Beyond the Affordable Care Act: A Physicians' Proposal for Single-Payer Health Care Reform

This proposal was drafted by the 39 member Working Group on Single-Payer Program Design and has been endorsed by 2,231 other physicians and 149 medical students, who are listed at the end of this article. *[See www.pnhp.org/nhi for full list.]*

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Abstract

Even after full implementation of the Affordable Care Act (ACA), tens of millions of Americans will remain uninsured or only partially insured, and costs will continue to rise faster than the background inflation rate. We propose to replace the ACA with a publicly financed National Health Program (NHP) that would fully cover medical care for all Americans, while lowering costs by eliminating the profit-driven private insurance industry with its massive overhead. Hospitals, nursing homes, and other provider facilities would be nonprofit, and paid global operating budgets rather than fees for each service. Physicians could opt to be paid on a fee-for-service basis, but with fees adjusted to better reward primary care providers, or by salaries in facilities paid by global budgets. The initial increase in government costs would be offset by savings in premiums and out-of-pocket costs, and the rate of medical inflation would slow, freeing up resources for unmet medical and public health needs.

Introduction

In the United States the right to medical care remains a dream deferred, despite passage of the Affordable Care Act (ACA). The U.S continues to spend strikingly more on health care than other industrialized nations,[1] while our health outcomes lag behind. Even with the ACA fully implemented, an estimated twenty-seven million will remain uninsured,[2] while many more face rising copayments and deductibles that compromise access to care and leave them vulnerable to ruinous medical bills.[3-9]

We propose a single-payer National Health Program (NHP) covering all Americans for all needed medical care. The design of such a program has been previously described,[10,11] but intervening developments – notably the proliferation of large integrated delivery systems – require revisions.

The NHP can be conceptualized as an expansion of Medicare to the entire population, with correction of that system's deficiencies – most glaringly, high cost sharing, limitations on coverage, and subcontracting to wasteful private plans. By dramatically reducing administrative costs and other inefficiencies, the NHP could eliminate both uninsurance and underinsurance without any increase in overall health care expenditures. It would sever the problematic link between employment and insurance, and minimize patients' and physicians' paperwork burden. Although the system we envision would be publicly financed, it would rely largely on existing private hospitals, clinics and practitioners to provide care. However, because investor ownership of health care providers is known to compromise quality and divert funds from clinical care to overhead and profits,[12-14] the NHP would not include such providers. Following are the essential features of the proposed system.

Coverage

A single-payer NHP would cover every American for all medically necessary services, including mental health, rehabilitation and dental care, without copayments or deductibles. Covered services would be determined by boards of experts and patient advocates; ineffective services would be excluded from coverage.

Patient cost sharing blocks access to vital care (e.g. by delaying care for patients with myocardial infarction); reduces adherence to medications; and selectively burdens the sick and the poor.[5,15-19] Moreover, cost sharing has proven ineffective at containing system-wide costs, in part because collecting and tracking co-payments and deductibles entails substantial administrative effort and cost.

The NHP would, like Medicare, ban private insurance that duplicates the public coverage to forestall the emergence of a two-tiered health care system, in which insurers would compete by lobbying to underfund the public part of the system. Moreover, in the NHP, as in Medicare, inclusion of the affluent would serve as an important guarantor of adequate coverage.

Hospital Payment

The NHP would fund each hospital with a "global budget," a lump sum covering all operating expenses, eliminating per-patient billing. Global budgets would be negotiated annually between hospitals and the NHP based on previous years' operating expenses, changes in demand and input prices, and proposed service enhancements. Global budgets would cover operating expenses, but could not be used for expansion or modernization, which the NHP would fund separately through explicit capital allocations. Nor could operating funds be used for advertising, profit, or bonuses. For-profit hospitals would be converted to nonprofit governance and their owners compensated for past investments. In some instances, the NHP might fold hospital budgets into global operating budgets paid to non-profit or public integrated systems that provide primary through tertiary care.

