 2009), pp. 543–583, <https://doi.org/10.1215/03616878-2009-015>.

2. See Robert Murray and Robert A. Berenson, *Hospital Rate Setting Revisited* (Urban Institute, November 2015), <https://tinyurl.com/yyuvkmvq> (PDF, 1.16 MB).

current system to publicly owned hospitals and publicly employed physicians would entail significant changes for providers, and those changes could lead to lower quality of care for patients. To limit those changes, the government could attempt to employ as many of the current health care providers as possible, in addition to setting up an effective governance system to administer publicly owned hospitals and publicly employed physicians.

Another consideration is whether integrated delivery systems that provide both insurance and care, such as Kaiser Permanente or Geisinger Health System, would be allowed to continue to operate. Allowing that type of system to operate alongside a single-payer health plan would lead to a multipayer system because people in some areas would have a choice between the public plan and the integrated delivery system. As a result, policy-makers would need to address issues that are inherent in multipayer systems, such as selective enrollment based on information not known to insurers and competition among insurers (see Box 1 on page 16).

Single-payer systems in other countries involve both public and private provider ownership. In Canada, most hospitals are private, nonprofit entities, but hospital ownership varies across provinces, and physicians are mostly self-employed or privately employed.⁴⁷ In England, most hospital beds are in public NHS hospitals.⁴⁸ Most specialists are salaried employees of NHS hospitals, but most primary care physicians are self-employed or privately employed.⁴⁹

How Would a Single-Payer System Pay Providers and Set Payment Rates?

Two primary concerns of a single-payer health care system are the methods it would use to pay providers and set their payment rates, both of which would directly affect government spending, national health care spending, and providers' revenues. The impact on providers'

revenues would, in turn, affect their incentives to deliver services.

Provider Payment Methods

A single-payer system could pay participating providers on a fee-for-service basis, with bundled and episode-based payments, through global budgets, by capitation, with a salary, or through a combination of those methods.

Fee for Service. In an FFS system, providers are paid for each service they deliver. That method is the most common form of provider payment in the United States. Under an FFS system, the payer assumes the financial risk if enrollees use more care than projected. Many analysts have noted that the financial rewards inherent in an FFS payment system give providers incentives to deliver too much care. Pay-for-performance incentives could be combined with an FFS system to temper the incentives to deliver too much care.⁵⁰ In Canada, general practitioners (GPs) and specialists are mostly paid on an FFS basis, although the payment method varies by province.⁵¹

Bundled and Episode-Based Payments. With bundled and episode-based payments, providers receive a fixed payment to cover all services furnished during a single episode of care. The fixed payment can cover different types of providers, including physicians and hospitals. Under such payment arrangements, providers bear the financial risk if the cost of delivering care within the episode exceeds the payment from the insurer. Providers therefore have an incentive to deliver fewer services per episode, but they also have an incentive to deliver more episodes of care. Episodes can be defined by a diagnosis during an event, such as a hospitalization or admission to a skilled nursing facility, or over a certain period of time. Diagnosis-related groups (DRGs), which are an example of bundled or episode-based payments, currently form the basis of Medicare's hospital inpatient payment system. The payment rate for each DRG is based on an amount determined in advance for a given condition, which is then adjusted to account for factors such as the

47. See Gregory P. Marchildon, "Canada: Health System Review," *Health Systems in Transition*, vol. 15, no. 1 (2013), pp. 1–179; Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

48. See Seán Boyle, "United Kingdom (England): Health System Review," *Health Systems in Transition*, vol. 13, no. 1 (2011), pp. 1–486, <https://tinyurl.com/lqw8k2t> (PDF, 7.5 MB).

49. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

50. See James C. Robinson, "Theory and Practice in the Design of Physician Payment Incentives," *Milbank Quarterly*, vol. 79, no. 2 (June 2001), pp. 149–177, <https://doi.org/10.1111/1468-0009.00202>.

51. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

patient's principal diagnosis, secondary diagnoses, and procedures. In England, hospitals are also paid through nationally determined DRG rates.⁵²

A bundled or episode-based payment can include a range of services. For example, Medicare has a bundled-payment program that covers comprehensive care for joint replacements from 2016 to 2020. The bundled payment is designed to capture all necessary patient care related to the joint replacement during the inpatient hospitalization and for 90 days after discharge, and it includes all services covered by Medicare Parts A and B, including inpatient hospital care, physician care, and postacute care. When the program began, participation was mandatory for providers in 67 metropolitan areas. In 2018, participation became voluntary for providers in about half of those areas. About a quarter of the providers in areas with voluntary participation opted to continue participating.⁵³

Global Budgets. With global budgets, providers receive a fixed payment amount for a specific time period (usually a year). Under that arrangement, providers bear the financial risk if the cost of delivering care exceeds the global budget.⁵⁴ Because providers face greater risks under global budgets, the single-payer system could continuously monitor each provider's financial health and adjust payment amounts as necessary to ensure quality of care.

Global budgets are not common in the United States, although Maryland is operating a global budgeting system for hospitals.⁵⁵ Insurers in the state operate under an

all-payer rate-setting system for hospital care, in which all payers (Medicare, Medicaid, commercial insurers, and private-pay patients) pay essentially the same rates. A state agency specifies each hospital's annual budget, which determines the total amount of annual revenue the hospital can receive from all payers for inpatient, outpatient, and emergency department services. Each hospital's budget is calculated from data on its historical provision of services, expected changes in the provision of services, and projected changes in regulated prices. During the year, hospitals receive payments from each payer for the services they deliver, and those payments are periodically compared with the hospital's budget, which is set by the state agency. Each hospital adjusts its payment rates periodically so that its total revenues equal its budget. A hospital can also have its budget changed during the year to account for significant unexpected changes in patient volume.⁵⁶

Single-payer health systems typically include some form of global budgeting. Most hospitals in Canada operate under annual global budgets.⁵⁷ Some countries define global budgets more broadly to cover total health care spending or spending for major categories of services. (For additional information about how a single-payer system might use global budgets to help contain costs, see page 26.)

