

Single-Payer & Universal Coverage Health Systems

WASHINGTON STATE INSTITUTE FOR PUBLIC POLICY

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STUDY ASSIGNMENT

The 2018 Legislature directed the Washington state institute for public policy to conduct a study of single payer and universal coverage health care systems.

The study shall:

- a) *Summarize the parameters used to **define universal coverage, single payer, and other innovative systems**;*
- b) *Compare the **characteristics** of up to **ten universal or single payer models** available in the United States or elsewhere; and*
- c) *Summarize any available research literature that examines the effect of these models on outcomes such as **overall cost, quality of care, health outcomes, or the uninsured**.*

Engrossed Substitute Senate Bill 6032, Section 606(15), Chapter 299, Laws of 2018.

INTERIM AND FINAL REPORT

Interim Report

- ✓ Universal coverage
- ✓ Single-payer health care proposals
- ✓ Potential effects of single-payer on costs
- ✓ Challenges to implementation

Final Report

- ✓ Single-payer and multi-payer universal coverage systems in other countries
- ✓ Factors driving higher costs in the US
- ✓ Mechanisms to control costs in other countries
- ✓ Comparisons of health care access, outcomes and quality of care

UNIVERSAL COVERAGE

All residents have access to necessary health services without putting themselves through substantial financial hardship.

Among similar countries, the United States alone does not provide universal health coverage.

Roughly 400,000 Washington residents (6%) remain uninsured.

To promote universal coverage, some states have considered:

- ✓ Insurance mandates,
- ✓ Extending Medicaid and Marketplace coverage to undocumented immigrants,
- ✓ State-funded subsidies to lower the cost of coverage in the individual market, and
- ✓ A public plan for individuals and small groups.

Comparison countries:

Australia
Canada
Denmark
France
Germany
Japan
Netherlands
Sweden
Switzerland
United Kingdom

SINGLE-PAYER HEALTH CARE

- ✓ Individuals with Medicaid, Medicare, employer-sponsored insurance, individual coverage, and those without insurance would automatically be enrolled in a single public plan.
- ✓ Private insurance would be eliminated or confined to supplemental coverage.
- ✓ Cost sharing would be reduced or eliminated across the board and enrollee premiums would be eliminated.
- ✓ There would be a single set of provider payment rates.

POTENTIAL EFFECTS OF SINGLE-PAYER ON COSTS

Single-payer would increase health expenditures by:

- ✓ Extending coverage to the previously uninsured,
- ✓ Reducing or eliminating cost-sharing among enrollees, and
- ✓ Providing more comprehensive benefits (e.g., dental and vision).

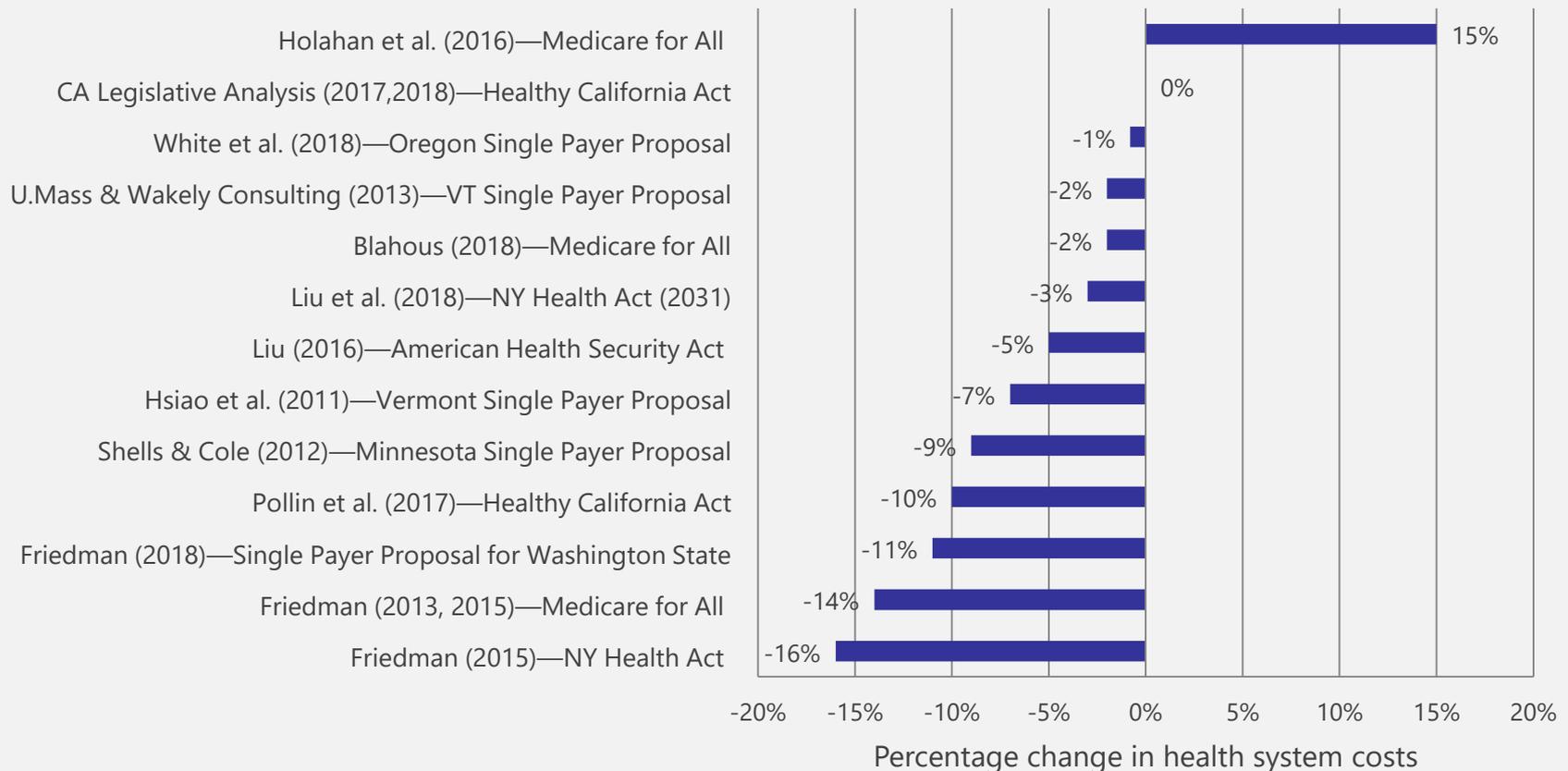
Single-payer system would likely reduce health expenditures through:

- ✓ Reduced insurer and provider administrative costs,
- ✓ Negotiated reductions in pharmaceutical prices and medical provider fees, and
- ✓ Potential promotion of cost-effective medicine.