At present, hospital CEOs anticipate their institution's budget for the upcoming year, but garner funds from thousands, even millions of individual transactions. Hospital billing offices tabulate lengthy itemized bills and charge a multitude of payers using inefficient, complex and separately negotiated rate schedules. Current payment systems have also encouraged rampant gaming through "upcoding" (exaggerating the severity of patients' illnesses), "cherry picking" (concentrating on lucrative services for well-insured patients), and other financial maneuvering.[20] Global budgeting with separate, explicit capital allocation would provide a "cost-neutral" payment framework, minimizing hospitals' incentives to avoid (or seek out) particular patients or services, inflate volumes, or upcode. Global budgets would also eliminate hospital billing and relieve clinicians of billing-related documentation, freeing up resources to enhance clinical services. In Scotland and Canada, which fund hospitals through global budgets, administration consumes about 12% of

hospital spending vs. 25% in the U.S. – suggesting that an NHP could shift about $150 billion annually from hospital administration to patient care.[21]

Payment for Physicians and Outpatient Care

The NHP would accommodate two different modes of payment for physicians and other outpatient practitioners: fee-for-service using a simple binding fee schedule, or salaries for those working in nonprofit hospitals, clinics, capitated group practices, HMOs, and integrated health care systems.

While conventional wisdom blames the failings of our health care system (especially cost)[22] on fee-for-service incentives, every mode of payment has pitfalls. Yet other countries have found fee-for-service – as well as capitation and salaried practice – compatible with quality and cost containment, as long as the fees do not unduly reward procedure-oriented specialists compared with primary care providers. Regardless of the payment mode, the NHP would prohibit the diversion of operating revenues to profits or capital investments, and the payment of bonuses tied (either positively or negatively) to utilization or to institutional profitability. The NHP would shrink physicians' overhead expenses by simplifying (under fee-for-service) or virtually eliminating (under salaried practice) billing-related tasks.

For fee-for-service practitioners, the NHP and organizations representing the practitioners would negotiate a simple, binding fee schedule. The NHP could draw on a number of tools that other countries have found effective in countering the inflationary tendency of fee-for-service, including: monitoring for extreme practice patterns; adjusting fee schedules to attenuate discrepancies between cognitive and procedural care; enforcing regional caps on fee-for-service payments; and facilitating education on low-value medical interventions.

Practitioners could also choose salaried practice in non-profit globally budgeted providers such as hospitals, clinics, group practices, etc. Where appropriate, the global budget could include funding for community programming (e.g. needle exchange programs or school-based services) not attributable (or billable) to individual patients.

Integrated health care systems would also employ salaried practitioners. In such systems, hospitals might be paid through a separate global budget, or through a unified global budget for the entire organization. Integrated provider networks and accountable care organizations (ACOs) offer potential benefits, but also the threat that they will exploit oligopoly market power to drive up costs and profits, and pressure physicians to help achieve these goals. Hence, the NHP would allow, even encourage integrated systems, but would mandate that regionally dominant systems be publicly controlled.

Long-Term Care (LTC)

The NHP would fund the full spectrum of LTC for the disabled of all ages. Local public agencies employing expert panels of social workers, nurses, therapists, and physicians would assess eligibility and coordinate care. These agencies would receive a global budget from the NHP to LTC for all individuals within their catchment area. They would contract with individual caregivers, as well as nonprofit and public agencies and facilities. Alternatively, integrated provider organizations could receive an augmented capitation fee or global budget to provide LTC as well as acute care services.

Countries such as Japan and Germany with universal LTC coverage provide more and better care, yet spend no more than the U.S.[23] The NHP would emphasize LTC provided in patients' homes and communities rather than institutions.

Health Planning and Explicit Capital Funding

The NHP would fund all major capital investments through explicit appropriations. Regional health planning boards would allocate capital funds for new facilities and expensive new equipment based on medical need, project quality and efficiency. Private donations for projects that would entail increases in NHP operating expenses would be proscribed.

When capital funding and operating payments are combined in a single revenue stream, as is now the case, profitable health care institutions are able to expand and modernize, regardless of medical need, while those with less favorable bottom lines fall further behind. Too often, profitability reflects not efficiency or quality, but the avoidance of unprofitable patients and services, a willingness to game payment systems, and the exercise of market clout. As a result, the implicit capital allocation process has created both medical deserts – areas of great need and few resources – and lavish, often redundant medical palaces that compete for lucrative patients and are tempted to provide unneeded care.

Planning should also assure that training programs produce an appropriate mix of health professionals. Residency programs (already publicly funded) must train generalists and specialists in proportions that reflect societal needs. Currently, debts incurred by medical students are, over the long run, paid off from medical salaries and fees, and skew students' career choices toward high-income specialties. Instead, we advocate that the NHP fully subsidize the education of physicians, as well as that of nurses, public health professionals and other health care personnel.