Capitated Payments. Capitated payments—a predetermined amount paid monthly or annually per patient—can be used to pay for nearly all covered services in a single-payer system. The payment amount for each patient is fixed regardless of the amount of care provided, but it is typically adjusted for the expected health care costs of that patient. This payment method can apply to individual physicians, groups of health

52. Ibid.

53. See Centers for Medicare & Medicaid Services, "Comprehensive Care for Joint Replacement Model" (accessed February 15, 2019), <https://go.usa.gov/xQdGH>.

54. See James C. Robinson, "Theory and Practice in the Design of Physician Payment Incentives," *Milbank Quarterly*, vol. 79, no. 2 (June 2001), pp. 149–177, <https://doi.org/10.1111/1468-0009.00202>.

55. An early evaluation of Maryland's global budget system found aggregate hospital savings of 4 percent for Medicare during the first three years of global budgets (2014–2016) relative to the baseline period. Expenditures for commercial plan members did not increase more slowly in Maryland than in the comparison group in the first two years of statewide adoption, however, and an analysis of the Medicaid population has yet to be undertaken. See RTI International, *Evaluation of the Maryland All-Payer Model: Third Annual Report* (March 2018), <http://tinyurl.com/>

[yxhyqao3](http://tinyurl.com/yxhyqao3); and Susan Haber and Heather Beil, "Another Look at the Evidence on Hospital Global Budgets in Maryland: Have They Reduced Expenditures and Use?" *Health Affairs* (blog, May 14, 2018), <http://tinyurl.com/y3vfvobu>.

56. See Eric T. Roberts and others, "Changes in Hospital Utilization Three Years Into Maryland's Global Budget Program for Rural Hospitals," *Health Affairs*, vol. 37, no. 4 (April 2018), pp. 644–653, <https://doi.org/10.1377/hlthaff.2018.0112>.

57. See Gregory P. Marchildon, "Canada: Health System Review," *Health Systems in Transition*, vol. 15, no. 1 (2013), pp. 1–179, <https://tinyurl.com/y2px2nvu> (PDF, 5.67 MB).

care professionals, provider organizations, or insurers.⁵⁸ Public programs in the United States use capitated payments when the government contracts with private insurers to deliver health care benefits, such as in Medicare Advantage and Medicaid managed care. Single-payer systems can also use capitated payments to pay physicians for a subset of services. In England, for example, the NHS mostly uses capitation to pay GPs for providing essential services.⁵⁹

Salaried Physicians. Instead of paying physicians for each service provided, medical groups (or health care systems) sometimes employ them and pay them a salary. In the United States, Kaiser Foundation Health Plans exclusively contracts with its in-network physicians, who are paid a salary by the Permanente Medical Groups.⁶⁰ In England, physician specialists are nearly all employees of NHS-owned or -contracted hospitals and are paid a salary.⁶¹ In this type of payment arrangement, providers have fewer incentives to increase their productivity or deliver more services relative to an FFS system.

Incentives and Risks Under Different Payment Methods. Combining the various provider payment methods can mitigate the effects of the incentives inherent in each payment method. Health care systems can use value- or quality-based payment methods, such as pay for performance, alongside those payment methods. Although GPs in England are paid mostly by capitation for essential services, some services (such as vaccinations for at-risk populations) are paid on an FFS basis. An optional pay-for-performance arrangement is also available.⁶²

Different payment methods carry different degrees of financial risk for providers and insurers. Receiving

payment as salary or on an FFS basis carries the least risk for providers. By contrast, payments from global budgets or capitation place providers at greater risk. For insurers, paying providers a salary or paying them from global budgets or capitation brings less risk, whereas FFS payments have greater risk.

Payment methods and their inherent financial risks may affect providers' behavior, which can affect the costs and cost-containment strategies of a single-payer system. For example, in Taiwan, physicians and hospitals are both paid on an FFS basis. Because Taiwan has an overall national health care budget, however, the FFS payment system has created fierce competition for patients among providers because one provider's gain is another provider's loss because of the fixed budget.⁶³

Determining Payment Rates

A single-payer system could determine provider payment rates through administrative rate setting, negotiation, or a combination of those approaches. In administrative rate setting, the government would set provider payment rates using formulas specified by law or by regulation. By contrast, provider payment rates determined through negotiations would depend on the relative market power of the provider and insurer, which is affected by the number of competing providers in a particular market.

Administered Rates. A single-payer system administered at the national level in the United States could follow a process similar to that of the Medicare FFS program in administratively setting a uniform fee schedule; a single-payer system administered by states could be modeled on the Medicaid program. Medicare FFS pays for hospital inpatient care using a DRG system, adjusting for factors such as geographic variation in input costs, operating a medical resident training program, having a large share of uninsured and low-income patients, and whether a case has costs that exceed a specified threshold.⁶⁴ A single-payer system could also follow the Medicare FFS process for setting payment rates for new

58. See Robert A. Berenson and others, *Primary Care Capitation* (Urban Institute, June 2016), <https://tinyurl.com/yy3bxwz>.

59. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

60. See Jesse Pines and others, *Kaiser Permanente—California: A Model for Integrated Care for the Ill and Injured* (Brookings Institution, May 2015), <https://tinyurl.com/yxskyo26> (PDF, 202 KB).

61. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

62. Ibid.

63. See Tsung-Mei Cheng, "Reflections on the 20th Anniversary of Taiwan's Single-Payer National Health Insurance System," *Health Affairs*, vol. 34, no. 3 (March 2015), pp. 502–510, <https://doi.org/10.1377/hlthaff.2014.1332>.

64. See Jared Lane Maeda and Lyle Nelson, *An Analysis of Private-Sector Prices for Hospital Admissions*, Working Paper 2017-02 (Congressional Budget Office, April 2017), www.cbo.gov/publication/52567.

treatments or procedures. Currently, the Medicare FFS program adjusts the DRG classification system at least annually to account for changes in treatment patterns, technology, and other factors that might affect the use of hospital resources.⁶⁵

Under administered pricing, a single-payer system could set payment rates in a variety of ways. For example, it could set the rates to match current Medicare FFS rates or at some other level, such as an average of the rates that public and private insurers pay. The system could also adjust payment rates over time if certain services or certain markets experienced a supply shortage.

Negotiated Rates. Alternatively, a single-payer system could establish provider payment rates through negotiations. Organizations representing providers, such as the American Medical Association, could negotiate payment rates with the system, and those negotiations could occur within broad budgetary guidelines such as a national spending limit. In England, the British Medical Association, which represents privately employed GPs, negotiates the General Medical Services contract with the government. In Canada's single-payer health care system, physicians' professional associations negotiate FFS schedules with provincial ministries of health, and hospitals negotiate their annual global budgets with provincial ministries of health.⁶⁶

In the United States, insurance companies establish and update provider payment rates through negotiations. Private commercial insurers negotiate payment rates with hospitals, physicians, and other providers directly, although for individual physicians and many physician groups, the payment rate insurers offer is often “take it or leave it” because of the relatively weak bargaining power of individual physicians. In recent years, however, more physicians have joined hospital systems or larger group

practices to increase their bargaining power with commercial insurers.⁶⁷

Other Considerations. Another decision for policymakers is whether government support for graduate medical education and for hospitals that treat a high proportion of low-income patients would continue under a single-payer system, and if so, how those payments would be structured. For example, teaching hospitals could have higher payment rates or receive compensation for their teaching costs through direct payments outside the single-payer system. Similarly, hospitals that treat a large portion of low-income patients could receive additional government support.

Implications of Alternative Payment Methods and Rates

Provider payment rates under a single-payer system would have important implications for government spending, national health care spending, and providers' revenues. The rates would also affect providers' incentives to deliver services, both initially and over the long term. The effects could vary across providers, depending on their current mix of patients and how the payment rates they currently receive for those patients compare with the payment rates under the single-payer system.

Under the current health care system, the rates commercial insurers pay providers for most services are higher than Medicare FFS rates—sometimes substantially higher. CBO found that three major insurers' commercial payment rates for hospital inpatient admissions in 2013 were 89 percent higher, on average, than Medicare FFS payment rates for the same types of

65. Section 1886(d)(4)(C) of the Social Security Act requires the Secretary of Health and Human Services to adjust the DRG classifications and relative weights at least annually. See Centers for Medicare & Medicaid Services, “MS-DRG Classifications and Software” (August 3, 2018), <https://go.usa.gov/xEUhb>.

66. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

67. See Robert A. Berenson and others, “The Growing Power of Some Providers to Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed,” *Health Affairs*, vol. 31, no. 5 (May 2012), pp. 973–981, <https://doi.org/10.1377/hlthaff.2011.0920>; David B. Muhlestein and Nathan J. Smith, “Physician Consolidation: Rapid Movement From Small to Large Group Practices, 2013–15,” *Health Affairs*, vol. 35, no. 9 (September 2016), pp. 1638–1642, <https://doi.org/10.1377/hlthaff.2016.0130>; David R. Austin and Laurence C. Baker, “Less Physician Practice Competition Is Associated With Higher Prices Paid for Common Procedures,” *Health Affairs*, vol. 34, no. 10 (October 2015), pp. 1753–1760, <https://doi.org/10.1377/hlthaff.2015.0412>; and Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, “Vertical Integration: Hospital Ownership of Physician Practices Is Associated With Higher Prices and Spending,” *Health Affairs*, vol. 33, no. 5 (May 2014), pp. 756–763, <https://doi.org/10.1377/hlthaff.2013.1279>.

admissions, although rates varied widely by geographic area.⁶⁸ Commercial rates for physicians' services are also higher than Medicare FFS rates, although the difference between the two payers varies greatly by type of service.⁶⁹

By contrast, Medicaid payment rates for physicians' services are significantly lower than both commercial and Medicare payment rates.⁷⁰ Evidence has been mixed, however, in comparisons of Medicaid payment rates for hospital services with commercial and Medicare payment rates. On the one hand, Selden and others found that Medicaid rates were essentially equal to Medicare FFS rates in 2012—and, according to that paper's appendix, the Medicaid estimate did not include supplemental payments to hospitals.⁷¹ On the other hand, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that, before accounting for Medicaid

supplemental payments, Medicaid rates for 18 Medicare Severity DRGs (MS-DRGs) averaged just 78 percent of Medicare rates. After including supplemental payments, MACPAC found that the Medicaid payment rate was 6 percent higher, on average, than the Medicare rate.⁷² The commission examined only 18 MS-DRGs, however, and the results might have been different if they had included more MS-DRGs. An additional complication in analyzing Medicaid rates for inpatient care is that, in 2018, all states made supplemental payments to hospitals, and most made additional payments to hospitals that treat a disproportionate share of low-income and Medicaid patients.

