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Moving Forward From the Affordable Care Act to a Single-Payer System

For almost a century, efforts to achieve universal health care in the United States raised hopes, fears, and prodigious lobbying, but yielded little beyond Medicare and Medicaid. In 2010, the Affordable Care Act (ACA; Pub L No. 111–148) ushered in a new era of reform. Last year, the Supreme Court upheld the legality of the ACA subsidies, rejecting the last serious legal challenge to President Obama's signature health care legislation. "[W]e finally declared," Obama said after the *King v. Burwell* decision, "that in America, health care is not a privilege for a few, but a right for all."

But was that the message? There's reason for skepticism. A decade from now, according to the Congressional Budget Office, 27 million Americans will remain uninsured despite full implementation of the law. Many more are underinsured or constrained by "narrow networks" of providers that limit choice and rupture longstanding therapeutic relationships. Doctors and nurses contend with growing requirements for mind-numbing electronic documentation[1] in a health care marketplace increasingly tilted toward giant insurers and hospital conglomerates that amass power through consolidation. Finally, the system's administrative complexity, which robs patients and providers of time, money, and morale, was further fueled by the ACA.

There is an alternative. Over a decade ago, three of us, together with many colleagues, published a detailed proposal for a single-payer national health program (NHP).[2] Recently, single-payer reform has reemerged in the context of the presidential primaries. While the need for such reform has not diminished, the ACA has shifted the health care landscape. For that reason, we have developed an updated proposal (available as a supplement to the online version of this editorial at http://www.ajph.org) that has thus far attracted the endorsement of more than 2200 colleagues. (Other health professionals are invited to add their endorsement at: www.pnhp.org/nhi.)

Here, we summarize the proposal, with an emphasis on how it would remedy the persistent shortcomings of the current health care system.

COVERAGE

Unfortunately, the ACA falls short in terms of both universality and comprehensiveness. Fewer than half of America's uninsured residents have gained coverage, and underinsurance remains ubiquitous. Employers seeking to restrain their health benefit costs have tripled deductibles since 2006,[3] and the ACA's excise tax on expensive "Cadillac" plans—recently postponed until 2020—is poised to accelerate this trend. Many of the estimated 11 million Americans who have purchased plans on the ACA's exchanges face punishingly high copayments and deductibles, which average more than $5300 in Bronze plans. Such underinsurance often compromises access to care and financial well-being. In 2014, 36% of nonelderly adults skipped needed care because of cost (down from 41% in 2010),[4] and more than half of all overdue debts on credit reports were medical.[5]

A single-payer NHP, in contrast, would provide comprehensive coverage without copayments or deductibles to everyone in the country, replacing our current complex and wasteful patchwork of coverage.

All medically necessary services would be covered, including inpatient, outpatient, and dental care, as well as prescription drugs. The NHP would also cover long-term care, a benefit that few Americans currently enjoy.

COSTS

The ACA's very name reflects the hope that it would, at long last, bring health costs under control. The experience of recent years seemed to provide cause for optimism: five years of relatively low spending growth coincided with the law's passage and implementation. However, the slowdown began before the ACA's enactment, suggesting that the deep recession was at least partly responsible, and that full economic recovery would rekindle medical inflation. Recent figures suggest that this is, indeed, happening.

The resumption of health care inflation should not be surprising, since many of the ACA's cost-control provisions rest on scant evidence. For instance, many hoped that replacing fee-for-service with capitation-like reimbursement—the Accountable Care Organization (ACO) strategy encouraged by the ACA—would spur providers to improve coordination and efficiency, thereby lowering costs. Yet, Medicare has, to date, realized little[6] or no savings[7] from ACOs. Moreover, the ACO strategy has encouraged the consolidation of hospitals and physicians' practices into giant systems with the market leverage to demand higher prices, driving up costs for the privately insured.[8] Meanwhile, tying payment to quality metrics—thought necessary to

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prevent the denial of care in capitation-like systems such as ACOs and Health Maintenance Organizations—has elicited ubiquitous gaming of risk adjustment and quality measures,[9] which distort the data needed for fair payment and real quality improvement.