Medications, Devices, and Supplies

The NHP would cover all medically necessary prescription medications, devices and supplies. It would directly negotiate prices with manufacturers, producing substantial savings. An expert panel would establish and update a national formulary, which would specify the use of the lowest cost medications among therapeutically equivalent drugs (with exceptions where clinically required).

Full drug coverage is an essential component of an NHP. Copayments reduce adherence to medications and worsen clinical outcomes. The NHP would, like other large purchasers, use its market clout and formularies to negotiate lower drug prices

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with manufacturers. For instance, the Veterans Administration pays only 56-63% as much as Medicare does for drugs,[24] because Medicare is prohibited from negotiating for lower prices.

Cost Containment

A single-payer system would trim administration, reduce incentives to over-treat, lower drug prices, minimize wasteful investments in redundant facilities, and eliminate almost all marketing and investor profits. These measures would yield the substantial savings needed to fund universal care and new investments in currently under-funded services and public health activities – without any net increase in national health spending.

Private insurers' overhead currently averages 12.0%,[26] as compared with only 2.1% for fee-for-service Medicare.[27] The complexity of reimbursement systems also forces physicians and hospitals to waste substantial resources on documentation, billing and collections. As a result, U.S. health care administration costs are about double those in Canada, where the single-payer system pays hospitals global budgets and physicians via simplified fee schedules. Reducing U.S. administrative costs to Canadian levels would save over $400 billion annually.[25]

Funding

Total expenditures under the NHP would be limited to approximately the same proportion of GDP as the year prior to its establishment. While the needed funds could be garnered in a variety of ways, we favor the use of progressive taxes in order to reduce income inequality – itself an important social determinant of poor health.

During a transition period, all public funds currently spent on health care – including Medicare, Medicaid, and state and local health care programs – would be redirected to the unified NHP budget. Such public spending – together with tax subsidies for employer-paid insurance and government expenditures for public workers' health benefits – already accounts for 60% of total U.S. health expenditures.[28] Additional funds would be raised through taxes, though importantly these would be fully offset by a decrease in out-of-pocket spending and premiums.

During the transition period, these additional public funds could be raised through a variety of measures, e.g. redirecting employers' health benefit spending to the NHP through payroll taxes. In the longer term, however, direct funding through progressive taxes would be fairer. By unburdening employers, the NHP would facilitate entrepreneurship while increasing the global competitiveness of American business.

Alternatives to NHP

The failings of our health care system have called forth a welter of other proposals for reform. All except an NHP would maintain a central role for private insurers and profit-oriented providers.

The Affordable Care Act

The ACA embodies the hopes of many for a more just health care system. Yet it will, according to the Congressional Budget Office (CBO), leave approximately 27 million Americans uninsured,[2] in part reflecting some states' refusal to expand Medicaid. Nor will it eliminate underinsurance. Disturbingly, the ACA has facilitated the imposition of new out-of-pocket costs on Medicaid recipients, and the skimpy coverage provided by many of the plans sold through the exchanges codifies the trend towards higher cost sharing for the privately insured.

While the law laudably reduces copayments and deductibles for some families with incomes 100-250% of poverty, the financial burden on the middle class will remain high despite the recent (and likely temporary) deceleration in health care inflation. Bronze plans purchased through the exchanges cover, on average, only 60% of enrollees' expenses, with families expected to bear out-of-pocket costs (on top of premiums) of up to $13,200 annually for covered services. Moreover, care obtained outside of the narrow provider networks provided by many exchange plans is neither covered nor applied to the out-of-pocket cap.

Unlike an NHP, expanded coverage under the ACA will increase bureaucracy. In the decade ahead, the law will funnel an estimated $895 billion in new federal subsidies2 (and billions more in premiums paid by families) to private insurers, reinforcing their grip on care, and wasting billions on their overhead. Much of the $700 billion in new Medicaid spending will also flow through private managed care firms. Overall, government actuaries predict that the reform will boost insurance overhead by $265.8 billion between 2013 and 2022.[29]

Accountable Care Organizations (ACOs)

ACOs are now widely promoted as a solution to our health care problems. These organizations combine groups of medical providers and hospitals that, in the words of the Center for Medicare and Medicaid Services (CMS), "come together to give coordinated high quality care … while avoiding unnecessary duplication of services."[30] Proponents argue that aligning the financial incentives of insurers and providers will upgrade quality and motivate providers to be thrifty. Under ACO arrangements, insurers offer bonuses to hospitals and medical groups if they reduce health care costs, and (under some arrangements) penalize them when costs exceed targets. Like the HMOs of a previous era, ACOs invert fee-for-service incentives to provide excess care, instead offering rewards for reducing care. To counter the obvious risk that these inverted incentives may lead to the denial of needed care, ACO payment schemes invariably mandate extensive reporting of quality indicators, and withhold some payments unless quality targets are met.