There is uncertainty over the size and timing of these effects.

POTENTIAL EFFECTS OF SINGLE-PAYER ON COSTS

Single-Payer Effects on Health Care Costs: Percentage Change in Costs



SINGLE-PAYER FINANCING

Roughly \$55 billion was spent on medical care in 2018 for Washington residents.

About half of the spending is covered by Medicaid and Medicare. Most of the remainder is financed by employer-sponsored insurance.

Single-payer funding proposals assume that federal and state health care spending would be pooled to help finance state single-payer plans.

Employer and employee premiums, individual premiums, and cost-sharing payments would be replaced by additional tax revenue.

Friedman (2018) estimates that \$28 billion in additional revenues would be needed to implement single-payer in Washington, and this is after factoring in estimated cost savings which reduce overall system spending by 11%.

SINGLE-PAYER PROS AND CONS

Advantages

- More equal and universal access to care;
- Centralized administration; and
- Potential cost savings.

Disadvantages

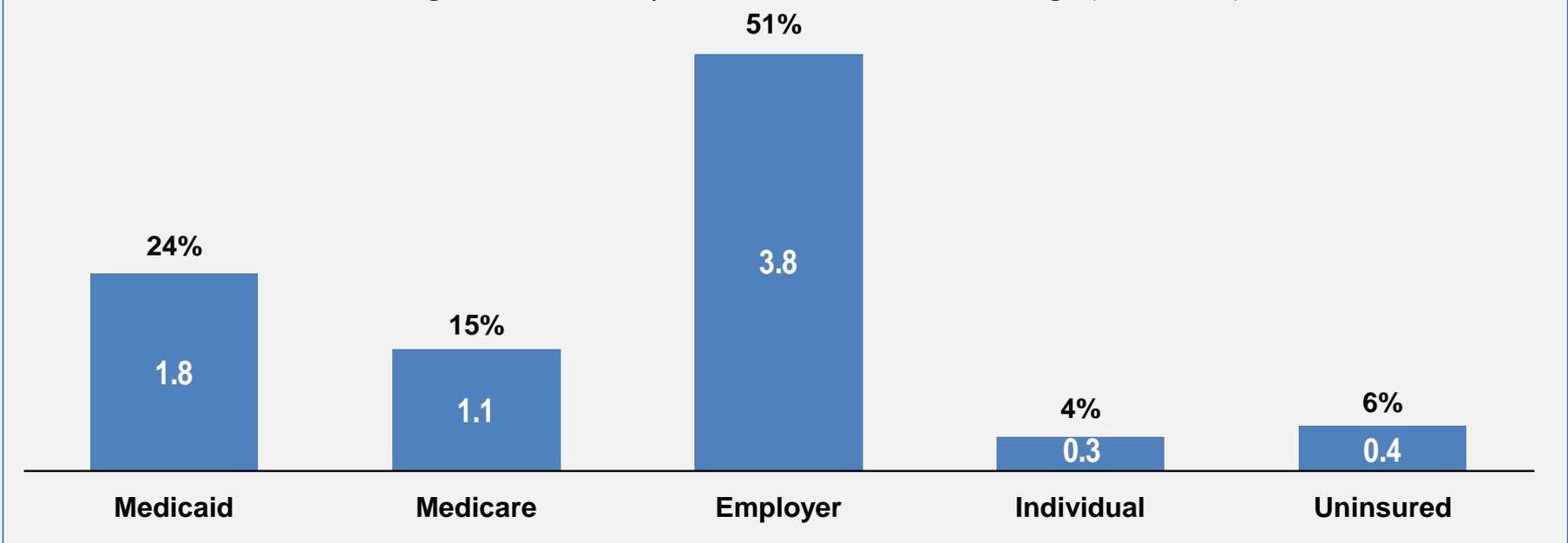
- Public concerns—higher taxes, government control, excessive rationing of care;
- Possible underfunding;
- Disruption to employment; and
- Implementation challenges.

IMPLEMENTATION CHALLENGES

Single-payer funding proposals rely on pooling federal health care spending to help pay for state plans. Gaining federal approval to do so would be a major challenge.

State single-payer initiatives are limited by the federal law regulating employee benefits, the Employee Retirement Income Security Act of 1974 (ERISA).

Washington Residents by Source of Healthcare Coverage (in millions)



HEALTH CARE SYSTEMS IN COMPARISON COUNTRIES

Single-Payer Countries

- ✓ Some have national health services—many hospitals and clinics are government-owned and many physicians are government employees (e.g., United Kingdom, Scandinavian countries)
- ✓ Others have national health insurance systems—providers are typically private and are reimbursed through a tax-financed government plan (e.g., **Canada**, Australia)

Multi-Payer Countries

- ✓ Mandatory health insurance systems (e.g., **Germany**, France, **the Netherlands**, **Switzerland**)
- ✓ Coverage administered through multiple, mostly nonprofit, insurers
- ✓ People are free to choose among insurers and can change plans – but, required to have coverage
- ✓ Insurers are required to accept all applicants
- ✓ Financing varies across countries (payroll taxes, premiums, out-of-pocket spending)

GOVERNMENT ROLES IN HEALTH CARE MARKETS

How governments intervene in health care markets varies across these countries.

However, in both the single-payer and multi-payer countries we reviewed governments play active roles in health care markets.