Government spending and total national spending on health care would be lower if provider payment rates under a single-payer system were set at Medicare FFS rates rather than at a higher level, such as average commercial rates. Setting payment rates equal to Medicare FFS rates under a single-payer system would reduce the average payment rates most providers receive—often substantially. Such a reduction in provider payment rates would probably reduce the amount of care supplied and could also reduce the quality of care. Studies have found that increases in provider payment rates lead to a greater supply of medical care, whereas decreases in payment rates lead to a lower supply.⁷³ But because those

68. According to that analysis, Medicare Advantage payment rates were similar to Medicare FFS payment rates. See Jared Lane Maeda and Lyle Nelson, "How Do the Hospital Prices Paid by Medicare Advantage Plans and Commercial Plans Compare With Medicare Fee-for-Service Prices?" *Inquiry*, vol. 55 (June 2018), pp. 1–8, <https://doi.org/10.1177/0046958018779654>. Another study found that inpatient hospital payment rates of private insurers were about 10 percent higher than Medicare's rates over the 1996–2001 period and increased to about 75 percent higher in 2012. See Thomas M. Selden and others, "The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care," *Health Affairs*, vol. 34, no. 12 (December 2015), pp. 2147–2150, <https://doi.org/10.1377/hlthaff.2015.0706>.

69. A recent analysis by CBO found that commercial insurance payment rates were, on average, 11 percent higher than Medicare FFS rates for office visits for established patients and more than double Medicare FFS payment rates for magnetic resonance imaging procedures. Medicare Advantage payment rates were similar to Medicare FFS payment rates. See Daria Pelech, "Prices for Physicians' Services in Medicare Advantage and Commercial Plans," *Medical Care Research and Review* (June 2018), pp. 1–21, <https://tinyurl.com/y3kb7wae>.

70. See Stephen Zuckerman, Laura Skopec, and Marni Epstein, *Medicaid Physician Fees After the ACA Primary Care Fee Bump* (Urban Institute, March 2017), <https://tinyurl.com/yaand3mz> (PDF, 424 KB). Under current law, however, Medicare's payment rates for physicians' services are projected to fall below Medicaid's payment rates by 2035. See Centers for Medicare & Medicaid Services, Office of the Actuary, "Projected Medicare Expenditures Under an Illustrative Scenario With Alternative Payment Updates to Medicare Providers" (June 2018), <https://go.usa.gov/xEMzV> (PDF, 440 KB).

71. See Thomas M. Selden and others, "The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care," *Health Affairs*, vol. 34, no. 12 (December 2015), pp. 2147–2150, <https://doi.org/10.1377/hlthaff.2015.0706>.

72. This analysis was based on Medicaid Analytic Extract data from calendar year 2010 and Medicare payment data from fiscal year 2011, and it used MS-DRGs to compare Medicaid payment rates with Medicare payment rates for hospital inpatient services. MS-DRGs, which were developed for the Medicare population, group patients by characteristics such as principal diagnosis, secondary diagnoses, procedures, sex, and discharge status. See Medicaid and CHIP Payment and Access Commission, *Medicaid Hospital Payment: A Comparison Across States and to Medicare* (issue brief, April 2017), <https://go.usa.gov/xQdAT> (PDF, 249 KB).

73. Evidence suggests that both physicians and hospitals respond to changes in payment rates. One study found that, on average, a 2 percent increase in Medicare's physician payment rates was associated with a 3 percent increase in the supply of care to Medicare beneficiaries; see Jeffrey Clemens and Joshua D. Gottlieb, "Do Physicians' Financial Incentives Affect Medical Treatment and Patient Health?" *American Economic Review*, vol. 104, no. 4 (2014), pp. 1320–1349, <https://dx.doi.org/10.1257/aer.104.4.1320>. A 10 percent decrease in Medicare FFS hospital inpatient payment rates was associated with a 4.6 percent decrease in the number of elderly discharges; see Chapin White and Tracy Yee, "When Medicare Cuts Hospital Prices, Seniors Use Less Inpatient Care," *Health Affairs*, vol. 32, no. 10 (2013), pp. 1789–1795, <https://doi.org/10.1377/hlthaff.2013.0163>.

studies are based only on changes in Medicare's payment rates for a given set of services within the context of a multipayer system, the results may be less relevant to a single-payer system, and providers' responses to changes in payment rates are difficult to predict under such a system. Under a multipayer system with different payment rates, providers might be able to offset their loss of income from one payer by adjusting their rates for other payers, as well as by adjusting their patient mix toward payers with higher payment rates, but such opportunities would be eliminated or limited under a single-payer system.

If average provider payment rates were lower under a single-payer system relative to current law, several factors might help ease the transition for providers. First, the system could initially set provider payment rates at the dollar-weighted average across all payers under current law but then gradually reduce them to Medicare FFS rates. Although a longer transition period would mitigate the impact on providers' income, the government's cost to establish a single-payer system would be substantially higher.

Second, if participating providers were allowed to provide private care, they might still be able to offset a loss of income from lower payment rates. For example, if participating providers were allowed to provide private care at higher prices, physicians could privately contract with patients or see privately insured patients. Although that option would allow providers to increase their income, it could also lead to longer wait times for people in the single-payer system.

Finally, a single-payer system might give providers new opportunities to lower their costs. Because providers would need to deal with only one payer and one payment method, they would probably be able to reduce their administrative costs; the single-payer system could then adjust provider payment rates to reflect those lower administrative costs. A single-payer system that succeeded in delivering universal coverage would substantially reduce bad debt, uncompensated care, and charity care for providers.⁷⁴

74. Some bad debt, uncompensated care, and charity care might remain if certain groups of people are excluded from coverage and are unable to pay for their care, such as noncitizens who are not lawfully present or temporary visitors.

