

# Commentary on “Health Spending Under Single-Payer Approaches”

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**Abstract:** One of the most controversial areas in discussions of single-payer approaches for the United States, such as “Medicare for All,” concerns its implications for costs. Confusion over differences between federal and total spending and effects of lower patient cost sharing gets in the way of “apples-to-apples” comparisons. Key areas with potential to lower costs are lower administrative costs and lower provider prices. But cost reduction would likely be smaller than some envision, especially in the price area because of the need for a long process to gradually allow providers to adjust to lower prices and Americans’ unique attitudes toward regulation.

**Key words:** *costs, prices, single-payer*

ONE OF THE MORE controversial questions related to the prospect of single-payer health care in the United States is how

costly it would be. The headline number that many refer to is the Urban Institute’s estimate that Senator Bernie Sanders’ Medicare-for-All plan would add \$34 trillion to federal spending over a decade (Blumberg et al., 2019). For a fully implemented plan, annual federal spending in 2020 would be more than triple what it would be under current law—\$4.1 trillion instead of \$1.3 trillion.

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## THE NEED TO COMPARE “APPLES TO APPLES”

But federal spending is not the same as total spending, which also includes spending by individuals, employers, and states. A large part of the increased federal spending for the Sanders plan reflects shifts in responsibility from individuals (zero premiums, zero cost sharing, and payment for services not covered today such as long-term care services and support) and from employers, which would no longer be contributing to employer-sponsored insurance. For this reason, it is instructive to also look at total national spending. For 2020, according to the Urban Institute analysis, national health spending would increase from \$3.5 trillion to

\$4.2 trillion, an increase of 21%. While this is a much smaller increase than federal spending, the change in the latter would nevertheless be very important, since it would require very large tax increases, which, in turn, would sacrifice productivity in the national economy. Overall, this shift of burdens from individuals and employers to government could mean substantial redistribution of income, depending on how single payer was financed.

But comparisons of total or federal spending still mask other key elements in understanding costs. For example, the Sanders proposal would eliminate the cost sharing that patients are responsible for in both private insurance and in Medicare itself. For services that enrollees have already been getting, the cost burden would shift from patients to the taxpayers. But lower cost sharing would also increase service use, some of it valuable and some of it not, so this would be a net cost increase from the single-payer approach. The same logic applies to payment for services that are not typically covered by either Medicare or private insurance. Covering these additional services would transfer responsibility from the individuals who pay for the services but would lead those individuals—and others who do not currently use the services because of the expense—to use more of the services. So the increased costs would come from the higher use of services. Although the Sanders plan includes dental, vision, and long-term care services and supports, other conceivable single-payer plans, such as an option offered by the Urban Institute, leave the list of covered services unchanged from current law.

## ADMINISTRATIVE COSTS

Focusing on “apples-to-apples” comparisons, single-payer advocates focus on savings in administrative costs from the elimination of private insurers and lower provider prices through the single payer’s administered prices. If traditional Medicare became the only payer, it would eliminate most of the private insurance industry, which would lead to administrative cost reductions. Medicare does contract with private insurers for its

claims processing, which presumably would continue. Cutler (2020) estimates that about \$100 billion per year goes to the private health insurance industry for administrative costs and profits. This is a substantial sum, but it is less than 3% of national health spending. And some of the spending by private insurers more than pays for itself by reducing medical spending. For example, prior authorization, which is not done by traditional Medicare, likely is critical in a delivery system that does not constrain the purchase of medical technology, such as magnetic resonance imaging equipment, as is done by many single-payer systems. The Governmental Accountability Office (GAO) estimates that Medicare demonstrations of prior authorization have saved substantial amounts (GAO, 2018). Medicare has often been criticized for spending too little on administration, with numerous analyses by the GAO showing very high rates of return for increased Medicare administrative spending (GAO, 2016). A single-payer system could substantially reduce the cost of billing providers and patients, but the magnitude would depend on the details of its patient cost sharing and whether it abandoned fee for service in favor of a budgeted system like that of the Veterans Health Administration. But regardless of details, having one payer instead of many, with that payer having the authority to specify provider billing mechanisms, would reduce administrative costs.

But there are opportunities to substantially reduce administrative costs in health care in a multipayer system, some of which are being pursued. Cutler (2020) believes that administrative tools that are common in other industries could be created for health care and save substantial amounts. For example, health care providers and payers could follow the banking industry and set up a clearinghouse for bill submission and payment. Prior authorization, which also leads to substantial administrative costs for providers, could be substantially streamlined through federal legislation to create a uniform process. And quality reporting could be standardized, with private insurers and

Medicare agreeing on common requirements. The last 2 are discussed with increasing frequency at the federal level and are bipartisan, suggesting that such advances might be realistic over the next few years. Making data interoperable, a goal that appears only a few years from becoming a reality in the United States, would also reduce administrative costs substantially—regardless of whether payment is under a single- or multipayer system. Cutler estimates that these 4 changes together could lead to annual administrative savings of \$50 billion to \$75 billion per year, as well as making providers' and patients' lives better.