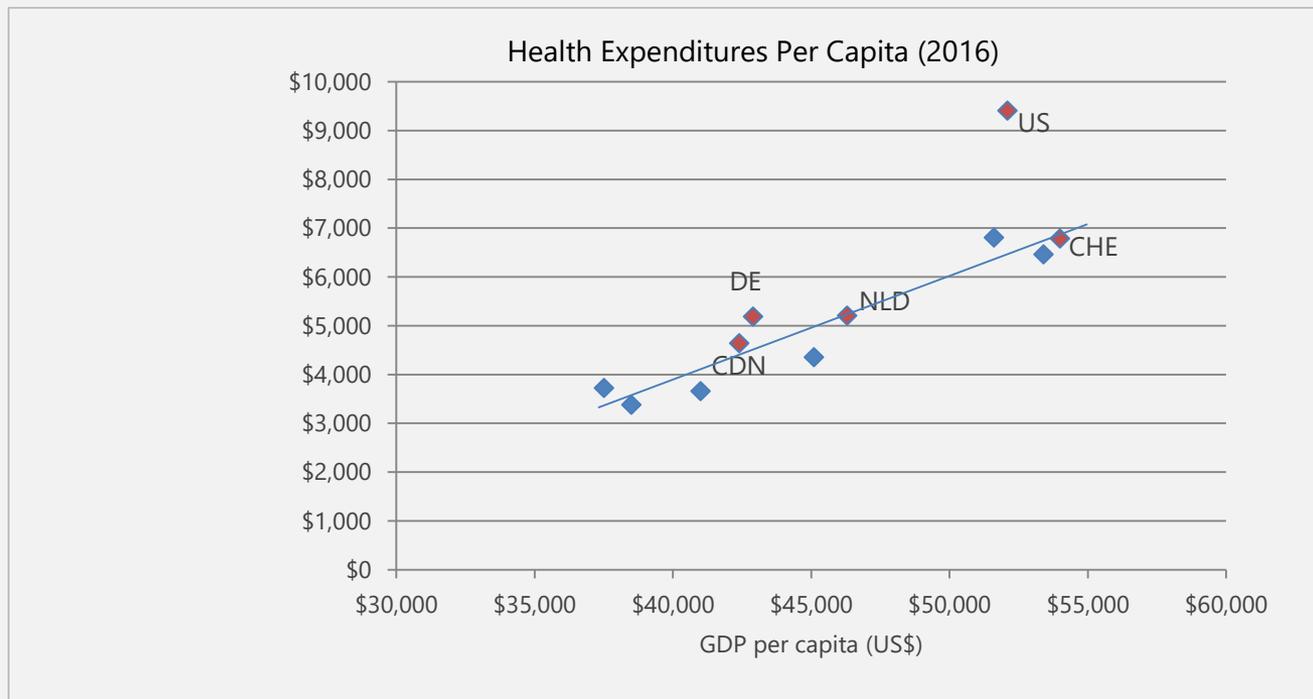
Governments:

- ✓ Regulate insurers (control margins)
- ✓ Subsidize coverage for residents with low incomes
- ✓ Determine standardized benefit packages
- ✓ Control (to varying degrees) prices of medical services and pharmaceuticals

HEALTH CARE COST COMPARISONS

High-income comparison countries—Japan, Germany, the United Kingdom (UK), France, Canada, Australia, the Netherlands, Sweden, Switzerland, and Denmark.

- ✓ US spends about 18% of GDP on health care; the other countries 11%
- ✓ US spends \$9,400 per person on health care; the other countries, on average, \$5,000



MAJOR FACTORS DRIVING COST DIFFERENCES

Higher costs in the US are largely due to:

- ✓ Higher prices of medical services and goods (with *pharmaceutical costs* playing an especially important role)
- ✓ Higher utilization of high-margin procedures and advanced imaging (CTs, MRIs)
- ✓ Higher administrative costs, and in the long-term
- ✓ More extensive diffusion of newer medical technologies and drugs with modest or uncertain effectiveness

PHARMACEUTICALS

US spends \$1,440 per person per year on pharmaceuticals versus an average of \$670 for the comparison countries.

The comparison countries have achieved lower spending through:

- ✓ Centralized price negotiations with pharmaceutical companies
- ✓ National drug formularies (i.e. a list of drugs covered by insurance)
- ✓ Cost-effectiveness research to set price ceilings for new and existing drugs
- ✓ Use of reference pricing for pharmaceuticals

Rx spending could account for roughly 21% of the total health expenditure differential.

PROVIDER FEES AND BUDGETS

Fee setting and cost control measures vary across countries.

- ✓ Some governments set fees for physician services and hospitals (through negotiations)
- ✓ Some set global budgets to control health expenditures
- ✓ Some broker collective agreements with insurers and providers on cost growth targets
- ✓ Negotiations are often conducted between insurer and provider associations at the national or regional level (rather than individual insurers and providers)

HIGH-MARGIN PROCEDURES

US has relatively high utilization of some costly procedures and tests—knee replacements, hysterectomies, cesarean deliveries, cataract surgery, coronary artery bypass, coronary angioplasty, and advanced imaging (MRIs and CTs).

Emanuel (2018)—pricing and volume of 25 high-margin procedures could explain approximately 20% of the difference in costs between the US and other high-income countries.

Advanced imaging could account for roughly 7%.

ADMINISTRATIVE COSTS

Insurer Administrative Costs (% of health expenditures)

- ✓ Single-payer countries (UK, Canada, Sweden) – 2% to 3%
- ✓ Multi-payer countries (Germany, Netherlands, Switzerland) – 4% to 5%
- ✓ US – 8%