In addition to the short-term effects discussed above, changes in provider payment rates under the single-payer system could have longer-term effects on the supply of providers. If the average provider payment rate under a single-payer system was significantly lower than it currently is, fewer people might decide to enter the medical profession in the future. The number of hospitals and other health care facilities might also decline as a result of closures, and there might be less investment in new and existing facilities. That decline could lead to a shortage of providers, longer wait times, and changes in the quality of care, especially if patient demand increased substantially because many previously uninsured people received coverage and if previously insured people received more generous benefits. How providers would respond to such changes in demand for their services is uncertain. To encourage the supply of providers in the longer term, the government could more heavily subsidize the cost of graduate medical education to encourage people to continue to enter medical professions.

How Would the Single-Payer System Purchase Prescription Drugs?

A single-payer system could use several different methods to pay for prescription drugs, including negotiated pricing, value-based pricing, reference pricing, and administered pricing.⁷⁵ It could also use different payment methods for different types of drugs. For example, it could exempt drugs that treat certain catastrophic conditions, such as cancer or HIV, from the regular pricing mechanism. How prescription drug prices are set by the single-payer system would affect the profits of drug manufacturers, which could affect their incentives to develop new drugs.

Determining Prescription Drug Prices

Prescription drugs accounted for about 10 percent of personal health care spending nationally in 2017, which is substantially smaller than the share of such spending for hospital services (33 percent) and physicians' services (20 percent).⁷⁶ Thus, the payment rates for drugs under a single-payer system would have a less direct effect on

75. See Darius N. Lakdawalla, "Economics of the Pharmaceutical Industry," *Journal of Economic Literature*, vol. 56, no. 2 (2018), pp. 397–449, <https://dx.doi.org/10.1257/jel.20161327>.

76. See National Health Expenditure Accounts, "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960–2017" (accessed February 15, 2019), <https://go.usa.gov/xEPqW>.

government spending and national health care spending than the payment rates for hospital and physicians' services. Prescription drugs are an important part of medical practice, however, and the designers of a single-payer system would need to consider whether a substantial reduction in drug prices would reduce manufacturers' incentive to develop new drugs. Under any of the pricing approaches discussed below, a single-payer system could decide to exclude certain drugs or place those drugs on a nonpreferred drug list because they are too expensive or because they do not have any additional benefit. In such cases, enrollees would either not have access to those drugs or face higher cost sharing.

Negotiated Pricing. Direct negotiations between a single-payer system and manufacturers could determine prescription drug prices, much like the negotiations that take place between individual insurers and manufacturers now. A single-payer system would have more negotiating leverage with manufacturers than private insurers have; however, it is uncertain whether the single-payer plan could use the threat of excluding certain drugs from the formulary as a negotiating strategy. It is also unclear whether a single-payer system could withstand the political pressure that might result from excluding some drugs. By contrast, private insurers can threaten to exclude drugs from their formularies and can follow through on that threat. Alternatively, a single-payer system could require higher cost sharing for some drugs instead of excluding them. Although those price-control tools would affect patients' access to certain drugs, the negotiated prices would probably be lower for drugs with more competitors in the same therapeutic class.

Value-Based Pricing. Prescription drug prices could also depend on the value of a particular drug, which is typically measured by its cost-effectiveness or its cost relative to the number of quality-adjusted life years gained.⁷⁷ The government could set up an independent board to evaluate the cost-effectiveness of each drug, or it could require manufacturers to submit information on a drug's cost-effectiveness at the time the Food and Drug Administration (FDA) approved it or after the drug had been on the market for a certain period of time. Cost-effectiveness measures are imperfect, however, because information about safety and effectiveness may be lacking, especially over the short term. Requiring a

longer study period or more years of data could improve the quality of such measures. But if that information was required at the time a drug was approved by the FDA, it would take longer for new drugs to become available. Because such an approach might delay some drugs that could potentially extend the lives of people with serious conditions, alternative payment methods might be needed. In Sweden, for example, manufacturers are free to submit drug prices for new drugs, and the government can reject drugs that it deems not cost-effective at the proposed price. If the government rejects a drug, the manufacturer can resubmit an application with a lower price in the hope that it will be accepted.⁷⁸

Similarly, the price for a prescription drug could be based on its comparative effectiveness or its additional benefit relative to existing treatments. The same system for evaluating a drug's cost-effectiveness could be used to evaluate its effectiveness relative to existing drugs. However, comparative effectiveness has many of the same limitations as cost-effectiveness. In Germany, new drugs are evaluated within six months of their introduction to determine their additional benefit. If a drug is determined to have additional benefits, the manufacturer and the insurance association negotiate the price; if they cannot agree, an arbitration panel determines the final price. If a new drug is determined not to have any additional benefits compared with existing drugs, insurers are only required to pay the price they pay for existing drugs. If the manufacturer chooses to sell its products at a higher price, patients can pay the difference out of pocket.⁷⁹

Reference Pricing. A single-payer system could also base prices for prescription drugs on the prices of drugs in a reference group, which could be an internal reference group of drugs in the same therapeutic class or an external reference group of peer countries.⁸⁰ Internal reference

77. Quality-adjusted life years, which include both quality of life and number of life years gained from a treatment, are commonly used to measure cost-effectiveness.

78. See Steven Morgan, *Summaries of National Drug Coverage and Pharmaceutical Pricing Policies in 10 Countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the U.K.*, Working Papers for the 2016 Meeting of the Vancouver Group in New York, NY (2016), <https://tinyurl.com/y22guwgv> (PDF, 636 KB).

79. See Karl Lauterbach, John McDonough, and Elizabeth Seeley, "Germany's Model for Drug Price Regulation Could Work in the US," *Health Affairs* (blog, December 29, 2016), <https://tinyurl.com/yy89jvo5>.

