



The Pros and Cons of Single-Payer Health Plans

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One of the often-discussed proposals to reform the health care system is a single-payer plan, sometimes called “Medicare for All.” Arguments for and against are wide ranging. There is also considerable confusion as to what “single payer” means and how it might operate. For example, some people use single payer and Medicare for All interchangeably with universal coverage. Consequently, we present both a general picture of the most frequently mentioned single-payer proposal, and we delineate the advantages and disadvantages of the approach without taking a position on its advisability. Such clarification is necessary to advance a constructive debate over next steps for improving the US health insurance system. We first make five contextual points that are critical to better understanding the debate around single-payer plans, as well as our list of pros and cons.

First, we must clarify that creating a system that leads to universal coverage can be accomplished in many ways; a single-payer plan is just one approach among many. In fact, most countries with universal health insurance programs do not have single-payer plans; they largely rely on multipayer systems.¹

Second, even single-payer plans can vary in design. At their core, however, they consist of a government-designed and run insurance plan that all members of a population (e.g., a country or state) are eligible for and ultimately enrolled in. The insurance plan’s costs are financed through a system of government revenues. However, single-payer approaches can vary in which benefits they cover, the out-of-pocket costs required when enrollees use medical care, the mechanisms through which or the levels at which health care providers are paid for their services, and the sources of revenue that finance

the system. In its purest form, a single-payer approach implies one financier of health care for the population (i.e., the government), and that entity assumes all of the health care risk associated with the enrollees, meaning no other insurers are envisioned as part of the system. A single payer does not necessitate government ownership of hospitals or direct employment of physicians and other personnel but does eliminate private health insurance for any benefits covered by the new program.

National health spending (the sum of public and private spending) under a single-payer system could increase or decrease, depending on the extent to which

- the generosity of benefits covered increases relative to current coverage;
- use of services increases because of lower out-of-pocket costs and more people insured, accounting for any utilization controls;
- provider payment rates can be reduced; and
- administrative costs of insurance can be cut.

Third, the current Medicare program is *not* a single-payer plan. It is a multipayer program that includes a government-run plan, enrollee premiums, an array of private insurance options, and significant beneficiary cost-sharing requirements. Therefore, the current Medicare for All bills do *not* equate to putting all Americans into the Medicare program; they would create a new government insurance program for all Americans, eliminating all other health insurance, including the current-law Medicare and Medicaid programs. Medicare, the federal insurance program for those ages 65 and older and certain people with disabilities, has multiple components, including a range of participating private insurers. Eligible individuals can pick traditional Medicare, consisting of Parts A (hospital care), B (physician care), and D (prescription drugs), or, alternatively, Part C (Medicare Advantage). Medicare-eligible people who do not choose Part C enroll in the traditional Medicare option's Part A and are given the choice of enrolling in parts B and/or D. Each component of the program has its own applicable out-of-pocket costs; parts B and D each have associated premiums paid by enrollees but no overarching out-of-pocket maximum. Each of parts A and B are administered by the federal government as fee-for-service plans,² but part D is offered and administered by private prescription drug plans under contract with the federal government. In addition, many traditional Medicare enrollees also purchase supplemental insurance plans sold by private insurers in the Medigap market or through employer-based private insurance plans.

Those taking the Medicare Part C option do not enroll in a government-administered public plan; they choose among a selection of private insurers that operate under federal regulations and contracts. These private insurers bear risk for the health care costs of their enrollees. Some charge premiums to beneficiaries and some do not. In addition, benefits covered by the Medicare program are set in statute; they are generally comparable to the essential health benefits covered by Affordable Care Act plans, but they do not include benefits such as adult dental, vision, and long-term services and supports.³

Fourth, our pros and cons of a single-payer plan, presented below, focus on the most frequently mentioned approach to this type of reform, that championed by Senator Bernie Sanders in his 2016

presidential bid (similar to the Senate bill he introduced following that campaign, S. 1804, but which has yet to be reintroduced in the 116th Congress, and H.R. 1384, a similar bill introduced in February 2019 by Congresswoman Pramila Jayapal, which updates an earlier bill sponsored by former Congressman Keith Ellison). This approach would provide coverage for all US residents for all medically necessary care within a broad set of benefits including dental, vision, hearing, and, in H.R. 1384 but not S. 1804, long-term services and supports. There would be virtually no out-of-pocket costs for services provided, the program would prohibit private insurers from selling coverage for benefits provided through the public system, the government would reimburse health care providers at levels related to the current-law Medicare program, and one proposal would use global budgets to pay institutional providers.⁴

As noted, single-payer systems could be designed in different ways (e.g., with less expansive benefits, cost-sharing requirements, different levels of provider payments), but because the approaches of S. 1804 and H.R. 1384 are currently the focus of significant support among some presidential hopefuls and an array of vocal consumer advocates, this is the framework on which we delineate advantages and disadvantages. Many of our points could be easily adjusted to account for modified versions of this framework.