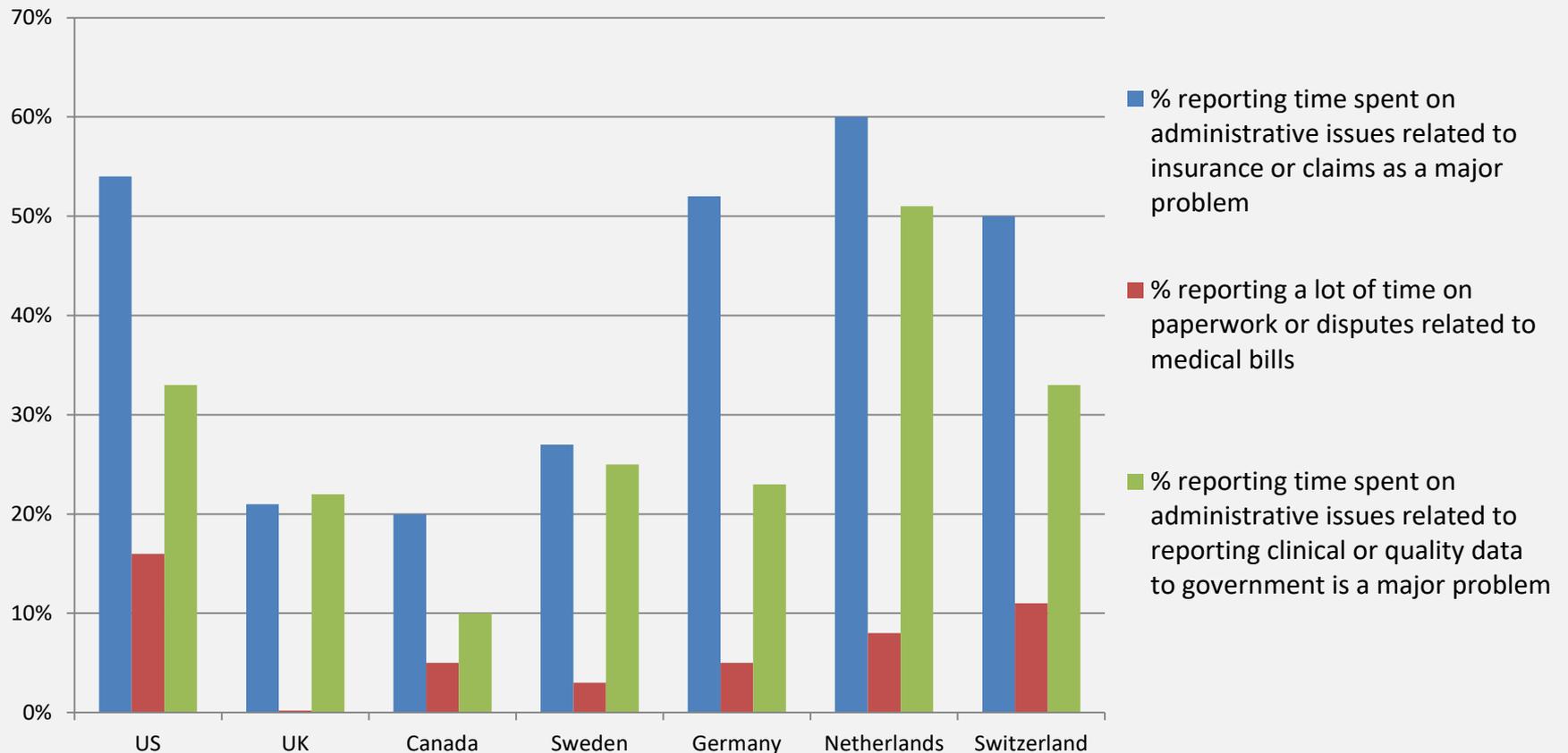
Insurer administrative costs could explain about 15% of the expenditure differential.
(This does not take into account provider administrative costs.)

Provider Administrative Costs

- ✓ Physicians and hospital administrative costs related to billing and insurance-related activities contribute to the higher health care costs in the US.

ADMINISTRATIVE COSTS

Administrative Burden Reported by Primary Care Physicians across Countries



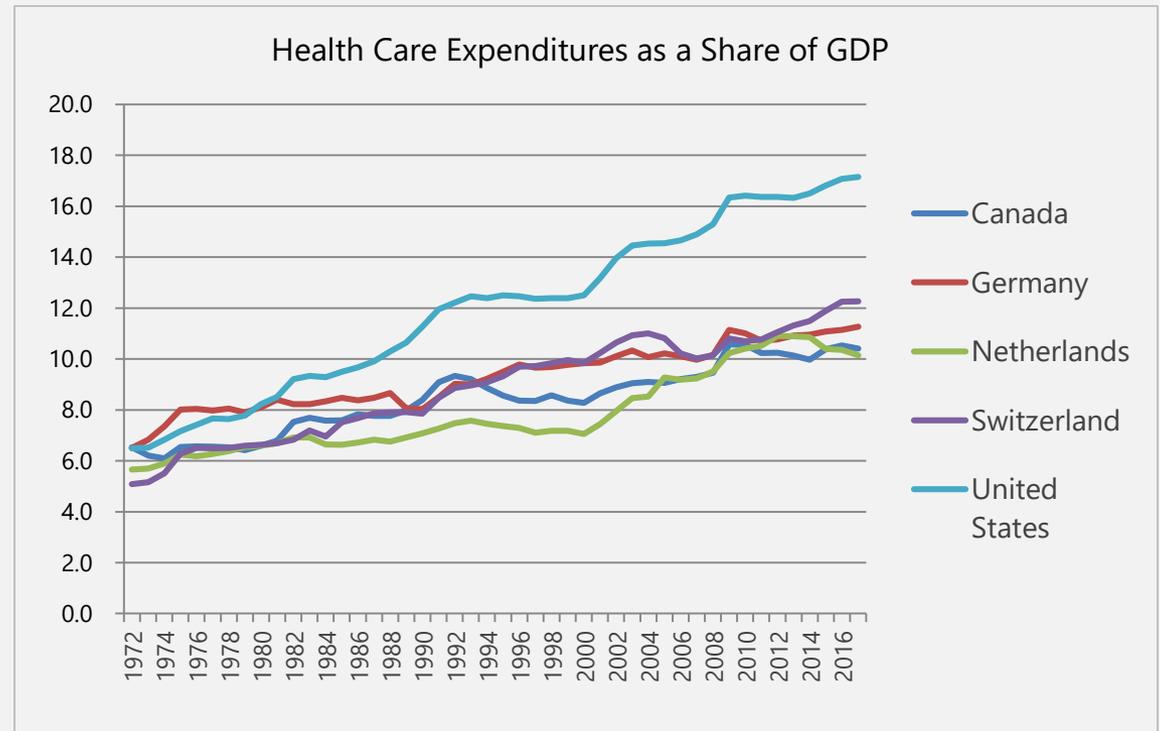
TECHNOLOGICAL INNOVATION

Economists attribute much of the long-term growth in health care costs to technological change (new devices, procedures, drugs)

Higher cost escalation in the US attributed to more rapid, and less discriminating, diffusion of new medical technologies.