80. See Kai Ruggeri and Ellen Nolte, *Pharmaceutical Pricing: The Use of External Reference Pricing* (RAND Corporation, 2013), <https://tinyurl.com/y6gcevku> (PDF, 493 KB).

pricing could determine the cost of new drugs in a therapeutic class, and external reference pricing could inform pricing decisions for new, innovative drugs. The reference price could be determined by a measure of the range of prices in the reference group, such as the median, average, or lowest price, or something else.

The reference price could be used as a benchmark for setting or negotiating prices. For example, the reference price could be the maximum amount that a single-payer health plan would contribute to the cost of a drug. Canada and many European countries use the internal and external reference pricing approach.

Although the use of external reference pricing has generally been associated with a decrease in drug prices and lower spending by the government and patients in countries that use that approach, a possible trade-off is delayed market access to new drugs. A drug typically cannot be launched in a country that uses external reference pricing until it has been launched in the reference countries. In addition, drug manufacturers sometimes delay launching drugs in countries that have an external reference pricing mechanism that would result in a low price.⁸¹

Administered Pricing. Finally, a single-payer system could base the prices for existing prescription drugs on current administered prices and use alternative methods to price new drugs. For example, the system could use the average of the current Federal Supply Schedule (FSS), Medicaid, and Medicare Part D prices as a starting point for drugs already on the market, and the prices could increase annually with some measure of inflation. Using an average of FSS, Medicaid, and Medicare Part D prices to set prices for existing drugs would result in prices that are significantly lower than the average prices that exist today because, under current law, FSS and Medicaid pricing is based either on a drug product's lowest price paid to any commercial insurer or on statutory requirements.⁸² The single-payer system could base prices for new drugs on an assessment of their cost-effectiveness or comparative effectiveness or on a reference price.

81. See Darius N. Lakdawalla, "Economics of the Pharmaceutical Industry," *Journal of Economic Literature*, vol. 56, no. 2 (June 2018), pp. 397–449, <https://dx.doi.org/10.1257/jel.20161327>.

82. See Congressional Budget Office, *Prices for Brand-Name Drugs Under Selected Federal Programs* (June 2005), www.cbo.gov/publication/16634.

Implications of Alternative Payment Methods for Prescription Drugs

Under current law, prices for prescription drugs vary greatly by payer. CBO found that, after accounting for rebates and discounts, the average price per prescription for 50 top-selling brand-name specialty drugs was nearly twice as high in Medicare Part D as in Medicaid.⁸³ Therefore, the payment rates under a single-payer system would affect manufacturers differently depending on their current payer mix. If the single-payer system used an average of FSS, Medicaid, and Medicare Part D prescription drug prices, the average price would decline for drugs that are currently purchased mostly by people with commercial insurance, but the average price might increase for drugs currently purchased mostly by Medicaid enrollees (with some exceptions) and by the VHA.

The impact of a single-payer system on manufacturers is uncertain because pharmaceutical products are sold globally. The United States is the largest single market for pharmaceuticals, however, and its drug prices are currently the highest among industrialized nations.⁸⁴ If average prescription drug prices fell under a single-payer system, manufacturers might be able to counter at least some of those declines in average U.S. prices if they could convince health systems in other countries to raise their prices.

If manufacturers could not offset the price decline in the United States by obtaining higher prices in other countries, they might reduce research and development of new drug products. For example, if a single-payer system paid for a new drug on the basis of its additional benefit relative to existing drugs, manufacturers might refocus their research and development on drugs that provide significant additional benefits instead of drugs that provide marginal improvements over other existing drugs.

How Would a Single-Payer System Contain Health Care Costs?

The cost of a single-payer system would depend on various design choices, such as the services covered, cost-sharing requirements, and provider payment rates. In addition to those design choices, policymakers could

83. See Congressional Budget Office, *Prices for and Spending on Specialty Drugs in Medicare Part D and Medicaid* (March 2019), www.cbo.gov/publication/54964.

84. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

consider using two other techniques to contain the growth of government spending on the single-payer plan and total health care spending: global budgets and utilization management.

Although such techniques could contain costs, increasing financial pressure for providers to lower their costs could adversely affect access to and quality of care by causing providers to supply less care to patients covered by the public plan. Less spending on medical services could also alter manufacturers' incentive to develop new technologies or providers' incentive to invest in capital, which could affect patients' choices over the longer term.

Global Budgets

Global budgets, which are a possible payment method for individual providers (see page 19), have also been extended to establish national or regional global budgets for major sectors of a system or for an entire system. The government could set the global budget administratively, or it could negotiate the budget with providers. If it set the budget administratively, the starting point could reflect the expected use of services in the next year.⁸⁵ In future years, the government could update the budget on the basis of anticipated changes in need and resources, or it could tie the budget to a macroeconomic metric such as nominal gross domestic product per capita or the consumer price index. To enforce the budget if it was exceeded, the government could adjust the global budget proactively by lowering the payment rates in the next year or retroactively by taking back the amount paid to individual providers in excess of the budget allocated to them in the current year.⁸⁶

Global budgets are rarely used as cost-control tools in the United States because they are difficult to implement in

multipayer systems that have many different payment systems and payers, but global budgets are commonly used in single-payer systems.⁸⁷ One major exception is Maryland's current global budget program for hospitals, which operates under an all-payer system. Medicare has attempted to control costs by setting spending targets for a broad set of services, such as the sustainable growth rate for spending on physicians' services and the former Independent Payment Advisory Board for overall Medicare spending, but those attempts were not successful.⁸⁸