Fifth, a single-payer system would constitute a major change in the way health care is financed in the US. There would be strong political resistance to the approach from providers, private health insurers, those invested in health care systems, the pharmaceutical and medical device industries, and some people satisfied with their current insurance. The political resistance to the Affordable Care Act, a much less ambitious and decidedly more incremental set of reforms than a single-payer approach, was tremendous and has continued since its enactment in 2010. The financial stakes for health care providers, manufacturers, and taxpayers are all far larger under a single-payer system. In addition, many Americans are wary of disruption and change, and a significant segment is likely to oppose giving up what they have and know for something new and untested. Recent polls show evidence of significantly decreased support of a single-payer approach once respondents are told the plan would eliminate employer-based insurance.⁵

Pros

- **Universal coverage.** All members of the eligible population would be insured or would become insured when seeking to access health care services.⁶ Coverage would also be continuous: people would not lose coverage or need to change coverage when their jobs, family status, income, state of residence, or age change.
- **Equity.** All US residents would have the same coverage. This would go a very long way toward redressing racial/ethnic and income-related disparities in coverage and access to care.
- **Affordability at point of service.** With no premiums, no out-of-pocket costs, and a broad set of medically necessary benefits covered (including services for any preexisting conditions), the cost of care would be spread across all taxpayers. Financial burdens would no longer fall

disproportionately on those with serious health problems, and segmentation of health care risks would be eliminated.

- **Access to care.** With broad benefits and no out-of-pocket costs at the point of service, access to care would increase, particularly for those with low or modest incomes. In addition, by including benefits such as long-term services and supports, dental, and vision, even many higher-income people should have increased access to some services. In principle, improved access would tend to improve health. See below for a caveat on potential increases in demand relative to the supply of health care providers.
- **Broad-based implementation of cost-containment strategies.** With all providers and health care consumers in the same system, the potential to implement effective system-wide cost-containment strategies increases. For example, a government-run system can regulate provider payment methods and incentives that would affect all providers serving all insured people, a strategy that is substantially harder to implement in a fragmented insurance system.
- **Elimination of employer and state government administrative responsibilities and possibly spending related to providing health coverage.** With a single-payer approach, employers and state governments could dismantle the administrative structures associated with providing health insurance coverage, resulting in savings. They would also eliminate direct payments for providing health insurance coverage to their workers and residents. Changes in their overall spending related to health, however, would depend on the mechanisms financing the new program. For example, state maintenance of effort requirements and new payroll taxes would offset other savings in whole or part if used for funding.⁷
- **Simplification of current system for consumers.** Without premiums, cost-sharing requirements, or insurer-specific provider networks, individuals and families would find interacting with the health care system significantly less administratively complex. Depending on the ultimate details of the program and its associated cost-containment efforts, however, certain care management features (e.g., utilization review, prior approval) might be adopted.
- **Administrative savings relative to the current system of public and private insurance.** Private health insurer administrative costs include commissions, claims administration, premium determination, risk and profit, and other general administration tasks. Many of these costs could be reduced or eliminated, most notably commissions and risk and profit. There would also likely be significant economies of scale in claims administration when managed by a single entity. However, administrative savings could be limited by the development of systems to effectively set provider payment rates, as well as programs to monitor and maintain care quality and efficiency. Many of the administrative “middlemen” (e.g., prescription benefit managers, agents who negotiate provider panels and health insurance rebates) would be eliminated. Some private third-party administrators might remain in the system, however, to process claims (as is done in the current Medicare program).
- **Administrative savings for providers.** Health care providers currently hire administrative staff focused solely on filing claims, collecting cost sharing, addressing claims denials, and meeting

prior authorization requirements that vary significantly across multiple public and private insurers. Limiting all patients to a single insurer would greatly reduce these administrative costs incurred by nearly every provider in the nation. These administrative savings would also make reduced provider payment rates more palatable. However, these savings could be limited by the strategies the single-payer system might implement to contain costs. For example, the traditional Medicare program requires hospitals to perform utilization review functions and appeal claims denials.