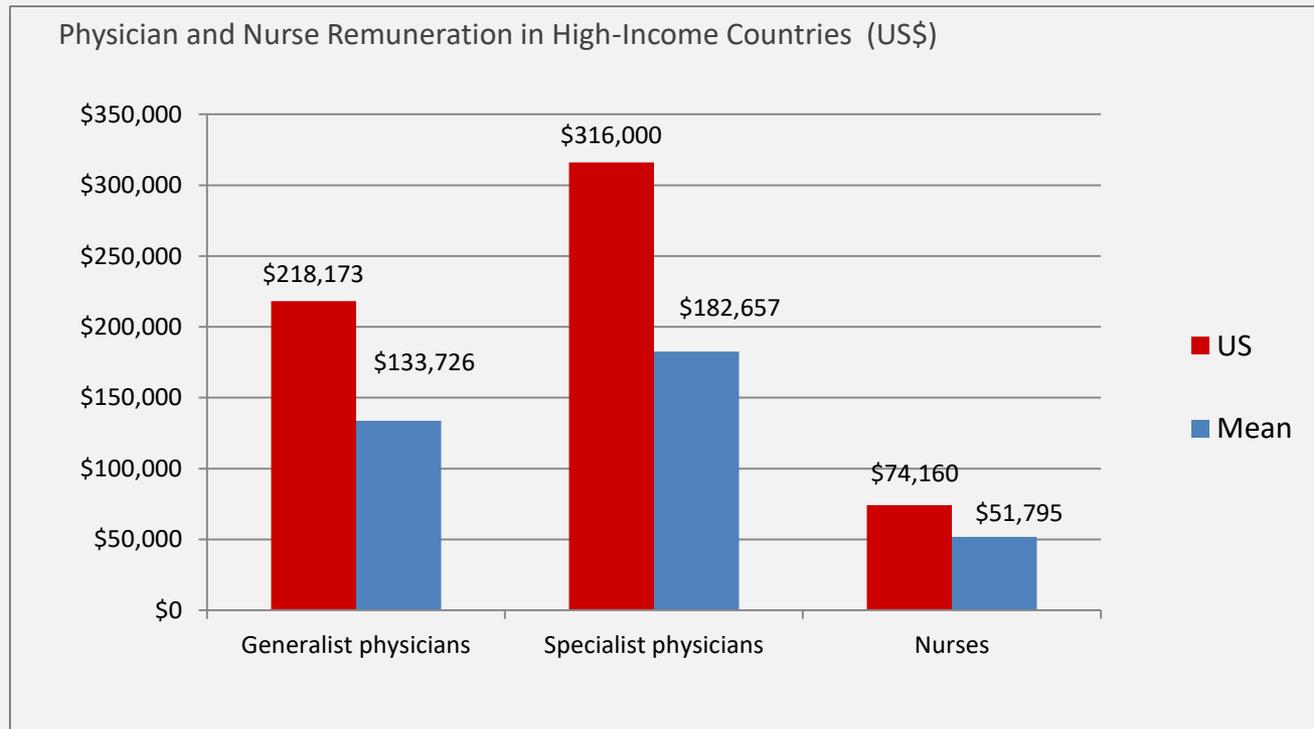
Washington State

- ✓ HCA's Health Technology Assessment program
- ✓ BREE Collaborative
- ✓ Washington Pharmacy and Therapeutics Committee