England and Taiwan both set national global budgets for their single-payer systems.⁸⁹ In England, the global budget is allocated to approximately 200 local organizations that are responsible for paying for health care. Since 2010, the global budget in England has grown by about 1 percent annually in real (inflation-adjusted) terms, compared with an average real growth of about 4 percent previously. The relatively slow growth in the global budget since 2010 has created severe financial strains on the health care system. Provider payment rates have been reduced, many providers have incurred financial deficits, and wait times for receiving care have increased. In Taiwan, the global budget is set nationally for five major service categories and is allocated across six geographic regions. Within each region, provider payment rates are periodically adjusted to keep spending within the budget.⁹⁰ The national global budget in Taiwan is determined each year through negotiation among key stakeholders with the goals of containing costs while ensuring access to care. The growth of the global budget

87. See Patrice R. Wolfe and Donald W. Moran, "Global Budgeting in the OECD Countries," *Health Care Financing Review*, vol. 14, no. 3 (1993), pp. 55–76, www.ncbi.nlm.nih.gov/pmc/articles/PMC4193373.

88. The sustainable growth rate was designed to control the costs of physicians' services in the Medicare FFS program. At the time it was replaced in 2015, physicians would have faced a cut in payment rates of more than 20 percent if the spending targets had been enforced. The Independent Payment Advisory Board was created under the ACA to control the costs of Medicare by targeting the growth in spending per capita, and it was repealed in early 2018 before it was established.

89. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

90. See Winnie C. Yip and others, "Managing Health Expenditure Inflation Under a Single-Payer System: Taiwan's National Health Insurance," *Social Science and Medicine* (forthcoming), <https://doi.org/10.1016/j.socscimed.2017.11.020>.

85. For example, the starting point for setting that budget could be the National Health Expenditure accounts under current law with necessary adjustments for the differences in expected use of services between the current system and a single-payer system. Those differences would include the difference in average payment rates, the costs of expanding coverage to the currently uninsured population, the difference in the design of an average plan under the current system and that of the single-payer health plan, and changes in the economic conditions after the implementation of a single-payer system.

86. For a more detailed discussion of the design choices and U.S. examples of global budgets, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (December 2008), pp. 157–160, www.cbo.gov/publication/41746.

has not fallen as sharply in Taiwan as it has in England since 2010, and Taiwan has not experienced the adverse effects that England has experienced recently.

Utilization Management

Utilization management refers to methods used by or on behalf of payers to manage health care costs by steering patients toward appropriate care.⁹¹ Utilization management can include care coordination and utilization review. The administrator of the single-payer plan could enforce utilization patterns that are deemed appropriate by monitoring claims and identifying outliers.

Under the current U.S. health care system, with its fragmented payment and delivery systems, coordination of care is difficult, and a comprehensive review of care is challenging because no centralized utilization database exists. A single-payer system that collected comprehensive data on patients' use of health care services could potentially manage available resources more efficiently.⁹² But the transition to a standardized IT system across all providers would require considerable efforts, such as reaching a consensus for a standard among stakeholders, enforcing that standard, and addressing privacy issues related to data sharing.

In the United States, public programs have implemented few utilization management programs, but private insurers have increasingly used them to lower costs. Some private insurers require prior authorization for patients seeking expensive therapies, for example, and Medicare Part D plans offer low or no copayments to patients who use cheaper generic medications. Many of those strategies could be continued under a single-payer system. The utilization management in such a system might not be much of a change for people who were previously enrolled in a private plan, but it would impose new constraints on the choice of health care services for those who were previously enrolled in the Medicare FFS program.

91. See Institute of Medicine (U.S.), Committee on Utilization Management by Third Parties, Marilyn Jane Field and Bradford H. Gray, eds., *Controlling Costs and Changing Patient Care? The Role of Utilization Management* (National Academies Press, 1989), www.ncbi.nlm.nih.gov/pubmed/25144100.

92. Using a standardized IT system, the administrator of a single-payer system could identify outliers in utilization patterns by individual providers or patients and reduce health care spending by eliminating duplicate services and overtreatments and preventing fraudulent claims by some providers. The administrator could use a similar approach to improve quality of care.

Other countries with single-payer systems also use various forms of utilization management. In Canada's single-payer system, some provinces make lower payments to specialists when a patient has not been referred by a primary care physician.⁹³ In England, access to specialists generally requires a referral from a primary care provider. Taiwan monitors use of services and costs in near-real time through its IT system to identify wasteful spending and inappropriate care.

How Would a Single-Payer System Be Financed?

Government spending on health care would increase substantially under a single-payer system. In 2017, just under half of the \$3.5 trillion in national health care spending came from private sources. Shifting a large amount of expenditures from private to public sources would significantly increase government spending and require additional government resources, but it would also reduce or eliminate the costs incurred by private sources, such as employers' and employees' contributions for employment-based insurance.

Financing for a single-payer system could come from federal, state, and local governments. If the federal government administered the single-payer system, some health care costs that state governments currently pay would shift to the federal budget. The amount of that shift would be smaller if the federal government required states to maintain their current level of funding.

In a federally administered single-payer system, the associated cash flows would be federal transactions, in CBO's view, and the spending and revenues for the system would appear in the federal budget. That would be true even if the federal government contracted with one or more private insurers to administer the program, and if the responsibilities of those insurers included collecting premiums and paying providers. Because those insurers would be acting as agents of the federal government, the cash flows would belong in the federal budget.⁹⁴

93. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).

94. See Congressional Budget Office, *How CBO Determines Whether to Classify an Activity as Governmental When Estimating Its Budgetary Effects* (June 2017), www.cbo.gov/publication/52803, and *The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System* (May 2009), www.cbo.gov/publication/41185.