### LOWER HEALTH CARE PRICES

Perhaps, the most challenging task in estimating spending under single-payer health care in the United States concerns assumptions about health care prices. It is well known that health care prices are much higher in the United States than in other advanced countries (see, eg, Papanicolas et al., 2018). Although it is difficult to compare prices directly, analyses have combined the higher per capita spending, either in purchasing power parity or as a percentage of gross domestic product, with various indicators that health care services per capita are not higher in the United States to conclude that “it’s the prices, stupid” (Anderson et al., 2019).

Medicare-for-All proposals envision setting all prices at Medicare rates, although the Urban Institute analysis (Blumberg et al., 2019) points to the current negative hospital margins for Medicare and assumes that hospitals would be paid at 115% of Medicare rates, with other types of providers at 100%. The Urban Institute assumes for its analyses that private insurers currently pay rates that average 240% of Medicare for hospital care, 190% for inpatient care, and 340% for outpatient care (Blumberg et al., 2020). Rates for physicians are paid at 120% of Medicare on average. Medicaid payment rates for hospital services are believed to be roughly equal to Medicare on average but below Medicare for physician services.

The key questions concern the economic feasibility and political feasibility of revenue reductions anywhere close to this magnitude. Would rates this much lower than under current policies be possible without bankrupting many providers? Would the US political system support rates under a single-payer system that are substantially lower than today?

Analysts have more visibility into hospital finances than into those of some other providers due to Medicare cost reporting. The Medicare Payment Advisory Commission (MedPAC), which advises the Congress on Medicare payment, estimates that in 2018, hospitals' all-payer operating margins were 6%, which is somewhat higher than has been typical in the recent past (MedPAC, 2020). An implication of this is that aggregate payment rates could not fall more than 6% without causing hospital margins to become negative. This would risk threatening the long-term viability for hospitals. But further reductions could be achieved if the increased financial pressure led hospitals to pursue cost containment more vigorously than they do now.

Hospital cost containment can be achieved in 2 ways—increasing productivity or paying workers or suppliers less. Producing a unit of service with fewer inputs has long been perceived as difficult in service industries where face-to-face contact between customers and staff is important. Sometimes, a lesser trained staff might be substituted for relatively routine services, although licensing laws often limit such opportunities. There is also the possibility that in response to pressure on hospital prices, inputs are reduced in ways that reduce quality. The opportunities for large increases in productivity are perceived to come from changing how care is delivered, for example, coordinating care more effectively so that fewer services are needed for a hospital stay. Many have embraced moving toward value-based payment to both motivate and reward providers that succeed in achieving efficiencies in delivering an episode of care or meeting all of a population's needs over a period of time. This means employing payment approaches such as bundled payment or accountable care organizations.

While there has been enthusiasm for these approaches among providers, payers, and policy makers, progress in achieving significant savings to Medicare and other payers has been slow (Chernew et al., 2020). Further progress is likely to involve better payment models, stronger incentives for providers and plans to participate, and more time for providers to revamp delivery of care.

Data from the Organization for Economic and Cooperation and Development (OECD), as reported in Papanicolas et al. (2018), show how physician earnings in the United States are far above those in 10 other high-income OECD countries and nurses' salaries are moderately higher. In 2016, generalist physicians in the United States earned 63% more than the average of the other countries, specialist physicians earned 73% more, and nurses earned 43% more. Opportunities likely exist to pay suppliers lower prices. US hospitals have tended to pay high prices for medical devices but have been achieving reductions through reducing the numbers of different devices that physicians use.

The upshot of this discussion is that obtaining lower provider payment rates cannot happen quickly. Margins are not large, so most savings will have to come from increasing productivity and from paying workers and suppliers less. A single-payer rate setter will have to proceed very cautiously, knowing that pushing too far too fast could lead to financial instability in health care delivery, risk serious problems in access for some populations in some areas, and lose political support for cost containment. This is exacerbated by the current pattern of payment rates by private insurers, where rates as a percentage of Medicare vary greatly across geographic areas (White & Whaley, 2019). So pressure on rates likely would be applied unevenly, with sharper reductions from private insurer rates in selected areas, but some pressure also applied to providers in areas with lower prices. The recent experience with the COVID-19 pandemic, which has placed many hospitals in financial peril through loss of revenue from fewer nonurgent procedures and

the high cost of treating patients infected with the virus, is likely to lead to caution in pressing providers for rapid reductions in payment rates.