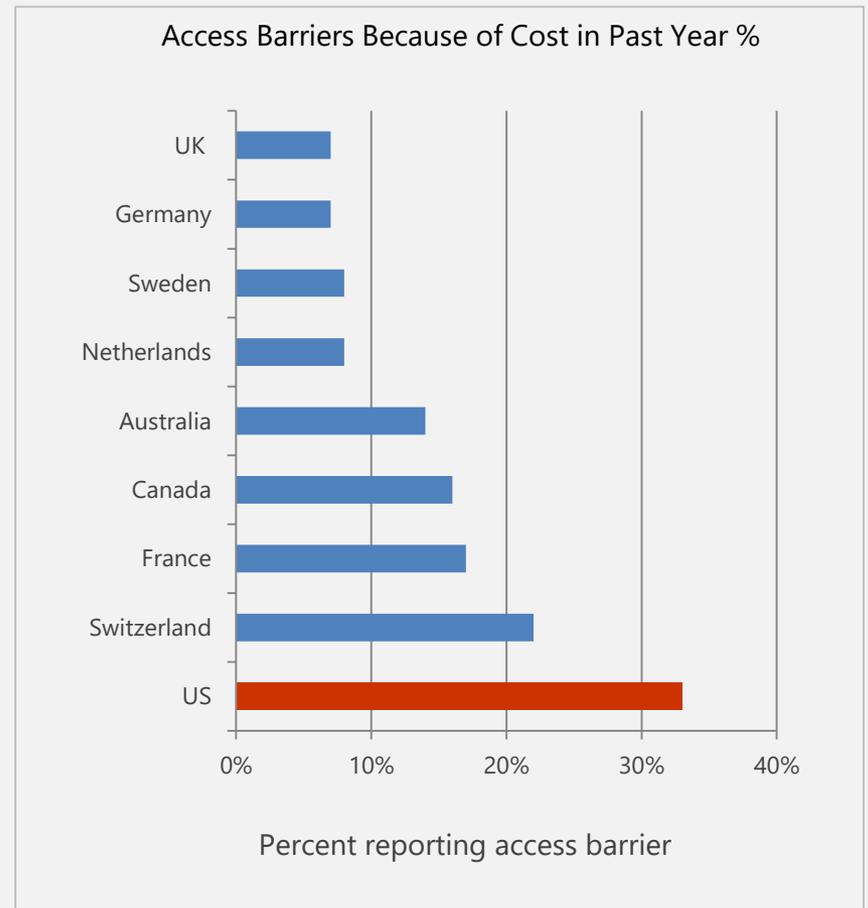
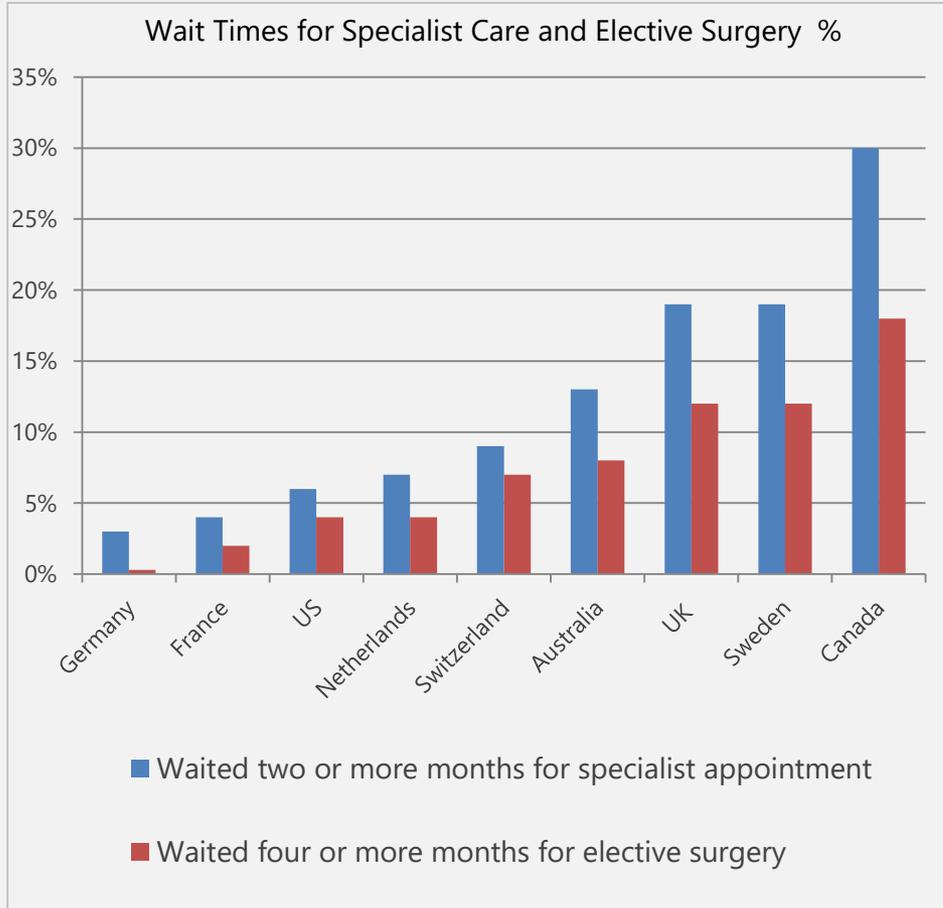


PHYSICIAN COMPENSATION

- ✓ Physicians and nurses earn substantially more on average in the US
- ✓ Variation in physician remuneration accounts for roughly 4% of the difference in overall health care spending between the US and these other countries.