Financing for a single-payer system could come from several sources:

- **Premiums**—that is, payments made to purchase health insurance;
- **Cost sharing**—that is, out-of-pocket payments for services covered by health insurance; and
- **Taxes**, including taxes that individuals or organizations pay directly to the government, such as income and payroll taxes, as well as taxes on goods and services, such as alcohol and cigarette taxes.⁹⁵

The system could also be financed partly by government borrowing. The choice of financing method affects who would pay for the single-payer system and whether that responsibility would vary with a person's ability to pay, also known as progressivity. A financing method in which lower-income people contribute a smaller share of their income to pay for the system relative to higher-income people is considered progressive; the opposite is true of a regressive method.

Because health care premiums per person and cost sharing per service are typically set at the same level for beneficiaries of private health insurance, those types of payments tend to be regressive. In a single-payer system, beneficiaries' out-of-pocket spending on premiums and cost sharing could be made more or less progressive through income-based subsidies or additional contributions from high-income beneficiaries, as is the case for some existing public insurance programs. For example, plans purchased through the health insurance marketplaces provide premium and cost-sharing subsidies that vary with income, and high-income Medicare beneficiaries pay income-related premiums for Parts B and D in addition to the regular premiums.

Taxes that could finance a single-payer system include income taxes (both individual and corporate), payroll taxes, and consumption taxes, all of which have different

implications for the progressivity of the financing system. A system financed by debt might require additional taxes in the future. The choice for policymakers between imposing taxes today versus boosting them in the future would shift the responsibility among different generations of taxpayers. The choice of tax structure would also have different implications for the labor supply and people's consumption of goods and services, which would affect the overall economy.

An issue related to the progressivity of the single-payer system's financing is the progressivity of the entire health care system's financing. That issue would be moot if the single-payer plan covered the entire population. But if a significant share of the population was allowed to opt out of the single-payer system, the progressivity of the single-payer system's financing and the entire system's financing could differ (though such a system would be more akin to a multipayer system as defined in this report). For example, if people in better health and with higher income could opt out and be exempt from contributing to the single-payer system, the financing of the entire health care system would probably be less progressive than the financing of the single-payer system.

For each of the financing methods, the choice of collection method would affect the system's administrative complexity because some methods would be easier to enforce than others. Taxes could be collected through the existing tax system, and cost sharing could be collected at the point of service. Premiums could also be collected through the existing tax system to take advantage of its enforcement mechanism.

The current U.S. health care system is financed by a mix of premiums, taxes, and out-of-pocket spending (including cost sharing), and that mix of finances varies by payer. Health care for people enrolled in Medicare is substantially financed by taxes, including payroll taxes and general tax revenue.⁹⁶ People enrolled in Medicare Parts B and D pay premiums, which cover about one-quarter of those programs' costs. Out-of-pocket spending on premiums and cost-sharing obligations

95. The collected funds could be put into general revenues or dedicated to the health care system or a combination of the two. The trade-offs between those alternatives largely depend on the budget process and policy priorities. See Cheryl Cashin, Susan Sparkes, and Danielle Bloom, *Earmarking for Health: From Theory to Practice*, Health Financing Working Paper 5 (World Health Organization, 2017), <https://tinyurl.com/ybo9obyj> (PDF, 2.55 MB).

96. In 2018, less than 40 percent of gross federal spending on Medicare was financed by the trust fund's dedicated taxes, about 15 percent came from offsetting receipts (consisting mostly of premiums), and the rest came from other sources (mostly transfers from the general fund). See Centers for Medicare & Medicaid Services, "2019 Medicare Trustees Report" (accessed April 25, 2019), <https://go.usa.gov/xQhh4>.

tends to be lower for low-income beneficiaries because they receive additional assistance and because high-income beneficiaries pay additional premiums.⁹⁷

Health care for people enrolled in Medicaid is mostly financed jointly by the federal and state governments. The federal share, which amounts to more than 60 percent of the total costs, is financed by general revenues. States have some flexibility to determine the sources of funding for their share of Medicaid spending; the primary source is state general fund appropriations.⁹⁸

In contrast, private insurance is mostly funded through premiums, cost sharing, and tax subsidies. For employment-based insurance, employers contribute a greater share of the total premium costs, on average, with

employees contributing the remainder.⁹⁹ The federal government subsidizes a portion of those premiums, primarily through the tax exclusion of employment-based insurance. Under the ACA, more than half of enrollees in nongroup health insurance purchase their plans through the health insurance marketplaces and receive federal subsidies in the form of premium tax credits.¹⁰⁰ In addition, insurers are required to offer cost-sharing reductions to eligible low-income enrollees in the marketplaces.

Countries with single-payer systems generally collect funds through the tax system.¹⁰¹ Canada and England finance their single-payer systems mostly through general revenues. Other means of financing include dedicated flat-rate income taxes (as in Denmark) or payroll-based premiums (as in Taiwan).

97. Low-income beneficiaries with Medicaid coverage do not pay Part B premiums, and low-income beneficiaries receive additional premium assistance for Part D coverage through the Low-Income Subsidy program. High-income beneficiaries pay higher premiums for Parts B and D.

98. See Laura Snyder and Robin Rudowitz, *Medicaid Financing: How Does It Work and What Are the Implications?* (Kaiser Family Foundation issue brief, May 20, 2015), <https://tinyurl.com/ybuntfed>.

99. See Kaiser Family Foundation, *Employer Health Benefits: 2018 Annual Survey* (October 2018), <http://tinyurl.com/y8bjvazq> (PDF, 18.1 MB).

100. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), www.cbo.gov/publication/53826.

101. See Commonwealth Fund, *International Profiles of Health Care Systems* (May 2017), <https://tinyurl.com/ybx6hj3v> (PDF, 3.35 MB).



About This Document

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CBO continually seeks feedback to make its work as useful as possible. Please send any comments to communications@cbo.gov.

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