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Financial Sustainability

Discussions of Reformed Payment Systems Re-emerge as a Single-Payer Proposal Fails Again in California

The Buzz This Week

California's proposed single-payer health system has flopped—again—reigniting discussions around health reform and alternative payment models in the U.S.

In 2017, the California (CA) Senate passed a bill for a single-payer system, which didn't pass in the state Assembly, primarily because it did not include a plan for funds to cover the \$400 billion annual cost. More recently, the bill was revised to include sizeable tax increases that would cover the cost. The tax increases sparked much opposition on both sides of the political aisle, and ultimately the bill was not presented for a vote in the CA Assembly. The author of the bill, San Jose Assemblyman Ash Kalra, stated in a recent Wall Street Journal article, "I don't believe it would have served the cause of getting single payer done by having the vote and having it go down in flames and further alienating members."

A single-payer system means an entire population of a state, territory, country, or age group (e.g., Medicare) shares one health insurer, typically managed by the local, provincial, or federal government. This model should not be confused with "socialized medicine," through which the government not only oversees health insurance for the entire population but also the healthcare delivery system.

Many have studied and analyzed single-payer systems, including renowned Princeton University professor and scholar in healthcare economics, Uwe Reinhardt (b. 1937, d. 2017). In a slightly dated but still very relevant piece in the British Medical Journal, Reinhardt articulates the pros and cons of the single-payer system:

Pros: Single-payer systems support more fair and equitable access to healthcare for all citizens, regardless of a person's/patient's socioeconomic status. Providers are not incentivized to favor higher-paying patients covered by commercial insurers and de-prioritize lower-paying patients like those covered by Medicaid. In addition, single-payer systems are administratively simpler on the payer and provider side. Overhead costs for administrative activities are typically lower with single-payer systems, leaving more funds for healthcare delivery.

Cons: Single-payer models give substantial market power to the payer, which—like any monopolistic economic scenario—can introduce asymmetry in suppliers (providers) and buyers (the single payer). This could potentially put providers in a position of financial risk. In addition, if the single-payer system is overseen by a government, as is most often the case, budgetary challenges and political dynamics can impact payment rates and coverage, introducing instability and political risk.

A single-payer system is not a new concept—the model currently exists in several other countries including the Canada and Taiwan and is often cited as a constructive path forward for the U.S. However, the concept has been the source of much political and social debate for years if not decades.

An alternative approach to containing costs and promoting health equity across socioeconomic groups has been the all-payer model, currently present in Maryland and Vermont. The model in Maryland, first established in 1977, has evolved over time but essentially mandates a reimbursement rate-setting system for hospitals. Payers reimburse hospitals the same amount for a service regardless of which hospital provided the service. In terms of lowering healthcare expenditures overall, it has resulted in successes and failures over the years. Vermont introduced an all-payer, voluntary ACO model in 2017, with goals of containing costs, improving quality, and maintaining patient choice. The goal of cost savings may be challenging in VT given that the state has comparatively lower healthcare expenditures per capita than the U.S. average. In addition, the ACO is privately managed, prompting doubts about data and outcomes transparency.

Why It Matters

While the current U.S. political and commercial climate makes it unlikely that the country will move to a single-payer system, such as the “Medicare-for-all” model often cited in the last few presidential elections, the concept continues to be discussed and considered. Though the California proposal did not move forward, the state (and others) may experiment with ways to implement such a system. Other states, like Maryland and Vermont as outlined above, are implementing alternative models in an effort to contain costs and make healthcare access and delivery more consistent.

What might be the impact of these new models on providers? Shifting from the current system in the U.S. would be complicated administratively, on the payer, provider, and patient sides. And, as Katharine London, a principal at the Center for Health Law and Economics at the University of Massachusetts Medical School, recently underscored that the devil will be in the details. "It depends on the details of how it's implemented," London stated. "I don't think how the plan is financed affects the practice of medicine necessarily. If you could change the system so doctors could practice medicine and spend time with their patients, I think that's really what doctors want."

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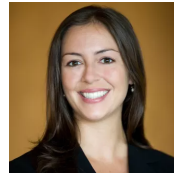
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