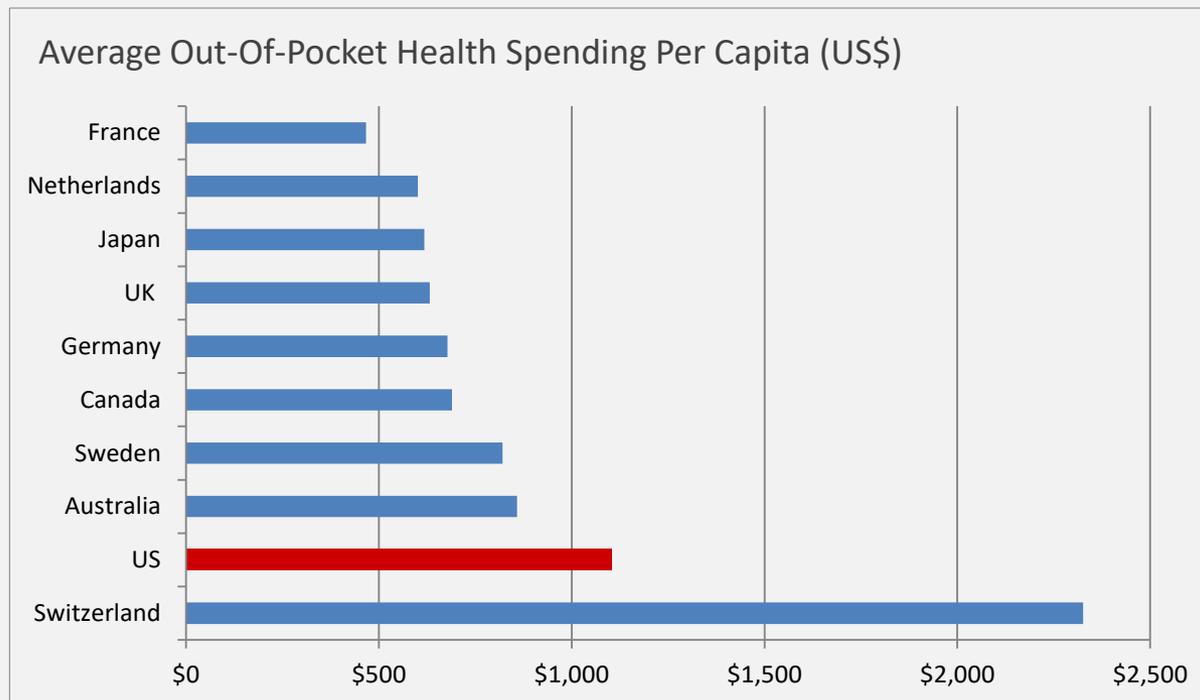


ACCESS TO CARE



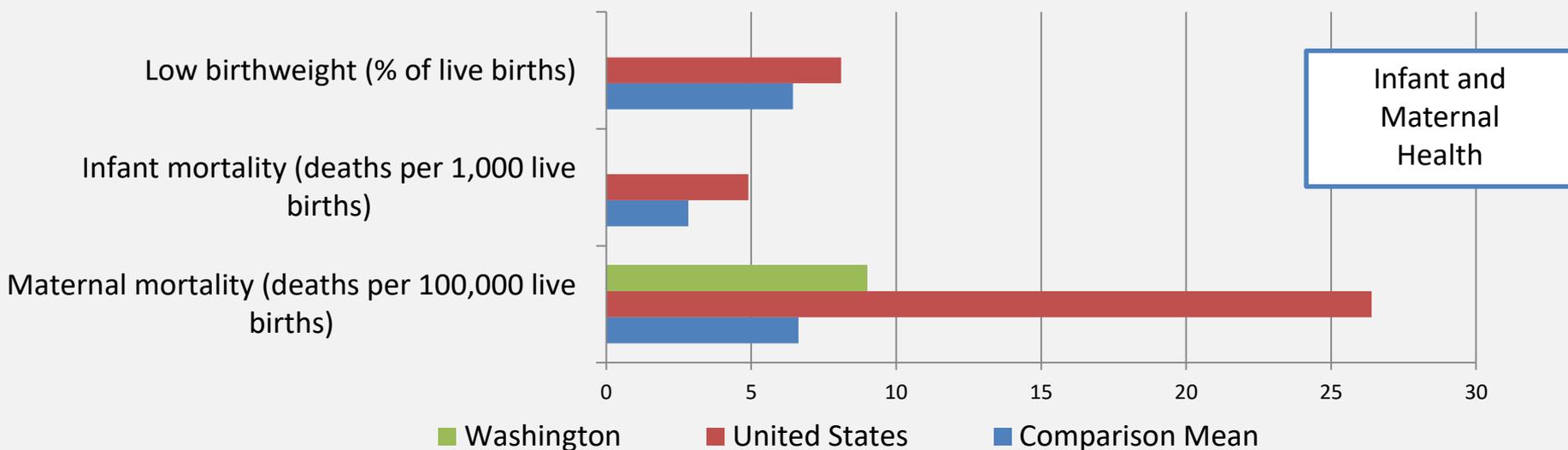
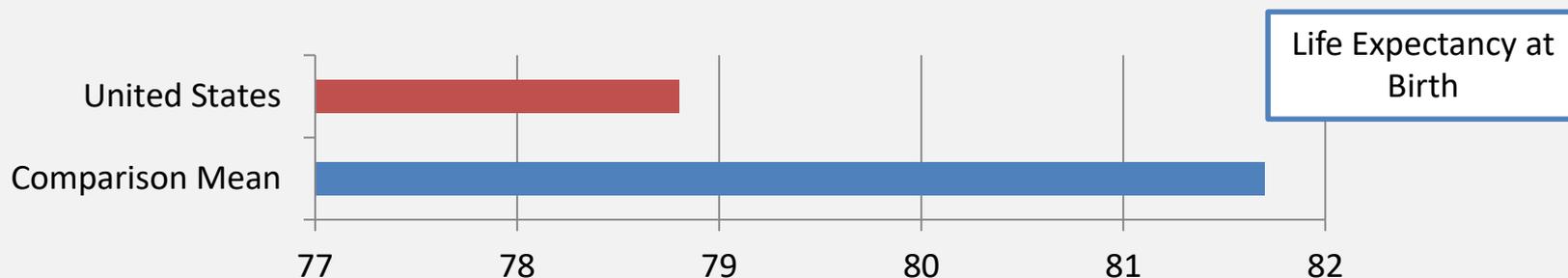
FINANCIAL BARRIERS

- ✓ Higher financial barriers in US due to out-of-pocket costs and uninsured
- ✓ Out-Of-Pocket spending is a component of health care financing in other countries
- ✓ Other countries cap out-of-pocket payments and reduce cost-sharing requirements for low-income persons, children, people with chronic diseases, and older adults