The potential to substantially lower provider payment rates under a Medicare-for-All approach would be heavily influenced by political processes. The United States has long been an outlier among advanced democracies concerning government having less authority to intervene in the economy (Zohlnhofer et al., 2017). This likely reflects cultural differences in support for collective initiatives and attitudes toward the role of individuals. So less of the gross domestic product is allocated by government and regulation is less extensive in the United States.

In the Medicare program, the Congress retains a great deal of authority in many aspects of the program. For example, in what many would consider a real weakness, the Medicare benefit structure was written into the statute, meaning that it can be changed only through legislation. While in 1965, the Medicare benefit design reflected what was then the "cutting edge" of health insurance, many aspects seem anachronistic today, such as the separate deductibles for Part A and Part B and the lack of an out-of-pocket maximum. The Congress often addresses very detailed aspects of the program, in many instances at the request of numerous stakeholders that are making contributions to Members' reelection campaigns. Extensive micromanagement of the Medicare program by the Congress may reflect at least, in part, a long-standing lack of confidence by legislators to use of executive authority by the Centers for Medicare & Medicaid Services, something that I have seen even when the same party controls the Congress and the executive branch.

An argument can be made that with Medicare for All, the Congress would be more highly motivated to squeeze provider payment than it would be under an alternative in which the federal government set limits on the rates paid by private insurers—an approach that is getting increasing attention from policy analysts. If Medicare was

the sole payer, every dollar saved from lower rates would reduce the budget deficit by that amount. But if private insurer rates were limited, it would affect the deficit through increased revenues. Since most of private insurance is provided by employers, premiums reductions would likely lead to smaller employer contributions and higher wage rates for employees. Since the former component of compensation is not taxed, using average marginal tax rates for employed populations, for every dollar in lower premiums, federal revenues would increase by 32 cents. So this would mean that policy makers might be more motivated to reduce payment rates in single-payer Medicare than in private insurance.

But my sense of recent history of Medicare policy on payment rates for different types of providers suggests that other considerations may be more important. For Medicare, payment rates for hospitals and physicians appear to be fairly stringent while those for post-acute care providers appear quite generous. For hospitals, MedPAC estimates that the Medicare margin in 2018 was  $-9.3\%$  (MedPAC, 2020). While margins cannot be calculated for physician practices, physician fees in Medicare have lagged the Medicare Economic Index, which measures input price changes, since early in the 2000s as a result of the sustainable growth rate formula and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which replaced it. Nevertheless, MedPAC has consistently reported that access for Medicare beneficiaries is good.

In contrast, Medicare margins for many post-acute care providers are very high. MedPAC (2020) estimates that Medicare margins in 2018 of  $10.3\%$  for freestanding skilled nursing facilities (SNFs),  $12.6\%$  for hospices,  $14.7\%$  for inpatient rehabilitation facilities, and  $15.3\%$  for home health agencies. Such margins are extremely high and have been so for many years. Could it be that policy makers feel less constrained for services for which a lot of the payment is coming from pri-

vate insurers? In contrast, most of post-acute care provider revenues are from Medicare patients.\* This raises the possibility that with Medicare responsible for all patients, policy makers might be much more concerned with rates being high enough to keep providers financially viable. This may be where the US political system, with more restraint on government power and being more open to stakeholder lobbying, may not be equipped to set low payment rates and press them still lower over time as providers are able to achieve further cost reduction under a Medicare-for-All approach.

In conclusion, it would not be wise to assume that a Medicare-for-All approach in the United States could quickly bring payment rates for those patients now covered by private insurance down close to Medicare rates. Achieving the provider productivity gains needed to keep providers financially viable with much lower payment rates would take a great deal of time, as would cutting real wage rates for large numbers of health care workers. And there are real doubts about the degree to which US policy makers would press substantial rate reductions on a sustained basis. Other relevant factors include the potential to achieve a large part of the administrative savings envisioned under single-payer approaches by innovations that appear potentially close to being feasible under the current multipayer approach in the United States. Finally, a portion of the price reduction that might be achieved under a single-payer approach might be achieved through rate limits in a multipayer system, something that, although politically challenging, might be easier to achieve than Medicare for All.

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\*An exception is SNFs where a large portion of revenue in many facilities comes from Medicaid, which pays for a lower degree of acuity but at very low rates. With Medicare being the more attractive payer, federal policy makers may feel pressure to pay higher Medicare rates to keep the facilities open.

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