- **Elimination of provider networks.** Many insurers (public and private) provide enrollees with either an exclusive or preferred network of health care providers and reimburse enrollees for these providers' services. Those with exclusive networks will not reimburse enrollees for the cost of any nonemergency care received by nonnetwork providers. Those with preferred networks generally reimburse a significantly higher percentage of health care costs provided by network providers than by nonnetwork providers. Depending on the insurer and plan, provider networks may be quite narrow. Under a single-payer approach, nearly all health care providers (especially hospitals) would be covered, offering substantially broader choices for many patients. However, as we discuss below, supply constraints could exist for some providers or provider types.
- **Elimination of surprise billing.** Under current law, each health care provider decides independently which insurers to participate with, so it can be extremely difficult for patients to identify participating providers a priori. This is particularly problematic in emergency situations, where patients do not have sufficient time to investigate provider options; it also arises when providers working on site at a hospital (e.g., radiologists, anesthesiologists, emergency room physicians) do not participate with the same insurers as does the hospital in which they work. In these cases, patients often assume that the care they receive at a network hospital is also in network, and they can be surprised by large out-of-network bills after the fact. Eliminating provider networks and applying Medicare-like prohibitions on balance billing would end such surprise billing.
- **A more equitable distribution of health care costs.** Even calculating the distribution of health care costs and benefits across people of different incomes and characteristics is an immense challenge in the current patchwork health care system. A single financing entity (i.e., the federal government) can be explicit and deliberate in distributing newly raised revenues to fund the population's health care costs.

Cons

- **Large increase in government revenue (i.e., taxes).** Some estimate that a single-payer system could increase total federal health care spending by more than 50 percent.⁸ There would be significant savings to households and employers that would partially offset the necessary increase in taxes. However, shifting nearly all private spending for health care onto the public

ledger would necessitate very large increases in government spending, and thus substantially higher taxes, cuts in other federal spending, and/or further increases in the federal deficit.

- **Possible unintended effects of a single national system of provider payments.** Cuts in hospital revenues and physician incomes could have large and widespread ramifications, and payment reductions could have implications in all health sectors. A single-payer system presumes substantial cuts relative to current private insurance levels. This would lead to large distributional effects across provider types and geographic locations. When such decisions are made for providers system wide, the consequences of setting provider payments at inappropriate levels are greater than when adjustments are made in one program or by one private insurer. In addition, the level of disruption to delivery systems would depend on the length of time allowed for decreases in payment rates to hospitals, physicians, medical device manufacturers, and prescription drug manufacturers. Additional monitoring of access and quality would be needed and would require additional administrative spending. Building in an ability to make real-time adjustments in payment policy when appropriate could be challenging.
- **The development and administration of a sizable new government entity.** Though the new program could base its administrative structure around current public programs, such as Medicare, a nationwide system would require large increases in capacity, and differences between the programs would require developing a sizable new infrastructure and operational systems. To attempt to set prices for health care services and products (e.g., prescription drugs, medical devices) appropriately, such an entity should include a monitoring and evaluation system that could account for value and incremental health benefits, both at introduction and over time. The federal government would probably have to develop new expertise and capacity to make such a system work well. This could be a positive over time but would increase the time frame and costs required for effective implementation and ongoing operations.
- **Significant administrative challenges from eliminating all current coverage and moving everyone into a new government program over a short period.** As the experience with the Affordable Care Act's original open enrollment period indicated with a much smaller segment of the population, educating people about a new system and administratively enrolling them is a substantial challenge. A single-payer system, by its nature, would not require an open enrollment period, because all health care risk would be borne by the government and everyone would be eligible. Thus, the process could naturally work slowly as people access health care providers and are enrolled simultaneously.
- **Addressing potential undermanagement of care in public insurance programs.** Though the Medicare system allocates a significantly lower percentage of its total spending to administration than do private insurers, at least some experts find that the traditional Medicare program "undermanages" the delivery of medical care to its beneficiaries (Berenson 2003; Berenson and Harris 2002). These analysts have concluded that quality of care and efficiency of delivery systems could be improved with more active management by the program. Such considerations should be accounted for when estimating the potential savings in administrative

costs achievable and desirable under a single-payer program. Plus, if care management declines, the cost of services increases.