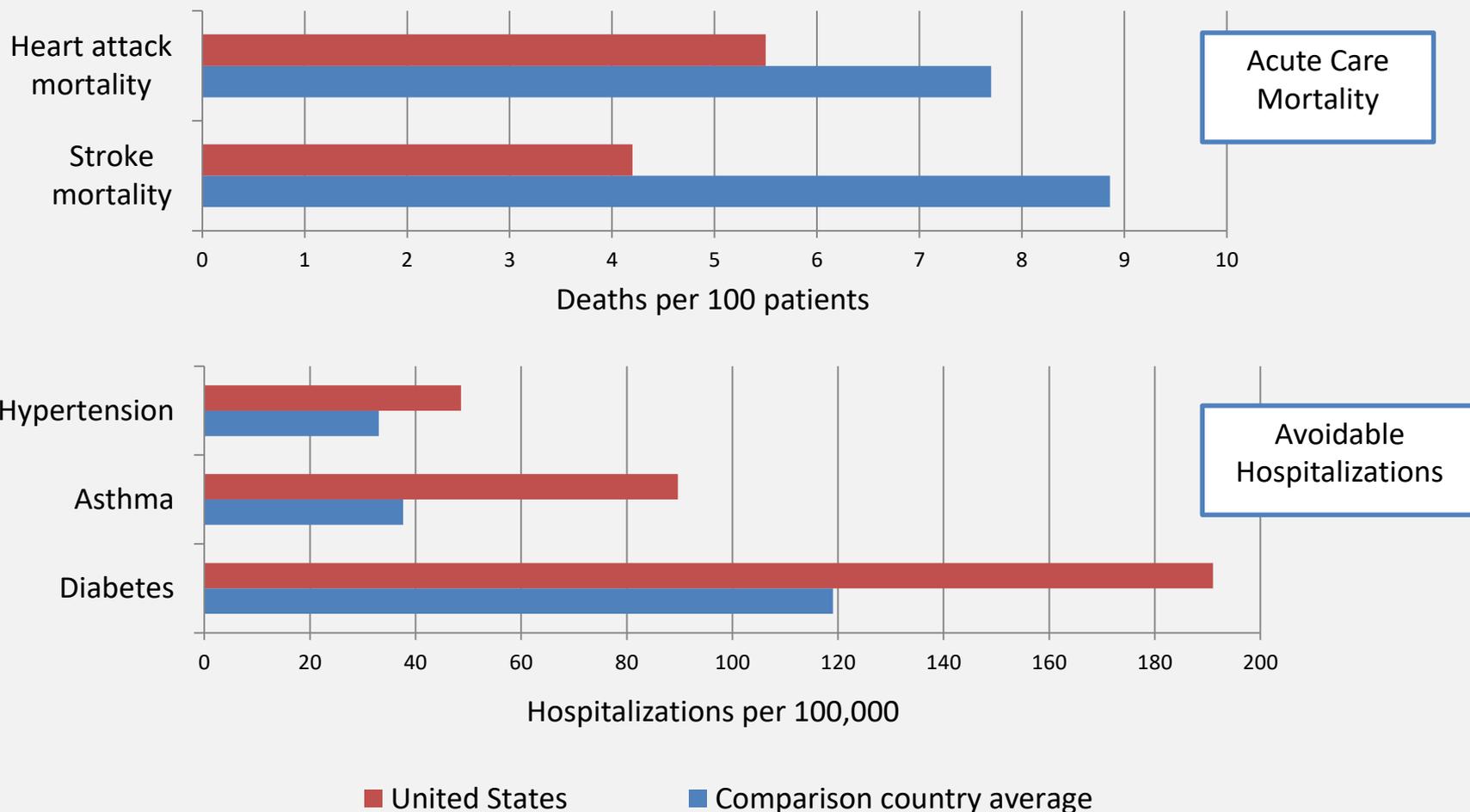
HEALTH OUTCOMES

The US performs poorly on measures of population health often cited in rankings. However, the usefulness of these and other crude measures of health is questionable.



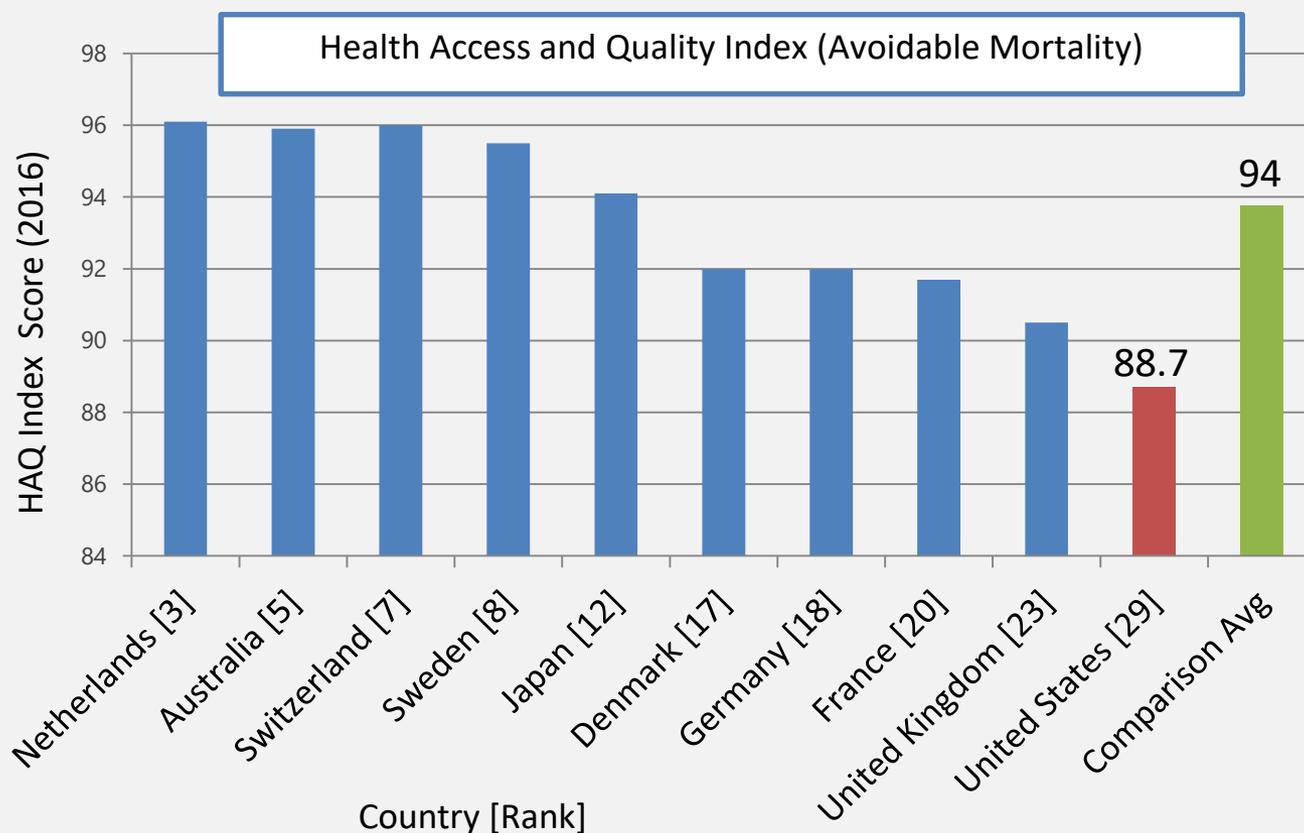
QUALITY OF CARE

The US performs well on some measures of the quality of its care and poorly on others.



QUALITY OF CARE

On a often cited summary measure—avoidable mortality—the US ranks below high-income countries with universal health care.



- HAQ index measures:
- ✓ Vaccine-preventable diseases,
 - ✓ Infectious diseases,
 - ✓ Non-communicable diseases (e.g., cancers, diabetes),
 - ✓ Maternal and child health, and
 - ✓ Gastrointestinal conditions (e.g., appendicitis)

CONCLUSION

*Assignment – summarize any available research literature that examines the effect of these models on outcomes such as **overall cost, quality of care, health outcomes, or the uninsured.***

- ✓ Higher costs in the US
- ✓ Quality of care and health outcome comparisons are mixed
- ✓ Universal coverage achieved in single-payer and other multi-payer countries
- ✓ Wait times relatively long in single-payer countries
- ✓ Financial barriers to access greater in US

It is not clear to what extent other countries' single-payer systems and universal coverage policies, governmental controls, and taxation systems are translatable to the US.

THANK YOU

Questions?