Unfortunately, experience warns that quality monitoring may not protect patients in a profit-driven medical environment. Such monitoring figured prominently in the seminal HMO proposal[31] that preceded the well-documented abuses of the 1990s. Even today, quality measurement remains rudimentary, with quality indicators assessing only a small slice of care, and

providers routinely "game" (and sometimes even falsify) quality metrics.[32]

Claims of cost savings are also suspect. Initial results from Medicare's Physician Group Practice Demonstration (PGP) suggested savings of 1.4% below expenditure targets.[33] But even these modest savings were called into question by the CBO's finding that PGP practices' aggressive upcoding boosted their expenditure targets, resulting in "apparent savings . . . but not actually fewer dollars spent."[34] Moreover, the PGP figures, and more recent studies reporting savings in Medicare and private sector ACO programs have ignored bonus payments to providers;[35] savings evaporate once bonuses are factored in.

Value-Based Payment and Pay for Performance (P4P)

In recent years, "value" – essentially the ratio of desired outcomes to cost – has become the preeminent health policy buzzword. Many argue that rewarding providers on the basis of the value they create for patients, rather than the volume of care they deliver, will improve outcomes, contain costs, and foster innovation.[36-38]

Unfortunately, empiric support for this approach is lacking, and it rests on dubious assumptions about measurement and motivation. In assessing outcomes, isolating the "signal" of medical quality amidst the "noise" of genetic, social and behavioral factors that influence health is almost impossible. No current or foreseeable risk-adjustment algorithm reliably accounts for the many patient factors that are beyond clinicians' control. Despite decades of effort to develop inpatient risk adjustment, four widely used algorithms yield strikingly divergent rankings of hospital mortality performance.[39] Hospitals that appear first-rate according to one algorithm can appear hazardous according to another. Similarly, even excellent doctors who care for disadvantaged patients often score poorly on quality metrics.40 The largest hospital P4P demonstrations found initial gains, but no lasting improvement in outcomes.[41-43] Systematic reviews on P4P have concluded that high-quality evidence of benefit is lacking.[44]

Conclusion

We face a historic crossroads in health care. One way would take us further down the path laid out by the ACA: down this road, millions of Americans remain uninsured, underinsurance grows, costs rise, and inefficiency and the search for profits are abetted. An alternative, market-based route, favored by conservative political leaders but not, according to surveys, by the public, would roll back the ACA's expansion of coverage, degrade Medicare and Medicaid, and reward entrepreneurs at the expense of patients.

The single-payer NHP that we advocate is a third path. It is the best way – indeed, the only practical way – to provide comprehensive care to all Americans that would be affordable over the long term.

Implementation will require a detailed transition process and pose novel problems; for instance, significant resources will be needed for job retraining and placement for displaced health insurance and billing workers. But those dislocations would be offset in part by increased employment in care delivery and in other sectors of the economy, since employers would be relieved of the burden of providing ever more expensive health insurance. Overall, the NHP would entail far less disruption for clinicians and patients than alternative reforms. Free choice of doctor and hospital would become the norm, not a privilege for the few. Clinicians would continue treating patients in their practices, albeit with substantially reduced paperwork and administrative expenses.

The reforms we propose would improve the fairness and efficiency of medical care, but additional measures would be needed to address other critically important determinants of health. Global warming would remain a looming threat. Policies that attenuate glaring income inequalities and assure an adequate standard of living for all Americans are essential if we are to reverse widening income-based health disparities[45]. Similarly, the stain of racial inequality and racism must be addressed if we are to achieve health for all.

While the NHP would achieve savings on administration and profiteering, the benefits of these savings can only be realized if funds are redirected to currently underfunded health priorities, particularly public health[46]. Moreover, many problems within medical care would remain. Regional health planning and capital allocation would make possible, but not assure, fair and efficient resource allocation; quality problems would persist; and areas such as long term and mental health care, and substance abuse will require new and creative solutions. Although an NHP would not solve these problems, it would establish a framework for addressing them.

Over the past century, myriad health care reforms – most well-intentioned – have been proposed and attempted. Yet continued reliance on private insurers and profit-driven providers has doomed them to fail. It is time to chart a new course, to change the system itself. By doing so, we can realize, at last, the right to health care in America.

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