- **Elimination of consumer choice of insurer and other benefits of competition.** With an entire population of consumers in the same insurance plan and private insurers prohibited as alternatives, consumers who are dissatisfied with the new government system could not “vote with their feet” and choose a new carrier. This could place significant pressure on the government to meet consumer needs in aggregate (see earlier concerns regarding cost-containment potential); however, it might make it more challenging for subgroups of consumers to have their needs or preferences met. Similarly, some potentially beneficial elements of competition and incentives would be lost; for example, differences in cost sharing would no longer encourage patients to use more efficient providers and providers to be more efficient.
- **Continued struggles with health care spending growth and cost-containment strategies.** Though uniform national systems better control health care spending growth, they are not a panacea, and by some measures, US spending growth (not spending levels) has been roughly average over the last two or three decades.⁹ As in other countries with a universal system, practical realities related to provider supply, demand for services, valuable technological advances, responses among manufacturers, and concerns over sufficient incentives for ongoing research and development of new treatments and technologies could frequently increase health care prices and spending faster than general price inflation. The trade-offs can be difficult, and they are not necessarily simplified by centralizing them in the government.
- **Likely persistent inequities in access.** Those with high incomes would likely continue to pay out of pocket to receive some care on terms they are more satisfied with than those of a uniform government health care system. The more this occurs, the more constraints it would place on supply in the government system. In other words, if more providers can support themselves on private-paying patients, fewer providers would provide care under the single-payer system.

Notes

- ¹ “Country Profiles : International Health Care System Profiles,” The Commonwealth Fund, accessed March 6, 2019, <https://international.commonwealthfund.org/countries/>.
- ² The traditional Medicare program for physician and hospital care is an example of what policy circles call a “public option.”
- ³ Some Medicare Advantage plans include benefits beyond those covered by traditional Medicare, to attract enrollees.
- ⁴ Global budgets provide a predetermined annual amount of funding to each hospital, leaving the hospital to assess how to distribute the funds to best provide care for those using the facility.
- ⁵ Ashley Kirzinger, Cailey Muñana, and Mollyann Brodie, “KFF Health Tracking Poll — January 2019: The Public on Next Steps for the ACA and Proposals to Expand Coverage,” January 23, 2019, <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/>.
- ⁶ These bills appear to include all residents of the United States as eligible for the program.
- ⁷ State maintenance of effort requirements are a possible reform financing strategy, where states would be required to contribute funds that approximate the level of spending they would have had under Medicaid and the Children’s Health Insurance Program, if those programs had continued. Essentially, this strategy intends to capture at least some of the savings states would have under a single-payer system.
- ⁸ Authors’ calculations based on Blahous (2018); Congressional Budget Office (2019); and Holahan et al. (2016).
- ⁹ “Per Capita Growth Rate,” Peterson-Kaiser Health System Tracker, accessed March 6, 2019, <https://www.healthsystemtracker.org/indicator/spending/growth-rate-per-capita/>.

References

- Berenson, Robert A. 2003. “Getting Serious about Excessive Medicare Spending: A Purchasing Model.” *Health Affairs* 22 (suppl. 1): W3586–W3602.
- Berenson, Robert A., and M. Harris. 2002. “Using Managed Care Tools in Traditional Medicare: Should We? Could We?” *Law and Contemporary Problems* 65 (3): 139–67.
- Blahous, Charles. 2018. “The Costs of a National Single-Payer Healthcare System.” Arlington, VA: George Mason University, Mercatus Center.
- Congressional Budget Office. 2019. *The Budget and Economic Outlook: 2019 to 2029*. Washington, DC: Congressional Budget Office.
- Holahan, John, Matthew Buettgens, Lisa Clemans-Cope, Melissa M. Favreault, Linda J. Blumberg, and Siya Ndwandwe. 2016. *The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending*. Washington, DC: Urban Institute.

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John Holahan is an Institute fellow in the Health Policy Center, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth, developing proposals for health system reform most recently in Massachusetts. He examines the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA. Holahan has conducted significant work on Medicaid and Medicare reform, including analyses on the recent growth in Medicaid expenditures, implications of block grants and swap proposals on states and the federal government, and the effect of state decisions to expand Medicaid in the ACA on federal and state spending. Recent work on Medicare includes a paper on reforms that could both reduce budgetary impacts and improve the structure of the program. His work on the uninsured explores reasons for the growth in the uninsured over time and the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments.

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