An NHP, in contrast, would shrink administrative costs, and have fewer incentives for corruption. Overall, cutting administrative spending to Canadian levels would save about 15% of national health expenditures,[10] freeing up nearly $500 billion annually for expanded and improved coverage. Significant sums would also be saved by allowing the NHP to negotiate with drug companies over prices, as do universal health programs in other advanced nations. The greater efficiency and simplicity of the NHP would curb inflation in health costs, so that cost savings would grow with time.

PAYMENT

There has been much hope (in truth, hype) that by simply changing how providers are paid, we can simultaneously lower health spending and improve quality. In reality, any method of payment can create perverse incentives in a market-based system when an ethos of professionalism and commitment is lacking. Therefore, under an NHP, we envision flexibility regarding modes of payment: physicians and other practitioners could be paid either through a streamlined, binding fee-for-service schedule or through salaries at not-for-profit hospitals, group practices or other facilities.

The NHP would pay institutional providers like hospitals and nursing homes for their operating expenses through global ("lump-sum") budgets, akin to how cities fund fire departments. By eliminating per-patient billing, the administrative savings from such a change would be enormous. Operating funds could not be diverted to profits, advertising or capital investments. Instead, the NHP would fund modernization and expansion projects through separate, explicit capital grants targeted to community needs, rather than profitability.

CHOICE AND CONTINUITY

Free choice of providers and the preservation of doctor–patient relationships are threatened by our current system. With each enrollment cycle, patients seeking affordable premiums or changing jobs must often switch insurers and risk breaking existing relationships with providers.

An NHP, in contrast, would do away with narrow networks, replacing them with one large network that allows free choice of hospital and clinician, thereby eliminating involuntary turnover and preserving therapeutic relationships.

CONCLUSIONS

Despite the ACA, many serious problems remain in American health care. Uninsurance and underinsurance endure, bureaucracy is growing, costs are likely to rise, and caring relationships take second place to the financial prerogatives of health insurers and providers. A single-payer NHP offers a salutary alternative, one that would at long last take the right to health care from the realm of political rhetoric to that of reality. AJPH

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REFERENCES

1. Friedberg M, Crosson FJ, Tutty M. Physicians' concerns about electronic health records: implications and steps towards solutions. *Health Affairs Blog*. 2014. Available at: http://healthaffairs.org/blog/2014/03/11/physicians-concerns-about-electronic-health-records-implications-and-steps-towards-solutions. Accessed February 17, 2016.

2. Woolhandler S, Himmelstein DU, Angell M, Young QD. Physicians' working group for single-payer national health insurance. *JAMA*. 2003;290(6):798–805.

3. Claxton G, Rae M, Long M, Panchal N, Damico A. *Employer Health Benefits: 2015 Annual Survey*. Menlo Park, CA: Henry J. Kaiser Family Foundation; 2015. Available at: http://files.kff.org/attachment/report-2015-employer-health-benefits-survey. Accessed February 18, 2016.

4. Collins SR, Rasmussen PW, Doty MM, Beutel S. *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014*. New York, NY: The Commonwealth Fund; 2015. Available at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf. Accessed February 18, 2016.

5. Consumer credit reports: A study of medical and non-medical collections. Consumer Financial Protection Bureau. December 2014. Available at: http://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf. Accessed February 18, 2016.

6. Nyweide DJ, Lee W, Cuerdon TT, et al. Association of pioneer accountable care organizations vs traditional medicare fee for service with spending, utilization, and patient experience. *JAMA*. 2015;313(21):2152–2161.

7. Rau J, Gold J. Medicare yet to save money through heralded medical payment model. *Kaiser Health News*. September 14, 2015. Available at: http://khn.org/news/medicare-yet-to-save-money-through-heralded-medical-payment-model. Accessed December 27, 2015.

8. Cooper Z, Craig SV, Gaynor M, Reenen JV. The price ain't right? Hospital prices and health spending on the privately insured. National Bureau of Economic Research Working Paper Series 2015; No. 21815.

9. Cooper AL, Kazis LE, Dore DD, Mor V, Trivedi AN. Underreporting high-risk prescribing among Medicare Advantage plans: a cross-sectional analysis. *Ann Intern Med*. 2013;159(7):456–462.

10. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *N Engl J Med*. 2003;349(8):768–775.

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PNHP note: To read the full text of the Physicians' Proposal, please turn to p. 39.